View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by National Documentation Centre on Drug Use

drugnet IRELAND
Issue 33
Spring 2010
Alcohol and Drug Research Newsletter

Directory of courses and training programmes on drug misuse in Ireland 2010
is now available online at
www.drugsandalcohol.ie/12853

To have *Drugnet Ireland* delivered to your desktop, sign up on the
NDC website at
www.drugsandalcohol.ie

→ Alcohol results from SLÁN 2007

→ Growing Up in Ireland – findings on children's exposure to drug use and alcoholism

→ Treated alcohol and drug use figures for 2008

→ Trends in alcohol and drug admissions to psychiatric facilities

→ Effective implementation of policy – lessons from Mental Health Commission report

→ Health profile of users of Cork Simon services

→ Debt-related intimidation of drug users and their families

→ Nursing in the Irish Prison Service

→ Irish Needle Exchange Forum conference

Conference on psychoactive drugs sold in head shops and on line

Mr John Curran TD, Minister of State with responsibility for the National Drugs Strategy, opened a national conference on 'legal highs' organised by the regional drugs task forces on 26 January in Mullingar. Minister Curran said that he had expressed concerns about the sale of legal highs and their possible health hazards on numerous occasions in the last year. He has asked the Minister for Health and Children, who has responsibility in relation to the importation, exportation, production, supply and possession of a range of named narcotic drugs and psychotropic substances under the Misuse of Drugs Acts, 'to ensure that every effort is made to expedite the response to this issue through the early control of substances under that Act'. He has also asked the Department of Enterprise, Trade and Employment to examine issues relating to insurance and consumer protection.

Photos: JJ Berkeley

Dr Jean Long of the Health Research Board presented a review of the availability of psychoactive drugs in head shops and on line across Europe. She said that more than 90 new psychoactive substances had been reported through the EMCDDA's early-warning system since its establishment in 1997. Until recently, phenethylamines and tryptamines accounted for a large proportion of notifications to the EMCDDA. However, since 2004, a much more diverse range of substances has become available; among these are numerous piperazine compounds, cathinone derivatives and Spice products, as well as a heterogeneous mix of other substances.

Dr Long reported that all countries in the EU had controlled the use of BZP, that eight countries had introduced controls on the use of synthetic cannabinoids (found in Spice), and that many countries were at present examining the issues pertaining to cathinone derivatives. She noted that there were reports that drug users were injecting some of the cathinone derivatives, which can lead to local infections, blood-borne viral infections and deep venous thrombosis. One of the cathinone derivatives was implicated in two deaths in Sweden.

Laboratories across Europe reported that the ingredients listed on the packaging of head shop products did not always match the ingredients found on forensic analysis, and that it was difficult to advise people about the use of such drugs when their exact chemical contents were not known. Some of the products contained synthetic rather than herbal substances.

Dr Bobby Smyth, consultant child and adolescent psychiatrist, presented some of the known and probable health-related harms associated with psychoactive drugs sold in head shops. He said that 7% of young people attending adolescent addiction services in the south west of

contents

1 Conference on psychoactive drugs sold in head shops and on line
3 Legal highs and head shops: the basic facts
3 Alcohol and drug use among young people in Ireland
7 Alcohol use in Ireland: results from SLÁN 2007
9 Exposure to illicit drug use and alcoholism among 9-year-old Irish children
10 Levels of alcohol and drug use are indicators of wellbeing
11 Rape in Ireland – what role does alcohol play?
12 FSN annual service of Commemoration and Hope
13 Treated problem alcohol use in Ireland: figures for 2008
14 Treated problem drug use in Ireland: figures for 2008
14 Trends in alcohol and drug admissions to psychiatric facilities
15 How effectively is policy being implemented?
17 Health profile of people using Cork Simon services
18 Debt-related intimidation of drug users and their families
19 Newly diagnosed drug-related viral hepatitis infections in 2008
21 Drug Treatment Centre Board pioneers nurse prescribing in addiction in Ireland
22 Legal update 2009
23 Report on nursing in the Irish Prison Service
24 Irish Prison Service annual report 2008
26 The State Laboratory annual report 2008
26 Anthrax outbreak in heroin users in the UK and Germany
27 The Irish Needle Exchange Forum conference
27 2010 Directory of training courses
28 From ***Drugnet Europe***
29 In brief
30 Recent publications
31 Upcoming events

Conference on psychoactive drugs sold in head shops and on line *(continued)*

Dublin were using head-shop drugs as part of a polydrug cocktail. Dr Smyth reported that these drugs may become another gateway drug, alongside alcohol and tobacco. He presented eight cases of individuals who had experienced adverse effects of head shop products, such as anxiety, excessive aggression, paranoia, psychosis and hallucinations. A small number of these individuals had a previous history of mental illness. He said that it is likely that these drugs exacerbate mental illness and that they were likely to negatively affect brain development in adolescents. He made the point that there were no quality control measures on the production, distribution or sale of these substances, and that, in the instances of adverse reactions, no one was accountable.

Mr Noel O'Connor of Merchants Quay Ireland spoke of the difficulty in developing harm-reduction strategies to deal with legal highs because the contents of each drug were not known or guaranteed. The substances were not rigorously tested in a controlled environment prior to selling them to the public. The ingredients were unfamiliar to the general population and it was difficult to find information on the products.

Dr Des Corrigan, chairman of the National Advisory Committee on Drugs, presented an overview of the products available in head shops, their ingredients and their effects. He said that it was common for head shops to use the Latin name of plants and chemicals in their list of ingredients. He said that a number of plants were used as stimulants and that there were many strong caffeine-based products on the market. In addition, he noted that many head-shop drugs contained piperine, the main chemical in black pepper, which increases the ability of the body to absorb the drugs.

Dr Corrigan's description of the main psychoactive drugs sold in head shops in Ireland is summarised below:

- **Ephedrine**, which is chemically similar to amphetamine, is available in head shops in the form of *Sida cordifolia*, which is not controlled in Ireland. Two other forms of the drug, Ma Hung and synthetic ephedrine, are available in Ireland only on medical prescription dispensed by a pharmacist. The producers of one product containing *Sida cordifolia* state on the packaging that they take no responsibility for any consequences associated with its use. Chemically similar to amphetamine, ephedrine can induce dependence, psychosis, high blood pressure and increased heart rate.
- **Morning glory *(Ipomoea)* and Hawaiian baby woodrose *(Argyreia nervosa)*** are listed as ingredients in a number of head-shop products that may be labelled 'not for human consumption'. Both plants contain LSA (lysergic acid amide), a relative of LSD. The side effects of LSA and related chemicals include: apathy, tiredness, decreased psychomotor activity and feelings of unreality. As a form of lysergamide, LSA is controlled under the Misuse of Drugs Act.
- ***Salvia divinorum* (divine mint)** contains chemicals called salvinorins that have a potency similar to that of LSD. Its use can lead to euphoria, feelings of levitation, out-of-body experience and, at high doses, uncontrolled delirium. The duration of its effects is short and the come-down is quick and therefore severe. It can induce mental health symptoms such as paranoia and derealisation.
- Three types of **hallucinogenic cacti** containing mescaline are sold in head shops. Their common names are peyote, San Pedro and Peruvian torch. Mescaline from peyote induces hallucinations as well as nausea and vomiting.
- **Kratom**, which contains mitragynine (an opioid agonist), is a leaf chewed in south-east Asia as a stimulant at low doses and as a painkiller or sedative at higher doses. It can cause constipation, weight loss, dependence, psychosis and withdrawal symptoms. It is not controlled in Ireland.
- **Piperazines** such as 1-benzylpiperazine (BZP), methylbenzylpiperazine, meta chlorophenyl-piperazine (mCPP) and 1-(4-fluorophenyl) piperazine are synthetic drugs with psychedelic and euphoric effects which mirror those of ecstasy. They are sold as an ingredient in recreational drugs known as 'party pills'. BZP was banned in Europe in March 2008 and in Ireland in March 2009. Other forms of piperazine are not controlled in Ireland. BZP can lead to hyperthermia, high blood pressure, fast pulse, and convulsions.
- **Spice products** are largely a mix of innocuous herbs, but six synthetic cannabinoids have been detected in the various spice products sold across Europe. Synthetic cannabinoids are more potent than the main psychoactive compound (THC) in natural cannabis, and do not contain the anti-psychotic substances found in natural cannabis. They may therefore lead to a higher incidence of psychosis associated with cannabinoid use. There is also potential for dependence. These products have been banned in eight countries across Europe.
- **Cathinone** is a naturally occurring stimulant found in the khat plant, and cathinones are a group of drugs related to amphetamine compounds. Methcathinone, methylmeth-cathinone (mephedrone) and methedrone, derivatives of cathinone, are sold as 'legal

Conference on psychoactive drugs sold in head shops and on line *(continued)*

highs' online and in head shops in Ireland and across Europe under a variety of names, such as MCAT, Snow, Charge. Some of these products are sold as bath salts or plant food. The contents listed on the package may contain the word 'ketones'. These compounds are advertised as a replacement for 'Charlie' (cocaine). Some users have reported injecting the compounds. The use of these drugs can induce anxiety and paranoia. Reports say that their use can become compulsive and can create a state of psychological dependence. Mephedrone was linked to two deaths in Sweden in 2008.

(Jean Long)

Podcasts of the presentations given at the conference are available at www.drugs.ie/media

Department of Health and Children statement in relation to legislation to be made under Misuse of Drugs Act 1977

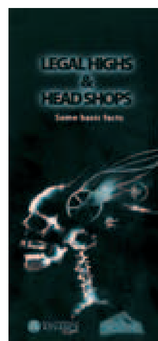
The Government agreed at its meeting on 2 March 2010 to the commencement of a notification process under Directive 98/34/EC (the 'Technical Standards' Directive) as amended by Directive 98/48/EC, of the Government's intention to make a Declaration Order under the Misuse of Drugs Act 1977 declaring certain substances, products and preparations to be controlled drugs for the purposes of the Misuse of Drugs Acts 1977 and 1984.

The substances concerned include a range of products sold in so-called 'head shops' including:

- synthetic cannabinoids (for example, Spice products)
- benzylpiperazine (BZP) derivatives
- mephedrone, methylone and related cathinones
- GBL and 1,4 BD

In addition, the Declaration Order to be made under the Misuse of Drugs Act 1977 will include Ketamine and Tapentadol which are substances that have legitimate uses as medicines but which can be subject to misuse. The Declaration Order will also cover certain narcotic and psychotropic substances which Ireland is obliged to bring under control in order to comply with the UN Single Convention on Narcotic Drugs and the UN Convention on Psychotropic Substances.
www.dohc.ie/press/releases/2010/20100303.html

Legal highs and head shops: the basic facts



In response to interest among drug workers regarding 'legal high' drugs available in head shops, Ballyfermot Advance Project and The Base youth and child centre in Ballyfermot have produced an information leaflet.

The leaflet outlines the current legal status and effects of common drugs such as Salvia, Spice, Piperazine, BZP and Kratom. There is also harm reduction information that may be used to advise clients of risks.

Content has been approved by Dr Des Corrigan, chairperson of the NACD, and Dr Bobby Smyth, consultant child and adolescent psychiatrist.

This brief, timely and straight-forward resource is available to download from www.drugsandalcohol.ie/12941

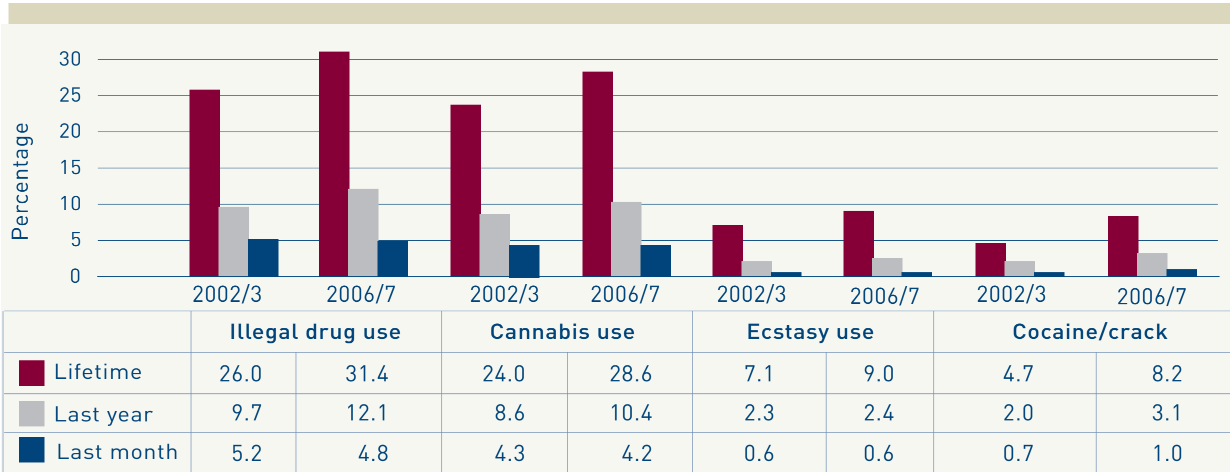
For more information, or for hard copies, please email community@ballyfermotadvance.ie.

Alcohol and drug use among young people in Ireland

There are three sources of data that estimate the prevalence of alcohol and other drug use among young people in Ireland: the National Advisory Committee on Drugs (NACD) surveys on drug use among the general population,[1,2] the European School Survey Project on Alcohol and Other Drugs (known as the ESPAD surveys)[3,4,5] and the Health Behaviour in School-aged Children (HBSC) surveys.[6,7,8] The NACD surveys classify young adults as those aged between 15 and 34, while the ESPAD surveys ascertain alcohol- and drug-using practices among 15–16-year-old school children. The HBSC surveys record health behaviours (including cannabis use) among school children aged 13–17 years. Drug use was measured for three time parameters, lifetime use, use in the 12 months prior to the survey and use in the month prior to the survey.

Drug use

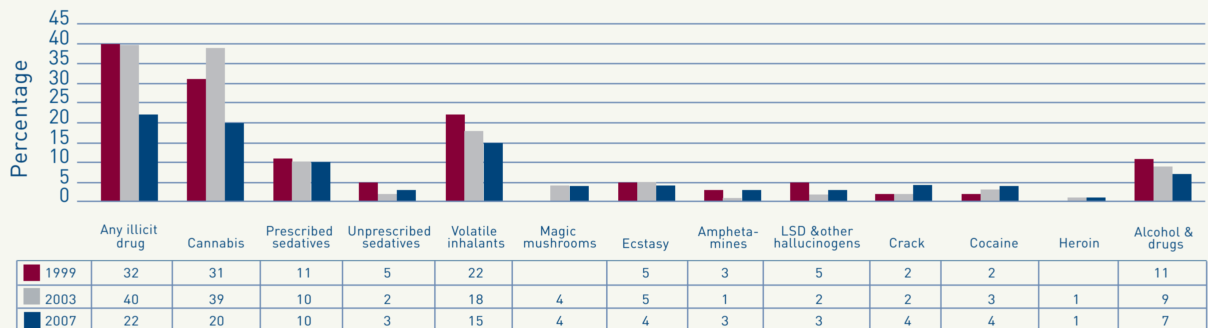
According to the NACD general population surveys, the proportion of young adults who reported using an illegal drug in the year prior to the survey increased from 10% in 2002/3 to 12% in 2006/7 (Figure 1). The proportions using cannabis showed a similar increase, rising by almost two percentage points, to over 10%. The proportions using cocaine increased for all three time parameters and the proportions using ecstasy during their lifetime or in the 12 months prior to the survey increased marginally.



	Illegal drug use		Cannabis use		Ecstasy use		Cocaine/crack	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	26.0	31.4	24.0	28.6	7.1	9.0	4.7	8.2
Last year	9.7	12.1	8.6	10.4	2.3	2.4	2.0	3.1
Last month	5.2	4.8	4.3	4.2	0.6	0.6	0.7	1.0

Figure 1 Lifetime, last-year and last-month prevalence of illegal drug use among 15–34-year-olds in Ireland, 2002/3 and 2006/7
Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

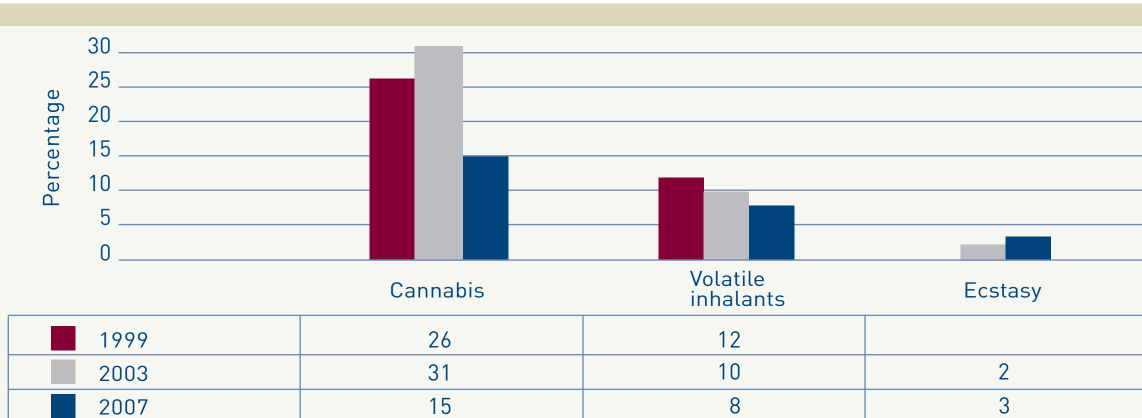
In the ESPAD surveys, the proportion of 15–16-year-old school children who reported use of any illicit drug at some point in their life decreased markedly between 2003 (40%) and 2007 (22%), a fall of 18 percentage points (Figure 2). As the majority of those who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the considerable decrease in the percentage of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 (European average 19%). Lifetime use of solvents/inhalants decreased from 18% in 2003 to 15% in 2007, but remained higher than the European average (9%). In the case of amphetamines and cocaine powder, the proportions reporting lifetime use increased marginally to equal or exceed the European average of 3%. In 2007, one in ten of the survey participants reported that they had taken prescribed tranquillisers or sedatives at some point in their lives; the use of such drugs had decreased marginally since 1999.



	Any illicit drug	Cannabis	Prescribed sedatives	Unprescribed sedatives	Volatile inhalants	Magic mushrooms	Ecstasy	Amphetamines	LSD &other hallucinogens	Crack	Cocaine	Heroin	Alcohol & drugs
1999	32	31	11	5	22		5	3	5	2	2		11
2003	40	39	10	2	18	4	5	1	2	2	3	1	9
2007	22	20	10	3	15	4	4	3	3	4	4	1	7

Figure 2 Lifetime use of drugs among 15–16-year-old school children in Ireland, ESPAD 1999, 2003 and 2007
Source: ESPAD (2000, 2004, 2009)

As shown in Figure 3, trends in the use of cannabis and volatile inhalants in the 12 months prior to the ESPAD survey mirror the trends in lifetime use reported above.

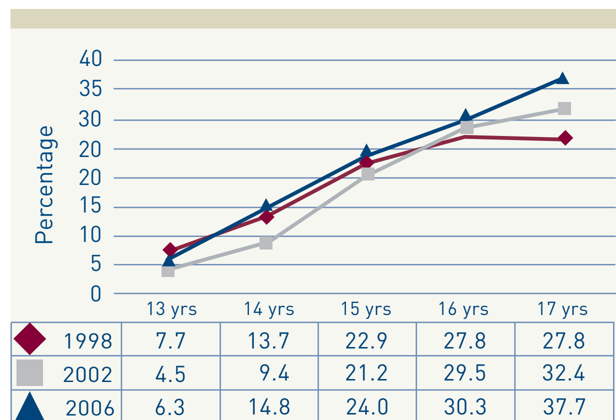


	Cannabis	Volatile inhalants	Ecstasy
1999	26	12	
2003	31	10	2
2007	15	8	3

Figure 3 Use of drugs in the 12 months prior to the survey among 15–16-year-old school children in Ireland, ESPAD 1999, 2003 and 2007
Source: ESPAD (2000, 2004, 2009)

Alcohol and drug use among young people in Ireland *(continued)*

The proportion of school children who reported cannabis use at some point in their life increased with each year of age between 13 and 17 in all three HBSC surveys, except for 17-year-olds in 1998 (Figure 4). In 2006, 6% of 13-year-olds reported lifetime use of cannabis, and the proportion increased steadily with each year of age, to 38% for those aged 17 years. The proportions of those who had used cannabis in each age group from 14 to 17 years increased between 1998 and 2006.

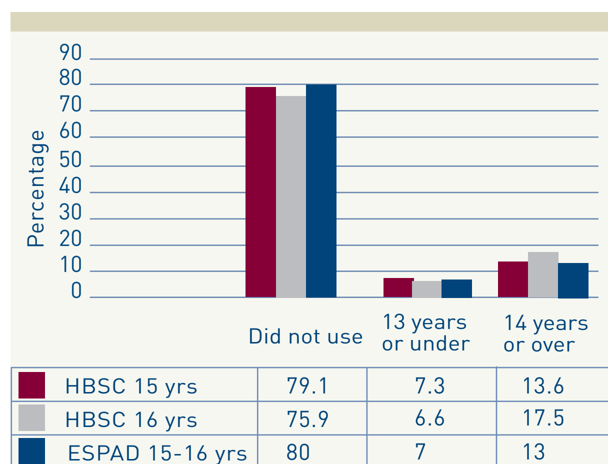


	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
1998	7.7	13.7	22.9	27.8	27.8
2002	4.5	9.4	21.2	29.5	32.4
2006	6.3	14.8	24.0	30.3	37.7

Figure 4 Proportion of children who used cannabis at least once in their life, by age, HBSC 1998 2002 and 2006
Source: Unpublished data from HBSC surveys

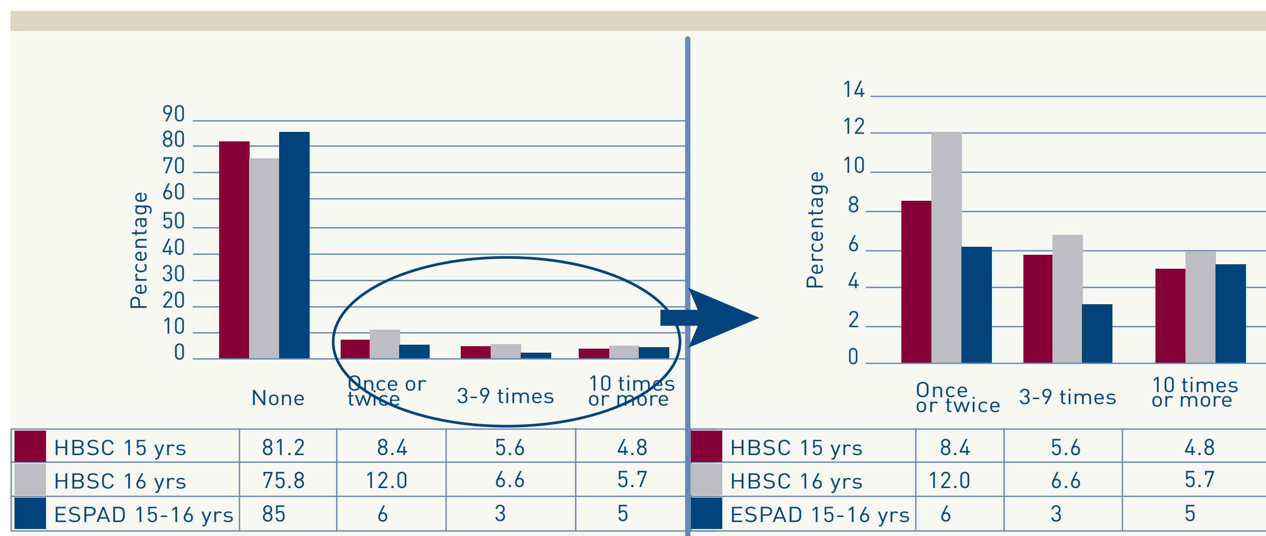
The proportion of children who reported commencing cannabis use at 13 years or under was considerable, and similar in both the HBSC and ESPAD surveys (Figure 5).

In 2006/7, the proportion who had used cannabis three or more times was higher in the HBSC (10.4% and 12.3%) than in the ESPAD survey (8%) (Figure 6).



	Did not use	13 years or under	14 years or over
HBSC 15 yrs	79.1	7.3	13.6
HBSC 16 yrs	75.9	6.6	17.5
ESPAD 15-16 yrs	80	7	13

Figure 5 Age commenced cannabis use for children aged 15–16 years, HBSC 2006 and ESPAD 2007
Source: Unpublished data from HBSC survey 2006 and published data from ESPAD (2009)



	None	Once or twice	3-9 times	10 times or more
HBSC 15 yrs	81.2	8.4	5.6	4.8
HBSC 16 yrs	75.8	12.0	6.6	5.7
ESPAD 15-16 yrs	85	6	3	5

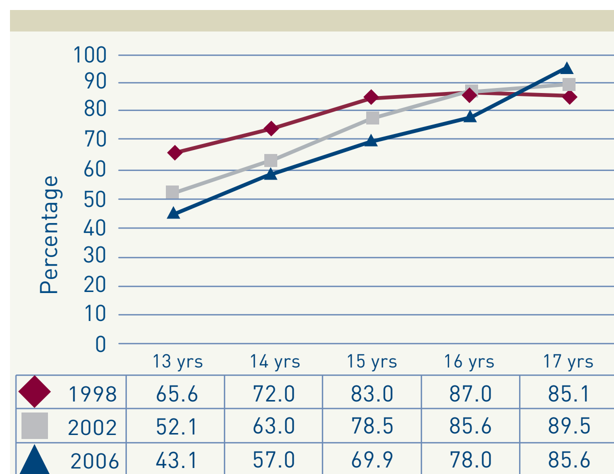
	Once or twice	3-9 times	10 times or more
HBSC 15 yrs	8.4	5.6	4.8
HBSC 16 yrs	12.0	6.6	5.7
ESPAD 15-16 yrs	6	3	5

Figure 6 Frequency of cannabis use in the 12 months prior to the survey among 15–16-year-olds, HBSC 2006 and ESPAD 2007
Source: Unpublished data from HBSC survey 2006 and published data from ESPAD (2009)

Alcohol and drug use among young people in Ireland *(continued)*

Alcohol use

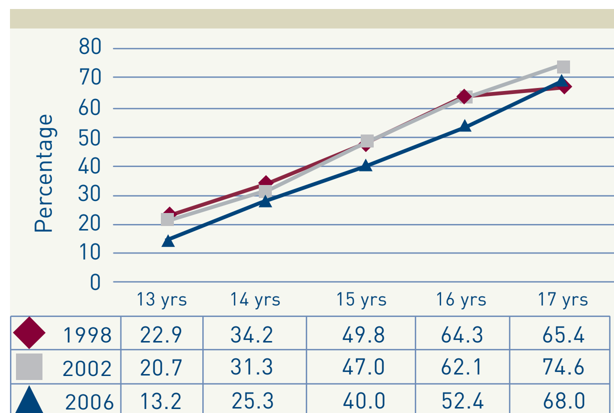
The HBSC and ESPAD surveys also examined alcohol use among schoolchildren. According to the last three HBSC surveys, the majority of schoolchildren had consumed alcohol, although the rate of lifetime use among the age groups from 13 to 16 years was lower in 2006 than in 1998. The largest decrease was observed among 13-year-olds; in 1998 66% reported having ever consumed alcohol, compared to 43% in 2006. The likelihood of having ever consumed alcohol increased with each year of age, with almost nine in ten 17-year-olds having ever consumed alcohol (Figure 7).



	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
1998	65.6	72.0	83.0	87.0	85.1
2002	52.1	63.0	78.5	85.6	89.5
2006	43.1	57.0	69.9	78.0	85.6

Figure 7 Lifetime use of alcohol among 13–17-year-old schoolchildren, HBSC 1998, 2002, 2006
Source: Unpublished data from HBSC surveys

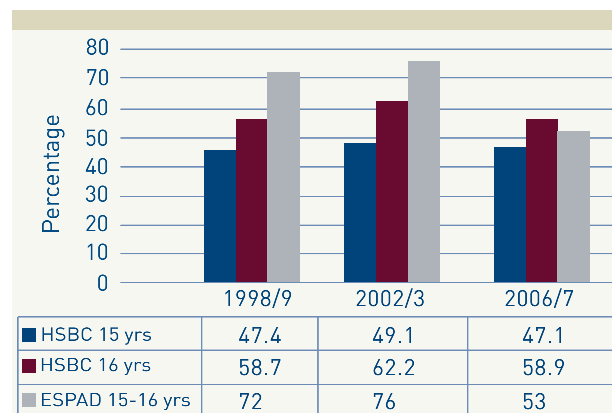
Last-month use of alcohol decreased among the age groups from 13 to 16 years between 1998 and 2006. In all three surveys, rates of alcohol use were higher at each year of age; for example, in 2006, 13% of 13-year-olds, and 25% of 14-year-olds had consumed alcohol in the previous month, (Figure 8).



	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
1998	22.9	34.2	49.8	64.3	65.4
2002	20.7	31.3	47.0	62.1	74.6
2006	13.2	25.3	40.0	52.4	68.0

Figure 8 Last-month use of alcohol among 13–17-year-old school children, HBSC 1998, 2002, 2006
Source: Unpublished data from HBSC surveys

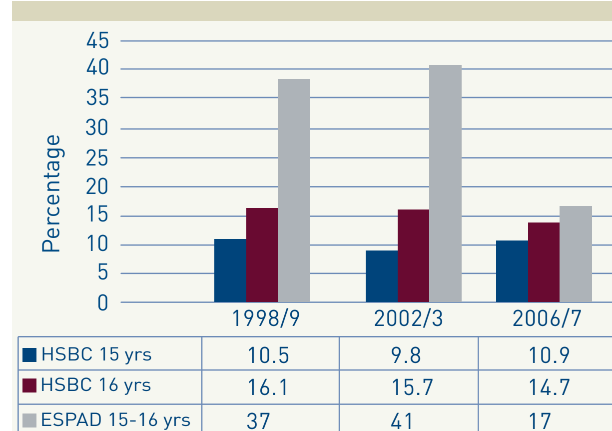
According to the 2007 ESPAD survey, over half of 15–16-year-olds reported having ever been drunk (Figure 9). The percentages reporting drunkenness did not vary to any great extent across the three HBSC surveys. However, there were variations between the ESPAD and the HBSC surveys: in the 1999 and 2003 ESPAD surveys, the proportion of 15–16-year-olds who reported having ever been drunk was considerably higher than in the HBSC surveys. The 2007 ESPAD results were similar to those of the 2006 HBSC survey.



	1998/9	2002/3	2006/7
HSBC 15 yrs	47.4	49.1	47.1
HSBC 16 yrs	58.7	62.2	58.9
ESPAD 15-16 yrs	72	76	53

Figure 9 Proportion of 15–16-year-olds who reported having ever been drunk, HBSC 1998, 2002, 2006; ESPAD 1999, 2003, 2007
Source: Unpublished data from HBSC surveys; Data from ESPAD (2000, 2004, 2009)

The proportion of 15-year-olds who reported having been drunk at least 10 times remained relatively stable over the three HBSC surveys, while the proportion of 16-year-olds decreased marginally (Figure 10). The ESPAD surveys of 1999 and 2003 reported 37% and 41%, respectively, of 15- and 16-year-olds who had been drunk at least 10 times. In comparison, just 17% reported the same in 2007. The results of the ESPAD and HBSC surveys were closer in 2007 than in previous years.



	1998/9	2002/3	2006/7
HSBC 15 yrs	10.5	9.8	10.9
HSBC 16 yrs	16.1	15.7	14.7
ESPAD 15-16 yrs	37	41	17

Figure 10 Proportion of 15–16-year-olds who reported having been drunk at least 10 times (HBSC 1998, 2002, 2006; ESPAD 1999, 2003, 2007)
Source: Unpublished data from HBSC surveys; Data from ESPAD (2000, 2004, 2009)

Alcohol and drug use among young people in Ireland *(continued)*

Conclusion

Overall, the HBSC surveys show a steady increase in cannabis use between 1998 and 2006, whereas the ESPAD surveys show a large increase between 1999 and 2003 and a larger, unexpected, decrease between 2003 and 2007. The HBSC survey results are in line with those of the NACD survey and other epidemiological indicators. They show a steady decrease in lifetime and last-month use of alcohol among 13–16-year-olds, but do not report major changes in drunkenness. In comparison, the 2007 ESPAD survey shows a large decrease in drunkenness compared to the 1999 and 2003 figures.

It is important to investigate the reasons for the marked decrease in alcohol use and in cannabis use reported in the ESPAD survey of 2007; these figures could represent a genuine fall in the use of alcohol and cannabis, or a change in the profile (age, gender or socio-economic group) of the sample chosen, or in the way the questionnaire was administered.

(Jean Long and Deirdre Mongan)

1. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005) *Drug use in Ireland and Northern Ireland: first results (revised) from the 2002/2003 drug prevalence study.* Bulletin 1. Dublin: National Advisory Committee on Drugs.
2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2008) *Drug use in Ireland and Northern Ireland: first results from the 2006/2007 drug prevalence survey.* Bulletin 1. Dublin: National Advisory Committee on Drugs.
3. Hibell B, Andersson B, Ahlström S, Balakireva O, Bjarnason T, Kokkevi A *et al.* (2000) *The 1999 ESPAD report: alcohol and other drug use among students in 30 European countries.* Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Council of Europe Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group).
4. Hibell B, Andersson B, Bjarnason T, Ahlström S, Balakireva O, Kokkevi A *et al.* (2004) *The ESPAD report 2003: alcohol and other drug use among students in 35 European countries.* Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Council of Europe, Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group).
5. Hibell B, Guttormsson U, Ahlström S, Balakireva O, Bjarnason T, Kokkevi A *et al.* (2009) *The 2007 ESPAD report: substance use among students in 35 European countries.* Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group of the Council of Europe.
6. Friel S, Nic Gabhainn S and Kelleher C (1999) *The national health & lifestyle surveys: survey of lifestyle, attitudes and nutrition (SLÁN) & the Irish health behaviour in school-aged children survey (HBSC).* Galway: National University of Ireland.
7. Kelleher C, Nic Gabhainn S, Friel S, Corrigan H, Nolan G, Sixsmith J *et al.* (2003) *The national health & lifestyle surveys: survey of lifestyle, attitudes and nutrition (SLÁN) & the Irish health behaviour in school-aged children survey (HBSC).* Galway: National University of Ireland.
8. Nic Gabhainn S, Kelly C and Molcho M (2007) *The Irish health behaviour in school-aged children (HBSC)* study 2006. Dublin: Department of Health and Children.

Alcohol use in Ireland: results from SLÁN 2007

On 1 December 2009, the SLÁN (Survey of Lifestyle, Attitudes and Nutrition) group published the results of the alcohol component of the 2007 SLÁN survey.[1] This was the third SLÁN survey – previous surveys were conducted in 1998 and 2002. The survey involved 10,364 adults aged 18 years and over, representing a response rate of 62%. As part of the survey, participants were questioned in face-to-face interviews about their rates and patterns of alcohol consumption, harm from their own drinking and harm from others' drinking.

Alcohol consumption and drinking patterns in Ireland

Four-fifths (81%) reported that they had consumed alcohol in the past year, with women (23%) more likely than men (15%) to be abstainers from alcohol. Higher rates of abstinence were reported by older respondents than by younger ones: for example, 41% of those aged 65 and over abstained from alcohol, compared to 11% of 18–29-year-olds. Three-quarters of the total number of respondents reported that they had consumed alcohol in the previous week, and 38% (45% of men; 30% of women) consumed alcohol at least twice a week. Twenty-nine per cent of drinkers reported consuming 1–2 standard drinks on a typical drinking occasion. A standard drink was defined as a half pint or a glass of beer, lager or cider; a single measure of spirits; a single glass of wine; or a longneck bottle of alcopops. Two-fifths (41%) reported drinking at least five standard drinks on a typical drinking occasion. This was more common among men (54%) than women (27%) and among younger age groups.

One in 10 drinkers reported drinking over the recommended weekly alcohol limit (defined as 21 standard drinks for men and 14 standard drinks for women) and 28% engaged in weekly binge drinking (defined as consuming at least six standard drinks or 60g of alcohol on a single occasion). Drinking patterns were also assessed using the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C), which identifies those with harmful drinking patterns by examining frequency of drinking, volume consumed and extent of binge drinking. Over half (56%) of drinkers had a positive AUDIT-C score. Applying this percentage to

Alcohol use in Ireland: results from SLÁN 2007 *(continued)*

the 2006 population census figures,, one may extrapolate that 1,453,250 people in Ireland aged 18 or over have a positive AUDIT-C score. Male and younger drinkers were more likely to drink over the recommended weekly limit, to be weekly binge drinkers and to have a positive AUDIT-C score.

Table 1 Selected drinking patterns by gender and age group

	Abstainer	Drinking at least twice weekly	Drinking in past week	5+ drinks per drinking occasion	Weekly binge drinking	Positive AUDIT-C score
	All respondents			Drinkers		
	%	%	%	%	%	%
Total	19	38	75	41	28	56
Gender						
Men	15	45	80	54	38	70
Women	23	30	70	27	17	42
Age group						
18–29	11	38	77	67	40	74
30–44	14	38	74	40	27	57
45–64	21	41	76	29	23	48
65+	41	28	73	16	12	28

Harm related to respondents' own drinking

One in 10 drinkers reported that their drinking had harmed their health in the previous year. Younger drinkers were more likely to report health harms; the percentages were: 17% of those aged 18–29; 10% of those aged 30–44; 7% of those aged 45–64; and 2% of those aged 65+. Drinkers who exceeded the recommended weekly limit were four times more likely to report that their drinking had harmed their health, while binge drinkers were three times more likely to report similar harm.

Harm to home life and/or marriage as a result of their own drinking was reported by 4% of men and 2% of women, while 6% of men and 3% of women reported that their drinking had harmed their work or studies in the previous year. Involvement in fights and/or accidents as a result of their own drinking was reported by 5% of drinkers (7% of men; 3% of women). Binge drinkers were almost five times more likely than non-binge drinkers to be involved in a fight or accident as a result of their own drinking.

Twelve per cent of drivers who were also drinkers reported driving a car in the previous year after consuming two or more standard drinks and this was reported more often by men (17%) than by women (5%). Self-reported rates of driving after consuming two or more standard drinks were similar across all age groups.

Harm related to other people's drinking

Drinkers experienced more harm from others' drinking than did non-drinkers. Six per cent of all respondents (5% of men; 7% of women) reported experiencing family or marriage problems in the previous year as a result of someone else's drinking. Six per cent reported being pushed, hit or assaulted as a result of someone else's drinking, with a higher rate (13%) reported by younger respondents. Binge drinkers were twice as likely to report being assaulted as all other respondents.

Conclusion

This report indicates that rates of alcohol consumption in Ireland are high and that our drinking patterns are problematic. Over one in four drinkers reported binge drinking weekly, and over half of drinkers scored positive on the AUDIT-C questionnaire, indicating that a large proportion of drinkers consume alcohol in a hazardous manner. This is worrying as the volume of consumption as well as patterns of drinking, especially regular heavy drinking, determine the burden of disease caused by alcohol. Binge drinking, apart from any long-term effects, can increase impulsivity, reduce inhibition and distort behaviour, which may lead to acute consequences such as accidents, assaults or suicide. There is a pressing need to introduce strategies that will reduce the harmful use of alcohol in Ireland and, by extension, the health and social harms it causes.

(Deirdre Mongan)

1. Morgan K, McGee H, Dicker P, Brugha R, Ward M, Shelley E *et al.* (2009) *SLÁN 2007: Survey of lifestyle, attitudes and nutrition in Ireland. Alcohol use in Ireland: a profile of drinking patterns and alcohol-related harm from SLÁN 2007*. Dublin: Department of Health and Children.

Exposure to illicit drug use and alcoholism among 9-year-old Irish children

On 7 December 2009 the Minister for Children and Youth Affairs, Barry Andrews TD, launched the first major report from Growing Up in Ireland, the national longitudinal study of children, tracking the lives of over 8,500 nine-year-olds. The data were collected between September 2007 and June 2008.[1] The nine-year-old cohort was selected through the primary school network.

A random sample of schools was drawn and, subject to the school's participation, age-eligible children in those schools and their families were invited to participate. The study included a wide range of perspectives, with information being recorded from parents, teachers, principals and carers, and the 'study child' himself or herself. Aspects explored included the children's living situations; experiences of family life; state of health; use of health care services; emotional health and wellbeing; education; peer relationships; activities; and neighbourhood and community settings.

With regard to the children's experiences of stressful life, their mothers were presented with a list of 13 potentially stressful events and asked to report which ones, if any, their child had experienced. Just over 78% of children were reported to have experienced some form of stressful life event; 4% had experienced drug taking/alcoholism in their immediate family. As the following table shows, in comparison with children from two-parent families, children from single-parent families were more likely to have experienced drug taking/alcoholism in their immediate family.

Family unit	Percentage of 9-year-olds experiencing drug-taking/alcoholism in their immediate family
Single-parent – 1 or 2 children	10.0
Single-parent – 3 or more children	10.7
Two-parent – 1 or 2 children	2.0
Two-parent – 3 or more children	2.0

With regard to the quality of their neighbourhood environments, the mothers were asked to rate four items on a four-point scale from *very common* to *not at all common*. Overall, rubbish and litter lying about appeared to be the most pervasive problem, with mothers of 34% of nine-year-olds reporting this as being *very common* or *fairly common* in their local area.

This was followed by people being drunk or taking drugs in public (15%), vandalism and deliberate damage to property (15%) and homes and gardens in bad condition (10%). There was a strong relationship between family social class and perceived quality of the local area, with those in the lower social class categories being much more likely to report unfavourable physical conditions in their neighbourhood. For example, those in the semi-skilled/unskilled manual category were more likely than those in the professional/managerial group to report that people being drunk or taking drugs in public was *very common* or *fairly common* (22% compared to 9%). The researchers also found a difference between urban and rural residents in terms of the quality of the neighbourhood environment, with respondents in urban areas being roughly twice as likely as their rural counterparts to report that people being drunk or taking drugs in public was *very* or *fairly common*.

The next wave of this longitudinal study is due to be conducted when the children in the cohort study reach the age of 13.

(Brigid Pike)

1. Williams J, Greene S, Doyle E, Harris E, Layte R, McCoy S *et al.* (2009) *Growing up in Ireland: national longitudinal study. The lives of 9-year-olds, child cohort.* Report 1. Dublin: Stationery Office.

Levels of alcohol and drug use are indicators of wellbeing

On 7 October 2009 the National Economic and Social Council (NESC) launched a report *Well-being matters: a social report for Ireland.*[1] Speaking at the launch NESC director Dr Rory O'Donnell called for a broader understanding of social progress than simply measuring GDP. The report tracks trends across six aspects of people's lives: their economic resources, their work and education, their relationships and care, their community and environment, their health, and societal values. Alcohol consumption is included as an indicator of health, together with four other behavioural components – smoking, physical exercise, eating and weight.

Indicators of health: behavioural components

Indicator	Finding
Smoking cigarettes has a detrimental effect on health and well-being.	Just under a third of the population smoke, with a slight reduction having taken place over the last nine years.
Excessive alcohol consumption has a detrimental effect on health and well-being.	Ireland is one of the highest consumers of alcohol in Europe, with high rates of heavy drinking compared to EU averages.
Physical exercise and good diet have positive effects on health and well-being.	Levels of physical activity have increased significantly over the last twenty years. In relation to diet, even though two-thirds of people are eating the recommended amounts of fruit and vegetables, many people (86%) are consuming more than the recommended servings of fat, sugar and salt.
Being overweight or obese can contribute to health problems.	Between one-half to two-thirds of the population can be classified as overweight or obese, and the proportion is increasing.
Source: Johnston (2009:115)	

The report's author, Helen Johnston, notes that health behaviours are influenced by a wide range of socio-economic and cultural factors. Some sub-groups of the population are more at risk of poor health than others and have less access to treatments and services. These sub-groups include people with lower educational levels or lower incomes, or who are unskilled. In addition, Johnston cites a recent study[2] which 'shows that "inequality seems to make countries socially dysfunctional across a wide range of outcomes" in that "rich" countries with a highly unequal income distribution are more likely to have lower levels of trust, higher levels of mental illness (including drug and alcohol addiction), lower life expectancy and higher infant mortality, higher levels of obesity, poorer educational performance, more teenage births, more homicides, higher imprisonment rates and more limited social mobility' (Johnston 2009: 76).

(Brigid Pike)

1. Johnston, H (2009) *Well-being matters: a social report for Ireland.* Report No 119. Volume 1. Dublin: National Economic and Social Council.
2. Wilkinson R and Pickett K (2009) *The spirit level: why more equal societies almost always do better.* London: Allen Lane.

What is well-being?

A person's well-being relates to their physical, social and mental state. It requires that basic needs are met, that people have a sense of purpose, that they feel able to achieve important goals, to participate in society and to live the lives they value and have reason to value. People's well-being is enhanced by conditions that include financial and personal security, meaningful and rewarding work, supportive personal relationships, strong and inclusive communities, good health, a healthy and attractive environment, and values of democracy and social justice. Public policy's role is to bring about these conditions by placing the individual at the centre of policy development and delivery, by assessing the risks facing him/her, and ensuring the supports are available to address those risks at key stages in his/her life.
Source: Johnston (2009: xiii)

Launch of D12 LDTF Managers Support Book

Minister Curran at the launch on 9 March 2010 of the Dublin 12 LDTF Managers Support Book, pictured with Dublin 12 interim project managers, from left: Rachael Cahill, Brede Quirke, Kay Bailey, Brian Murphy, Minister Curran, Michelle O'Brien and Susan Collins.

Rape in Ireland – what role does alcohol play?

The Rape Crisis Network Ireland launched its report, *Rape and justice in Ireland: a national study of survivor, prosecutor and court responses to rape*, on 7 December 2009.[1] The main aim of this study was to gather information about the causes of attrition in rape cases, to facilitate the development of a coherent response to the problem of rape in Ireland. The secondary aims were to build a more precise profile of rape in Ireland and to evaluate the experiences of victims who engage with the criminal justice system.

There were three strands to this study:

- 100 individual rape victims were interviewed about their experience of the legal process.
- 597 files on reported rapes received by of the Director of Public Prosecutions (DPP) from 2000 to 2004 were studied.
- 173 Central Criminal Court cases from 2000 to 2005 and 35 transcripts of contested trials were analysed.

Results

Interviews with rape victims

- All of the 100 rape victims interviewed were female, half were single, and the median age was 27. Over two-thirds of the incidents occurred in houses, with the victim's own home being the single most common location. Two-thirds were raped by someone known to them.
- In 70% of cases the victim reported that she had been drinking prior to the incident; 16% had consumed two drinks or less, 25% had consumed 3–5 drinks and 29% had consumed six drinks or more. In 58% of cases the victim reported that the offender had been drinking; 24% stated that the offender had consumed a moderate amount of alcohol; and a further 24% stated that the victim had been drinking a lot at the time of the assault.
- Two-thirds of the victims informed the gardaí about the rape and 49% pursued the case.

Analysis of DPP files

- Rates of alcohol consumption among complainants were high: over 80% had consumed alcohol around the time of the offence, with 45% described as severely intoxicated. These findings place Irish complainants of rape at the top of the list for alcohol consumption, when compared with British and United States studies.
- The majority of suspects were intoxicated at the time of the offence, with 41% severely intoxicated and 27% moderately intoxicated.
- The DPP prosecuted three out of every 10 reported rapes, and the main reason for failure to prosecute was lack of evidence.
- Uncertainty about the incident or about consent due to excessive alcohol consumption was cited as a factor in the failure to prosecute in many cases.

Analysis of Criminal Court cases

- Analysis of these cases found high levels of alcohol consumption by both complainants and defendants.
- There was reluctance among juries to convict unless the rape conformed to the stranger-rape stereotype.

Conclusions

The relationship between alcohol consumption and sexual violence is complex and caution should be taken before concluding that alcohol is a causal factor in rape. Those who drink heavily may find themselves in situations that are more likely to lead to an assault, such as socialising in a pub or at a party. Nevertheless, alcohol is a disinhibitor and can increase aggression, which may increase the likelihood of an individual committing a rape.

The results of this study indicate that alcohol consumption, especially drinking to intoxication, is a feature in a high proportion of rapes committed in Ireland. Alcohol use also decreases the likelihood of the victim reporting the rape and increases the likelihood of blame being attributed to the victim. Research has shown that 58% of clients attending the Sexual Assault Treatment Unit in the Rotunda Hospital in 2003 had consumed more than four drinks; alcohol has also been found to be involved in approximately half of all cases of adult sexual abuse.

The authors of the report highlight that Ireland's drinking culture needs to be tackled, particularly as it affects the behaviour of potential perpetrators. They also recommend that young men be targeted by a media campaign to make them aware that rape is a possible consequence of binge drinking, and to remind them that they are responsible for their own actions, and that voluntary intoxication does not relieve them of that responsibility, morally or legally.

(Deirdre Mongan)

1. Hanly C, Healy D and Scriver S (2009) *Rape and justice in Ireland: a national study of survivor, prosecutor and court responses to rape.* Dublin: The Liffey Press.

FSN annual Service of Commemoration and Hope

L to r: The Taoiseach's aide-de-camp Commandant Treacy, Minister Curran & Garda Commissioner Murphy at the Family Support Network annual Service of Commemoration & Hope (photo: JJ Berkeley)

The Family Support Network (FSN) held its 11th annual Service of Commemoration and Hope on 1 February in remembrance of loved ones lost to drugs and related causes and to publicly support families living with the devastation that drug use causes. The theme of the service this year was 'Families: The catalyst for change'.

The service was held in Our Lady of Lourdes Church, Sean McDermott Street. The congregation was welcomed by Fr. Thomas Grzegorzewski. The large attendance included Mr John Curran TD, Minister of State with responsibility for the National Drugs Strategy, Garda Commissioner Fachtna Murphy, the Lord Mayor of Dublin, Emer Costello, the Taoiseach's aide-de-camp Commandant Michael Treacy, Archbishop Diarmuid Martin and other religious representatives, and family members, friends and representatives from family support groups, and people working in this area.

Sadie Grace of FSN spoke about the importance of acting on the information now available on drug-related deaths and the urgent need to put measures in place to tackle this issue. She highlighted the importance of the family in preventing children becoming addicted, and stressed the family's need for support and resources in this role. She urged that all children should be 'cherished equally'.

Ruaidhri McAuliffe addressed the audience on behalf of the drug-users' forum, Uisce (Union for Improved Services, Communication and Education). Minister Curran, Archbishop Martin and Fr Edmond Grace also addressed the gathering.

Dublin West Community Church Music Group provided the music, Mick O'Brien sang his own composition 'Oh Lord Our Youth Are Dying', and John Carmody read a poem that he had written. An audio piece entitled 'Loss', featuring parents who had lost children due to drug use and the effect this had on their lives, was played during the service.

The FSN was announced as an independent organisation in November 2007. Formed in 2000 under the auspices of the CityWide Drugs Crisis Campaign, the Network consists of representatives of family support groups, individual family members and those working directly with families of drug users. It aims to raise awareness of family support work and its role in the community; highlight the importance and value of work done by family support groups; provide information to families and communities on existing services and supports; highlight the extent of the drugs problem and its effects on families; campaign for better services for drug users and their families; support the involvement of the people most affected – drug users and their families – in dealing with the problem; and remember and commemorate those who have died as a result of drugs. There are now over 80 member groups throughout Ireland.

The Family Support Network can be contacted at 01 836 5168, email info@fsn.ie or at www.fsn.ie

(Suzi Lyons)

Ruaidhri McAuliffe of UISCE speaking at the service (photo: JJ Berkeley)

Sadie Grace of Family Support Network speaking at the service (photo: JJ Berkeley)

Treated problem alcohol use in Ireland: figures for 2008

Figures from the National Drug Treatment Reporting System (NDTRS) for treated problem alcohol use in Ireland in 2008 by HSE area of residence are currently available on the HRB website.[1]

Some of the main results are:

- In total, 7,940 cases were treated for problem alcohol use in 2007, an increase of 628 on the 7,312 cases treated in 2007. This may be attributed to an increase in the number of people presenting for treatment, or it may reflect the increase in the number of treatment centres participating in the NDTRS in 2008.
- Both the incidence and prevalence of treated problem alcohol use among 15–64-year-olds increased in each of the years between 2004 and 2008.
- The incidence of treated problem alcohol use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased from 118.3 in 2007 to 120.0 in 2008 (Figure 1).
- The prevalence of treated problem alcohol use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased from 222.6 in 2007 to 243.3 in 2008 (Figure 1).

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

Almost one in five of those treated for problem alcohol use in 2008 also reported using at least one other substance, a similar proportion to that observed in 2007 and 2006.

In 2008, the most common additional drugs used by treated alcohol cases were cannabis, cocaine, ecstasy and opiates. This ranking reflects a minor change since 2007, when benzodiazepines were the fourth most common additional drug. Use of more than one substance increases the complexity of cases and leads to poorer outcomes for the patient. Information about combinations of substances used is important in terms of individual clients' care plans.

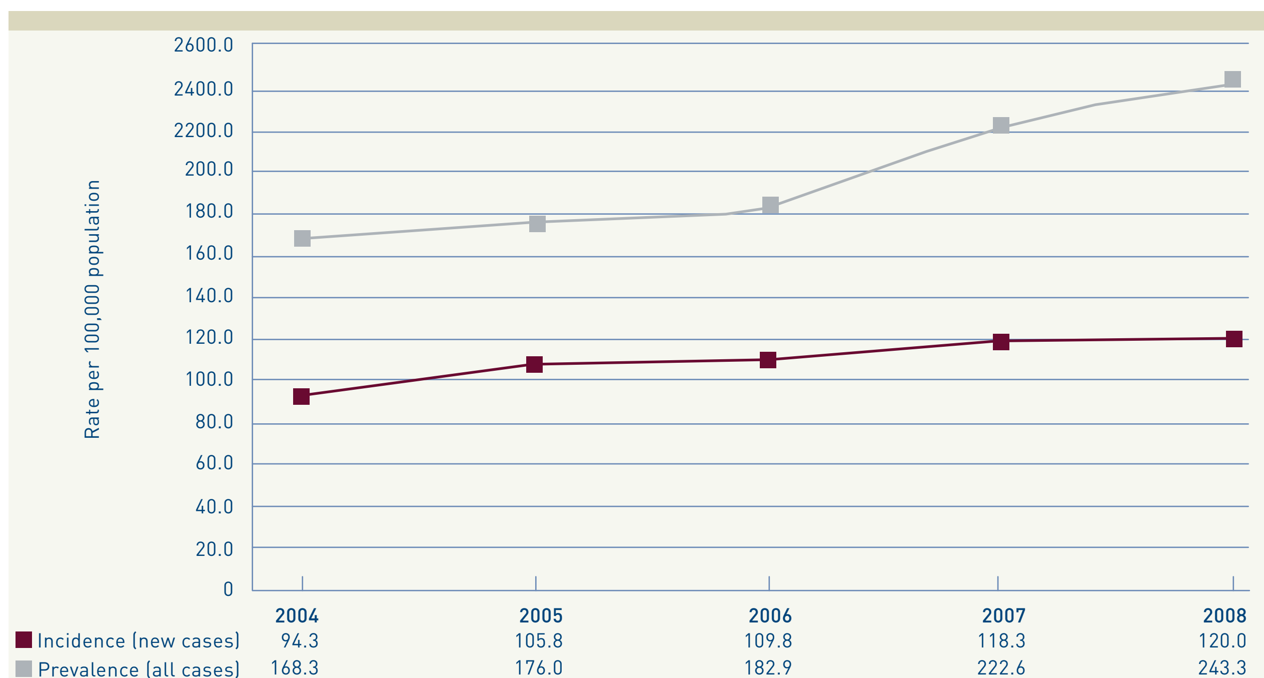
In 2008, the median age at which both new and previously treated cases began drinking was 16 years, similar to previous years.

The age profile of cases treated for problem alcohol use was the same in 2007 and 2008. The median age for all treated cases was 39 years; for new cases, the median age continued to be younger (36 years). While the proportion of cases under the age of 18 remained small, the number of 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.

(Anne Marie Carew)

1. Alcohol and Drug Research Unit (2010) *Treated problem alcohol use in Ireland: figures for 2008 from the National Drug Treatment Reporting System.* Dublin: Health Research Board. Available at www.drugsandalcohol.ie/12770



	2004	2005	2006	2007	2008
Incidence (new cases)	94.3	105.8	109.8	118.3	120.0
Prevalence (all cases)	168.3	176.0	182.9	222.6	243.3

Figure 1 Incidence and prevalence of treated problem alcohol use, per 100,000 of the 15–64-year-old population (NDTRS 2004–2008; CSO 2007, 2009)

Treated problem drug use in Ireland: figures for 2008

Figures from the National Drug Treatment Reporting System (NDTRS) for treated problem drug use in Ireland in 2008 by HSE area of residence are currently available on the HRB website.[1]

Some of the main results are:

- In total, 14,518 cases were treated in 2008, of whom 6,576 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 5%, from 444 in 2007 to 466 in 2008.
- 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 79.6 in 2007 to 85.8 in 2008.

An opiate (mainly heroin) was the most common main problem drug reported by cases entering treatment. Alcohol was reported as an additional problem substance in 41.4% of all treated cases. The majority of cases treated in 2008 reported problem use of more than one substance (70.0%), which was almost 3% higher than the 2007 figure. Cannabis (40.7%) and cocaine (36.8%) were the two most common additional problem drugs reported in 2008. The proportion of cases treated for benzodiazepines as an additional problem substance increased by 7.5% between 2007 and 2008. Polysubstance use increases the complexity of these cases, and is associated with poorer treatment outcomes.

In total, 561 new injector cases entered treatment in 2008, an increase of 88 cases on the 2007 figure. More than two in five of these cases were still injecting on entry to treatment, and 43% reported sharing injecting equipment, a decrease on the 2007 figure.

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

Over 14% of new cases and more than 3% of previously treated cases in 2008 were aged under 18 years, a slight increase on the 2007 figure in both cases. The proportion of new cases in employment decreased by more than 5% between 2007 and 2008.

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.

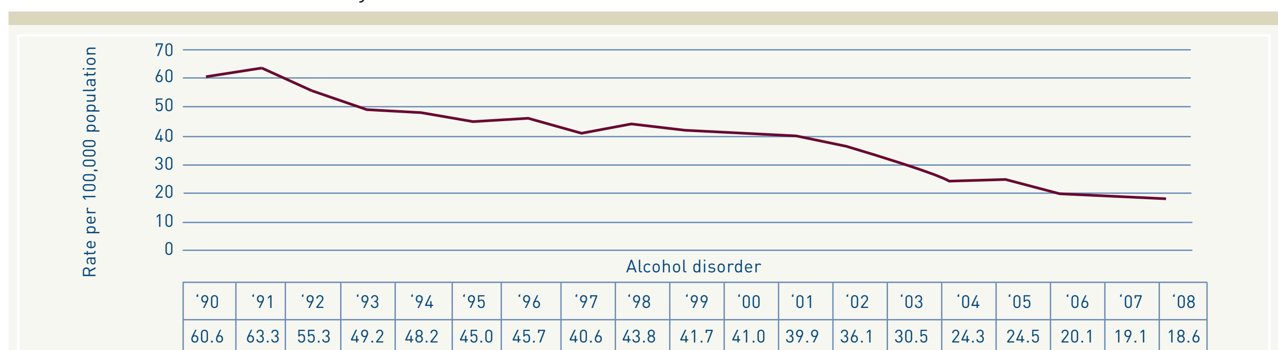
(Anne Marie Carew)

1. Alcohol and Drug Research Unit (2010) *Treated problem drug use in Ireland: figures for 2008 from the National Drug Treatment Reporting System.* Dublin: Health Research Board. Available at www.drugsandalcohol.ie/12771.

Trends in alcohol and drug admissions to psychiatric facilities

Activities of Irish psychiatric units and hospitals 2008, the annual report published by the Mental Health Research Unit of the Health Research Board in December 2009, shows that the total number of admissions to inpatient care has continued to fall.[1]

In 2008, 2,497 cases were admitted to psychiatric facilities with an alcohol disorder, of whom 789 were treated for the first time. Figure 1 presents the rates of first admission between 1990 and 2008 of cases with a diagnosis of alcohol disorder, per 100,000 of the population.[1-7] It is notable that the rate decreased fairly steadily in the period 1992 to 2004 and more than halved over the 12 years. The rate stabilised in 2004 and 2005, but decreased again in the years 2006 to 2008. The trend since the early nineties reflects changes in the policy and practice of alcohol treatment, and the resultant increase in community-based and special residential alcohol treatment services. Of the 2,392 discharges of cases with an alcohol disorder in 2008, just under 42% spent less than one week in hospital and 19% spent more than one month in hospital. Whether or not these admissions were appropriate, and in line with the recommendations of the mental health policy, *A vision for change*, could not be discerned from the report as the numbers with co-morbid illness were not reported.



'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08
60.6	63.3	55.3	49.2	48.2	45.0	45.7	40.6	43.8	41.7	41.0	39.9	36.1	30.5	24.3	24.5	20.1	19.1	18.6

Figure 1 Rates of psychiatric first admission of cases with a diagnosis of alcohol disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–2008

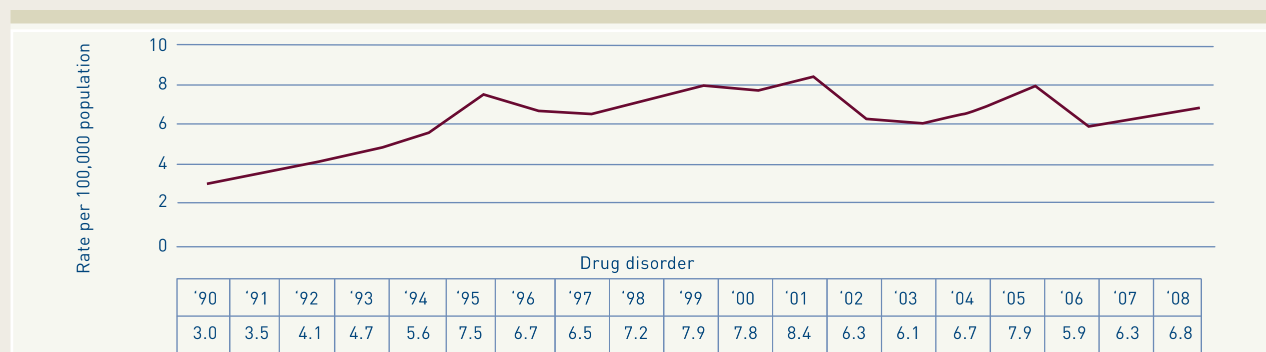
Trends in alcohol and drug admissions to psychiatric facilities *(continued)*

In 2008, 778 cases were admitted to psychiatric facilities with a drug disorder, of whom 289 were treated for the first time. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 2 presents the rates of first admission between 1990 and 2008 of cases with a diagnosis of drug disorder, per 100,000 of the population.1-6 The rate was almost three times higher in 2001 than it was in 1990. Notable dips in the rate occur in the census years 1996, 2002 and 2006, and can be partly explained by the increased population figure used as the denominator in calculating the rate for those years.

The overall increase in the rate of drug-related first admissions between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. The overall decrease in the rate since 2001 possibly reflects an increase in community-based specialised addiction services during this period. The increased rate in 2005 may be accounted for by the use of the 2002 census figure in calculating the rate. The decrease to 5.9 in 2006 reflects the new census figure used as denominator. The rate increased marginally to 6.8 in 2008. Of the 791 discharges with a drug disorder, 51% spent less than one week in hospital and just under 15% spent more than one month in hospital.

(Jean Long)

1. Daly A and Walsh D (2009) *Activities of Irish psychiatric units and hospitals 2008.* Dublin: Health Research Board http://www.hrb.ie/publications/hrb-publication/publications//495/
2. Daly A, Walsh D and Moran R (2008) *Activities of Irish psychiatric units and hospitals 2007.* Dublin: Health Research Board.
3. Daly A, Walsh D and Moran R (2007) *Activities of Irish psychiatric units and hospitals 2006.* Dublin: Health Research Board.
4. Daly A, Walsh D, Ward M and Moran R (2006) *Activities of Irish psychiatric units and hospitals 2005.* Dublin: Health Research Board.
5. Daly A, Walsh D, Comish J, Kartalova-O'Doherty Y, Moran R and O'Reilly A (2005) *Activities of Irish psychiatric units and hospitals 2004.* Dublin: Health Research Board.
6. Daly A, Walsh D, Moran R and Kartalova-O'Doherty Y (2004) *Activities of Irish psychiatric services 2003.* Dublin: Health Research Board.
7. Walsh D and Daly A (2004) *Mental illness in Ireland 1750–2002: reflections on the rise and fall of institutional care.* Dublin: Health Research Board.



'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08
3.0	3.5	4.1	4.7	5.6	7.5	6.7	6.5	7.2	7.9	7.8	8.4	6.3	6.1	6.7	7.9	5.9	6.3	6.8

Figure 2 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–2008

How effectively is policy being implemented?

Concerned at the slow progress in implementing Ireland's national mental health policy *A vision for change*, launched in 2006, and the consequences for the quality of mental health services available to service users, the Mental Health Commission (MHC) commissioned a study to explore the central issues, present the evidence base for effective implementation and highlight possible ways to speed up implementation. The resulting report was published in November 2009.[1]

This article outlines the analytical framework presented in the MHC report. Although intended to be applied in the mental health field, the framework is a generic evidence-based implementation framework, which may be applied equally to other policy domains such as drugs and alcohol policy. It identifies six specific tasks and activities associated with effective implementation:

- attention to implementation in the policy formulation process,
- skilled leadership in the implementation process,
- appropriate support and governance arrangements,
- adequate resources,
- a detailed plan, and
- continuous communication.

How effectively is policy being implemented? *(continued)*

These tasks and activities occur in three broad stages – the policy formulation process prior to implementation, implementation and monitoring – as summarised in the diagrammatic representation below. The twelve tasks listed in this diagram are elaborated on in the following paragraphs.

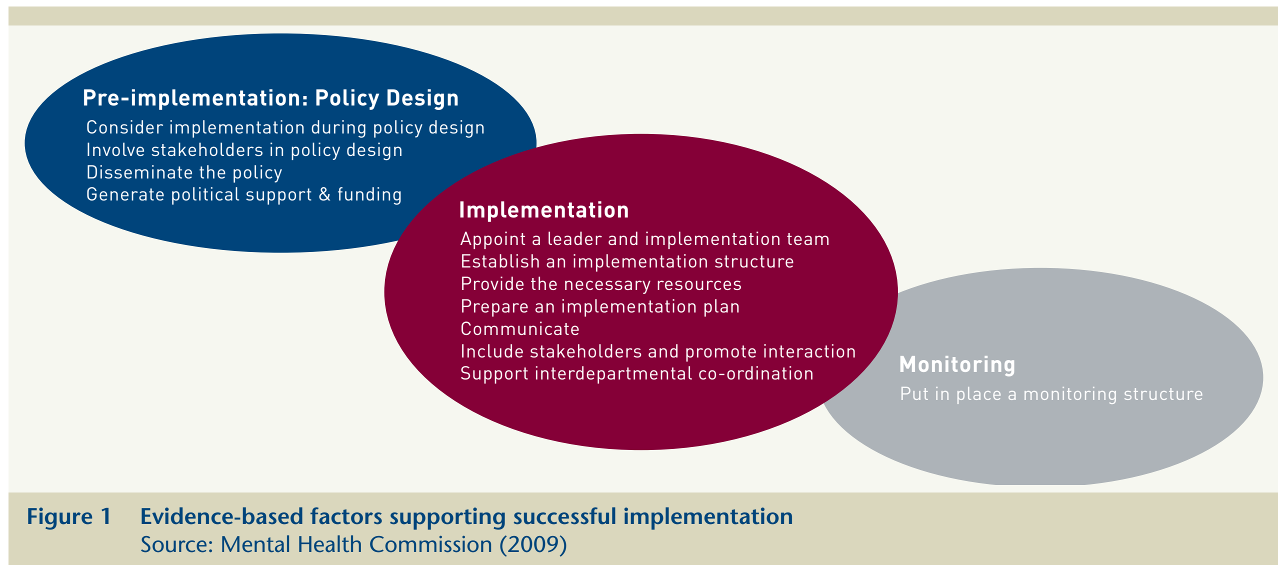


Figure 1 Evidence-based factors supporting successful implementation
Source: Mental Health Commission (2009)

Policy formulation process

1. *Make implementation an important consideration during policy design* – this includes identifying different means of achieving policy objectives and identifying barriers to implementation.
2. *Involve as many stakeholders as possible in policy formulation process* – including, and consulting with, stakeholders serves to inform the policy and also the implementation of the policy.
3. *Disseminate the policy* – all stakeholders need to know about the new policy.
4. *Generate political support and funding* – active stakeholder participation and communication activities are important in achieving this. Political leadership and support can be crucial in ensuring implementation.

Implementation

5. *Appoint a leader and an implementation team* – the World Health Organization (WHO) reports that a multidisciplinary team to implement policy has proved successful in several countries.
6. *Establish an implementation structure* – This national team should be echoed regionally and locally with, at a minimum, a regional leader and local leaders.
7. *Provide the necessary resources* – this includes an appropriately crafted budget, including managing contingency funding and financial risk. It is also strongly recommended that appropriately skilled and experienced financial management personnel should be part of the implementation team.
8. *Prepare a plan* – an implementation plan should provide a map of how the policy will be implemented and should deal in sufficient detail with:
   - timeframes, including the different phases for implementation,
   - roles and responsibilities of those involved in implementation,
   - resources, including funding and human resources,
   - risk management, including how any potential barriers to implementation will be addressed,
   - monitoring and reporting requirements.
9. *Communicate* – on-going communication is critically important to implementation because it is an effective tool for motivating employees, for over-coming resistance to an initiative, for preparing employees for the pluses and minuses of change and for giving employees a personal stake in the process.
10. *Include stakeholders and promote stakeholder interaction* – the purpose of stakeholder inclusion in the implementation process must be clear so that the right stakeholders can be identified. For example, is their inclusion to obtain support, to provide a communication channel or to test the design or roll-out?
11. *Support interdepartmental co-ordination* – Where cross-agency implementation is necessary, the likelihood of effective implementation is greater where there is a high-level implementation plan involving the relevant agencies.

Monitoring

12. *Put in place a governance structure* – governance arrangements are required to ensure adequate reporting and review mechanisms. Monitoring is essential to determine if the desired outcomes are being achieved and also to identify risks to implementation so that corrective action can be taken.

(Brigid Pike)

1. Mental Health Commission (2009) *From vision to action? An analysis of the implementation* of A vision for change. Dublin: Mental Health Commission.

Health profile of people using Cork Simon services

The Cork Simon Community, which works with homeless people, undertook a health audit of clients using the service in the first week of September, 2009.[1] A total of 183 individuals were supported by services throughout the week; 86% were male, 87% had a medical card, and 63% were in receipt of a social welfare disability allowance.

Table 1 presents a breakdown of the overall figure by type of service used, health status and substance use. Individuals using high-support accommodation were more likely to have a diagnosed physical or mental health condition; all of this group had medical cards, and the group had the highest proportion of people receiving disability benefit. Rates of alcohol use were relatively high among all service users.

Long-term homelessness

In the week of the health audit, 36% (n=20) of the residents in the Emergency Shelter were long-term homeless, defined by the strategy on homelessness as being in emergency accommodation for more than six months. All 20 were male; 80% had a medical card; 60% were receiving a disability payment; 55% had at least one diagnosed physical health condition; 55% had at least one diagnosed mental health condition; 90% used alcohol and 55% used drugs; 55% had a diagnosed mental health condition and used alcohol and/or drugs.

Rough sleepers

Sixteen people were recorded as sleeping rough for at least one night during the week of the audit, of whom six were consistent rough sleepers. Fifteen were male; 50% had a medical card; 31% were in receipt of a disability payment; 56% had a diagnosed physical health condition; 44% had a diagnosed mental health condition; 81% used alcohol and 56% used drugs; 44% had a diagnosed mental health condition and used alcohol and/or drugs.

Conclusion

This snapshot taken by the Cork Simon Community over the course of a week provides useful information on health and related behaviours among homeless people in Cork. Overall, the data paint a picture of poor physical and mental health, high dependence on social welfare payments, relatively high levels of alcohol and drug use and, for some, unstable accommodation. The relatively high prevalence of substance use among people who are long-term homeless and/or sleeping rough may exacerbate their situation and prolong their experience of homelessness. Individuals presenting with diagnosed mental health conditions who are substance users are also a concern. On a slightly brighter note, among the people who are being helped with independent living, the outcomes are less severe, as this group reports lower levels of heavy alcohol use and lower levels of drug use and heavy drug use compared to people in emergency accommodation. This snapshot demonstrates the myriad needs that homeless people with substance use problems can present with and highlights the enduring challenge facing service providers in responding to these needs and reducing the associated harms.

(Martin Keane)

1. Cork Simon Community (2009) *Sick and tired of homelessness: health profile of people using Cork Simon services.* Cork: Cork Simon Community. Available at www.drugsandalcohol.ie/12798/

Table 1 Health profile of users of Cork Simon services, September 2009

Service	No. of clients	Diagnosed physical condition	Diagnosed mental condition	Alcohol use	Drug use
	n	n (%)	n (%)	n (%)	n (%)
Emergency Shelter	55	21 (38)	20 (36)	43 (78)	24 (44)
High support (5 houses)	43	37 (86)	34 (79)	37 (86)	20 (47)
Housing Plus*	79	28 (35)	50 (67)	64 (81)	25 (32)

*Includes Simon and Galton flats for independent living (38 clients), private rented accommodation (21 clients), council accommodation (7 clients) and 'other' (13 clients).
Source: Data from Cork Simon Community (2009)

Debt-related intimidation of drug users and their families

In 2009 the Family Support Network (FSN)[1] published the findings of research into the issue of intimidation of the families of drug users by those involved in drug dealing.[2] Through its work, the FSN became aware of a large number of families experiencing intimidation by drug dealers as a result of a family member's drug-related debts. The research consisted of a postal survey of 91 family support workers or facilitators, of whom 50 responded – a response rate of 55%.

The study found that no locality or region from which responses were received was untouched by intimidation. Of the 50 survey respondents, 30 knew of cases of intimidation in relation to debts of €500 or less. At the other end of the scale, 16 respondents were aware of cases relating to debts of between €10,000 and €40,000, and one respondent reported a case involving €60,000. Many of those in debt belonged to families surviving on very low incomes, who were often given only days to repay the debt. Drug users themselves often resorted to criminal activity to repay debts to dealers: many agreed to deal drugs or to hide, hold or transport drugs or firearms for the dealer to whom they owed money. Others engaged in violent activity, including murder in one case, as a method of repayment. Many female drug users engaged in prostitution to repay their debts.

Respondents were asked to list the types of intimidation experienced by families they encountered. The resulting lists included verbal threats, physical violence and damage to the home or other property. Seven respondents were aware of cases in which individual family members had experienced sexual violence or threats of such violence. Thirty-five respondents reported cases of intimidation in which mothers of drug users were targeted; 23 reported targeting of siblings; 21 reported targeting of fathers; 17 reported targeting of grandparents and children; and 10 reported targeting of partners and others.

The report identified a number of issues complicating both the impact of intimidation and the responses available to families. Because the debt was normally collected by a person working for the dealer, it was not always easy for families to know to whom the money was owed or whether the money was being given to the correct person. In deciding whether or not to pay a debt, families were influenced by their assessment of whether the intimidation would stop once payment was made, as 'many families are caught in a recurrent cycle of debt, intimidation, repayment and further debt' (p. 22). Fear often stemmed from knowledge of the perpetrators and their capacity to follow through on threats. Fifty-one per cent of respondents stated that threats were sometimes carried out; 33% that threats were always carried out; and 4% that they were never carried out.

Table 1 shows the various ways that families sourced the money to pay a debt on behalf of a family member, as reported by the survey respondents (six respondents were not aware of any such cases). In the case of social welfare payments, including children's allowances and disability payments, the intimidators sometimes waited outside social welfare offices on collection days to collect the debt.

Table 1 Sources of funds used by families to pay drug debts

Source of funds	Respondents who reported each source	
	n	%
Credit union loan	36	72
Borrowing from family/friends	33	66
Salary/wages	25	50
Social welfare payments	22	44
Borrowing from money lender	21	42
Sale of personal property	17	34
Re-mortgaging of home	11	22
Bank loan	9	18
Other	3	6
Not applicable	6	12
Source: Adapted from O'Leary (2009: 23)		

Debt-related intimidation of drug users and their families *(continued)*

The study identified a number of themes through a case study analysis of reported incidents of intimidation. These included the following:

- **Threatening behaviour** included verbal threats, intimidation at the workplace, harassment, death threats, threats of shooting, beating or 'knee-capping', and live bullets posted through letterboxes.
- **Physical/sexual violence against women** included the forcing of drug users and partners into prostitution; two minors under 18 years of age were forced into prostitution; one dealer threatened to rape the daughter of a drug user.
- **Children** were encouraged by dealers to deal to friends or other children so as to create debt and force them into further dealing; children were often present when family members were beaten; in some cases mothers engaged in prostitution in the family home as a means of debt repayment.
- **Garda reaction** – family members were too fearful to approach gardaí in relation to intimidation; many believed the gardaí were powerless to act; in one case gardaí advised a family to pay the debt, while in another they provided protective custody to a family and a drug user.
- **Women** – perpetrators of intimidation targeted female drug users for debt repayment, in some cases forcing them, either directly or indirectly, into prostitution; a high proportion of families targeted were headed by a female lone parent; average weekly earnings of females were significantly less than their male counterparts and women were more likely to be out of the workforce; women often concealed intimidation and payment from their husbands/partners owing to fear that he might not be willing to pay.
- **Forced emigration** – in many cases drug users had been forced to move or emigrate and were unable to return home.

The report called for a pilot initiative whereby the gardaí would identify a member of staff to liaise with families experiencing intimidation. A safe reporting and advice-provision procedure for families willing to report the issue and/or pursue it through the legal system was also called for. The intimidation of drug users and their families has been highlighted as a key issue in the National Drugs Strategy 2009–2016.[3]

(Johnny Connolly)

1. The FSN was established in 2000 to support the development of family support groups throughout Ireland. There are currently over 70 family support groups affiliated to the FSN.
2. O'Leary M (2009) *Intimidation of families.* Dublin: Family Support Network. Available at www.drugsandalcohol.ie/12898
3. Department of Community, Rural and Gaeltacht Affairs *(2009) National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs.

Newly diagnosed drug-related viral hepatitis infections in 2008

Hepatitis B

Hepatitis B is a vaccine-preventable disease which is transmitted through contact with the blood or body fluids of an infected person. The main routes of transmission are mother-to-baby, child-to-child, sexual contact and unsafe injections. The number of cases notified to the Health Protection Surveillance Centre (HPSC) increased each year between 1996 and 2005. In 2006 the number decreased by 7% (to 810) and then increased steadily in 2007 and 2008. There were 949 cases in 2008, of whom 765 had a chronic infection, 82 had an acute infection and the disease status of 102 cases was unknown (unpublished data from the HPSC). The surveillance system has recorded risk factor data since 2004 and the number of cases notified to the HPSC that include data on risk factors has increased from 30% in 2006 to 59% in 2008. In 2008, 59% (557) of all cases had risk factor data reported, of whom seven (1.3%) reported injecting drug use as their main risk factor. The number of such cases remained consistently low between 2005 and 2008, indicating the effectiveness of routine administration of the hepatitis B vaccine.

Hepatitis C

Hepatitis C is transmitted through contact with the blood of an infected person, the main routes of transmission being mother-to-baby, unsafe injections, transfusion of blood and blood products, and unsterile tattooing and skin piercing. It is one of the most common blood-borne viral infections among drug users. There were 1,537 cases of hepatitis C reported to the HPSC in 2008, compared to 1,128 cases in 2004 (Table 1), and 85 cases of hepatitis 'type unspecified' in 2003.

Table 1 Number of hepatitis C cases and age-standardised notification rates (ASR) per 100,000 population, 2004–2008

Year	Number of cases	ASR per 100,000
2004	1128	26.6
2005	1415	33.4
2006	1219	28.8
2007	1556	36.7
2008	1537	36.3

Source: Unpublished data from the HPSC

Newly diagnosed drug-related viral hepatitis infections in 2008 *(continued)*

An enhanced surveillance system for hepatitis C was introduced in Ireland in 2007. Enhanced surveillance is essential to identify risk factors and to inform the development of prevention and treatment strategies. In 2008, 38% of newly-reported hepatitis C cases had risk factor status reported (Table 2). As expected, the majority (76.9%) of these cases reported injecting drug use as the main risk factor. Four per cent of cases said that they had been recipients of blood or blood products at some time in the past and, according to the HPSC, were late reports to the system (N Murphy, HPSC, personal communication, 2009).

Table 2 Number (%) of hepatitis C cases reported to the HPSC, by risk factor status, 2007 and 2008

Risk factor status	2007 n (%)	2008 n (%)
Total number of cases	1556	1537
Cases *with* reported risk factor data	664 (42.7)	581 (37.8)
Of which:		
Injecting drug users	503 (75.8)	447 (76.9)
Recipients of blood/blood products	34 (5.1)	24 (4.1)
Other risk factors	90 (13.6)	77 (13.3)
No known risk factor identified	37 (5.6)	33 (5.7)
Cases *without* reported risk factor data	892 (57.3)	956 (62.2)
Source: Unpublished data from the HPSC		

In 2007, 85% of cases who reported injecting drug use as their main risk factor were notified to the HPSC by services in Dublin, Kildare and Wicklow and the remainder by services in HSE areas outside these counties (Table 3). Seventy-one per cent were male and 62% were under 35 years old.

Table 3 Hepatitis C cases who reported injecting drug use, by age, gender and place of residence, 2007 and 2008

Risk factor status	2007 n (%)	2008 n (%)
Total number of known injector cases	503	447
Gender		
Male	339 (67.4)	319 (71.4)
Female	163 (32.4)	126 (28.2)
Unknown	1 (0.2)	2 (0.4)
Age		
Mean (in years)	32.7	33.3
Median (in years)	31	32
Under 25 years	49 (9.7)	45 (10.1)
25–34 years	282 (56.1)	233 (52.1)
Over 34 years	170 (33.8)	165 (36.9)
Unknown	2 (0.4)	4
Place of residence		
Dublin, Kildare and Wicklow	445 (88.5)	379 (84.8)
Elsewhere in Ireland	58 (11.5)	68 (15.2)
Source: Unpublished data from the HPSC		

(Jean Long)

Drug Treatment Centre Board pioneers nurse prescribing in addiction in Ireland

The two newly-graduated nurse prescribers in addiction, Claire Loomes (3rd from left) and Jane Bridgeman (6th from left), with their Drug Treatment Centre Board colleagues and Maureen Flynn of the HSE (2nd from left).

On 15 December 2009 the Drug Treatment Centre Board announced the graduation of two of its nurses as Nurse Prescribers in Addiction.[1] This treatment centre is the first addiction service in Ireland to have qualified nurse prescribers. Making the announcement, the Board's general manager, Sheila Heffernan, said: 'Our range of services, specialist teams and dedication to excellence has positioned us perfectly to become the first to introduce nurse prescribing in addiction nationally.'

The 1998 report, *Review of scope of practice for nursing and midwifery*,[2] produced by An Bord Altranais recommended that nurse prescribing be introduced in Ireland. Internationally, this practice has been seen to improve the quality of patient care when used in appropriate circumstances. The advantages of nurse prescribing in addiction services include increased access to services for clients, improved continuity of care, reduced waiting times and improved quality of service and care.[3]

In May 2007, the Minister for Health signed the legislation to provide the legal authority for nurses and midwives to prescribe medication: Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order 2007 (SI No. 194 of 2007), Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007 (SI No. 201 of 2007) and Misuse of Drugs (Amendment) Regulations 2007 (SI No. 200 of 2007).[4]

The first cohort of qualified nurse prescribers in Ireland was registered in January 2008.[5] Prospective nurse prescribers must complete an approved six-month course and adhere to a set of practice standards and competencies for prescribing. In addition, An Bord Altranais requires any health facility employing nurse prescribers to have certain support structures in place.

Currently, nurse prescribers cannot prescribe methadone. However, they can, where appropriate, prescribe certain controlled drugs under specific conditions of the Misuse of Drugs Regulations, including drugs for the purpose of midwifery, such as pethidine, or drugs for palliative care, such as morphine sulphate.[4]

(Suzi Lyons)

1. Drug Treatment Centre Board (2009) *The Drug Treatment Centre Board pioneers first nurse prescribers in addiction in Ireland.* DTCB online news report dated 15 December 2009. Accessed 19 February 2010 at www.dtcb.ie/news
2. An Bord Altranais (2000) *Review of scope of practice for nursing and midwifery: final report.* Dublin: An Bord Altranais.
3. Gallagher J, O'Gara C, Sessay M and Luty J (2006) Nurse prescribing in addiction services: client benefits. *Nursing Standard*, 20(48): 42–44.
4. For further information please see An Bord Altranais website at www.nursingboard.ie An Bord Altranais (2008) First registered nurse prescribers. *An Bord Altranais News*, 20(1): 1.

Legal update 2009

This update covers drug-related Bills and Acts of the Oireachtas introduced or progressed in 2009. It also identifies new substances brought under control within the terms of the Misuse of Drugs legislation.

The **Criminal Justice (Surveillance) Act 2009** provides, for the first time, a legal framework to allow covert surveillance material to be used in criminal trials. The Garda Síochána, the Defence Forces and the Revenue Commissioners will have a statutory framework for the operation of secret electronic surveillance to combat serious crime as well as subversive and terrorist threats against the security of the State. The legislation also builds in safeguards with regard to the authorisation, duration and operation of such surveillance.

The **Criminal Justice (Amendment) Act 2009** makes provision to enable all organised crime offences to be declared scheduled offences for the purpose of trial in the Special Criminal Court, which operates with three judges and without a jury. Section 3 of the 2009 Act amends section 70 of the Criminal Justice Act 2006 and defines a 'criminal organisation' as 'a structured group, however organised, that has as its main purpose or activity the commission or facilitation of a serious offence'. A 'structured group' is defined as 'a group of 3 or more persons, which is not randomly formed for the immediate commission of a single offence, and the involvement in which by 2 or more of those persons is with a view to their acting in concert; for the avoidance of doubt, a structured group may exist notwithstanding the absence of all or any of the following:

a) formal rules or formal membership, or any formal roles for those involved in the group;

b) any hierarchical or leadership structure;

c) continuity of involvement by persons in the group.'

In relation to bail, organised crime offences will be scheduled as 'serious offences' within the meaning of the Bail Act 1997, thereby providing for circumstances where bail may be refused by the courts.

In its passage through the Oireachtas, this legislation gave rise to a number of criticisms from lawyers and human rights groups. With regard to restrictions on the Irish constitutional right to trial by jury, the Irish Human Rights Commission (IHRC) stated: 'The IHRC is cognisant that organised crime is a problem in Ireland and that it has the potential to cause great harm to Irish society. However, the IHRC considers that the exigencies of the situation in Ireland do not justify the restriction of the Constitutional right to trial by jury.'[1] The IHRC suggested that with regard to the risk of jury intimidation, a number of other measures could be adopted to address this potential problem including having an anonymous jury, screening the jury from public view, protecting the jury during the trial, or locating the jury in a different place from where the trial is being held, with communication by video link.

The Criminal Justice (Miscellaneous Provisions) Act 2009 provides a statutory framework for the control of firearms.

The Housing (Miscellaneous Provisions) Act 2009 obliges local housing authorities to adopt a strategy to prevent and reduce anti-social behaviour in their housing stock, with the additional objectives of the co-ordination of services and the promotion of co-operation with other agencies to that end. The Act also broadens the definition of anti-social behaviour in the Housing (Miscellaneous Provisions) Act 1997 to include significant or persistent impairment of a person's use or enjoyment of their home, and damage to or defacement of any property.

The Health (Miscellaneous Provisions) Act 2009 makes arrangements for progressing the integration of health service agencies in line with Government policy on the rationalisation of public sector agencies. Part 5 of the Act provides for the dissolution of the Drug Treatment Centre Board and the transfer of its rights, liabilities, land and any other assets to the Health Service Executive.

The **Criminal Procedure Bill 2009** makes provision for a modification of the rule against double jeopardy in order to allow a person who has been acquitted of an offence to be re-tried in circumstances where new and compelling evidence emerges or where the acquittal is tainted due, for example, to corruption or intimidation of witnesses or jurors or perjury. The legislation applies to a number of drug-related offences.[2]

The **Communications (Retention of Data) Bill 2009** requires service providers, those engaged in the provision of a publicly electronic communication service or a public communication network by means of fixed line or mobiles or the internet to retain data relating to fixed and mobile telephony, for one year, and data relating to internet access, internet email and internet telephony for two years.[3]

The **Criminal Justice (Money Laundering and Terrorist Financing) Bill 2009** provides for offences of, and related to, money laundering in and outside the State; to give effect to Directive 2005/60/EC of the European Parliament and of the Council of 26 October 2005 on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing.

The **Road Traffic Act 2009** provides for a reduction in the blood alcohol content (BAC) limit for drivers and also provides powers to assist the Garda Síochána in forming an opinion as to whether a driver is under the influence of an intoxicant (drug or drugs) and to carry out a preliminary impairment test on such drivers.

New substances brought under control

In March 2009, Minister for Health and Children Mary Harney TD announced that 1-benzylpiperazine (BZP) is now a controlled drug through statutory instruments (121 and 122 of 2009) amending the Misuse of Drugs Act 1977, and that its possession or sale is now a criminal offence. The new statutory instruments will ensure that BZP is no longer available for sale in 'head shops' around the country or on the streets.

(Johnny Connolly)

1. Irish Human Rights Commission (2009) *Observations on the Criminal Justice (Amendment) Bill 2009*. Dublin: Irish Human Rights Commission. www.ihrc.ie
2. Bill at Committee stage March 2010.
3. Bill at Report and Final Stages February 2010.

Report on nursing in the Irish Prison Service

Nurses first began working in the Irish Prison Service (IPS) in 1999. The IPS and the Nursing and Midwifery Planning and Development Unit (NMPUDU) of the HSE Eastern Region collaborated in a recent study exploring the opportunities for the development of nursing services in prisons. The results of that study have now been published.[1]

The study included a literature review on the role of nurses in prison healthcare, a descriptive review of the IPS and the professional framework for nursing in Ireland, and a quantitative questionnaire completed by nurses and medical orderlies working in the IPS (32% response rate). The qualitative components were participant observation and semi-structured interviews with key informants, including prison management and those internally and externally involved in prison healthcare. Focus groups were held with three groups of nurses and three groups of prisoners. Data collection took place between November 2005 and December 2007.

The findings of the study covered a wide range of health and professional issues; this article will focus only on the results related to substance misuse and addiction. In the quantitative questionnaire, care related to substance misuse featured in the 14 most frequently performed clinical tasks, and was carried out on a daily basis by 50% or more of respondents to the questionnaire. More than half of the nurse respondents identified addiction as one of the areas where specialist training should be developed.

In the qualitative part of the study, participants highlighted addiction and its consequences as an important healthcare problem. Participants reported that cannabis, benzodiazepines and heroin were the most common illicit substances used in prisons, although availability varied between prison sites. While methadone maintenance treatment was available in most prisons, the need for improved treatment for problem use of other substances, in particular benzodiazepines and alcohol, was raised by many participants. Treatment for addiction was reported to be inconsistent, with a lack of counselling services[2] and there was 'some confusion in relation to approaches to detoxification, methadone dose and access to treatment' (p. 82). Most participants reported a need for improved education and training in addiction care for nurses. Prisoners also highlighted the need for peer support and improved discharge planning in relation to addiction care.

Mental health problems among prisoners, especially those who had a dual diagnosis (both a mental health issue and a substance use disorder), were identified as a significant and challenging health issue by all participant groups.

The authors conclude that nurses have a very important role in addressing the health needs of prisoners. They found that there was a strong awareness of the importance of prison healthcare and that nurses did receive recognition and support from all the stakeholders involved. However, it also found that nurses could be used more effectively within the IPS.

The report sets out 16 goals for the future development of prison nursing and healthcare in Ireland, each with its own set of recommendations. The authors state that many of the recommendations do not require additional resources or funding, but restructuring and integration of existing services and resources and effective collaboration at all levels.

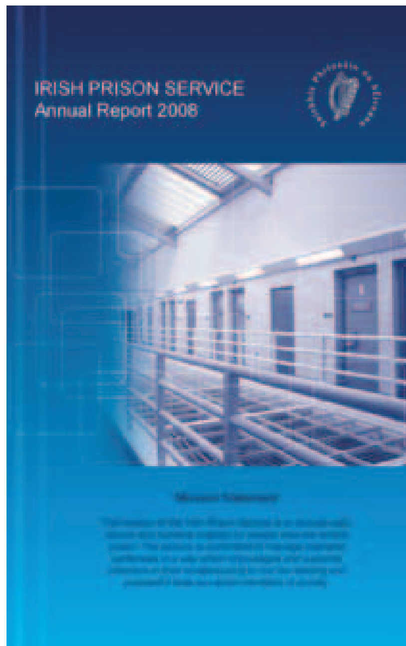
The goals are:

- Enhance the strategic development of prison healthcare
- Identify and meet prisoner health needs
- Develop and implement policies, procedures, protocols and guidelines
- Develop nursing role:
    - role definition
    - advance capacity for specialist and advanced nursing practice
    - advance skills and competencies
- Develop professional development infrastructure
- Support practice with the scope of Nursing and Midwifery Practice Framework
- Enhance quality and governance
- Develop workforce planning
- Strengthen nursing practice – access
- Strengthen nursing practice – committal assessment and care planning
- Balance the therapeutic and custody roles
- Develop prison healthcare infrastructure
- Implement recommendations.

(Suzi Lyons)

1. Nursing and Midwifery, Planning and Development Unit & the Irish Prison Service (2009) *Nursing in the Irish Prison Service: working together to meet the healthcare needs of prisoners.* Dublin: Health Service Executive.
2. Since 2008 Merchants Quay Ireland has provided national prison-based addiction counselling services to 13 prisons.

Irish Prison Service annual report 2008



The Irish Prison Service (IPS) annual report for 2008[1] notes a number of developments in relation to healthcare and drug treatment and reintegration services, as well as presenting data on drug offenders in custody and outlining the enhanced security measures in place to prevent access to contraband. These sections of the report are summarised in this article.

Healthcare services

The aim of the prison healthcare service is to provide prisoners with access to the same quality and range of health services as that available to those entitled to general medical services in the community, and which are appropriate to the prison setting.

Nursing

Nurse managers were in post in all closed prisons and in the three main prison complexes: Mountjoy, Cloverhill and Wheatfield, and Midlands and Portlaoise. The report states that this has significantly impacted on the co-ordination, organisation and quality of healthcare services in the IPS. Specific addiction nursing posts were also created, mainly in Mountjoy prison.

Pharmacy services

Professional pharmacy services were available in all except one prison (they were to be introduced in Cork prison in 2009). In addition, prisoners in Mountjoy/Dóchas complex had access to a drug treatment pharmacy service. This service dispensed methadone to approximately 200 patients every day.

Mental health

The report notes the high prevalence of mental health problems in the prison population and the importance of providing care in the most appropriate facility. In the latter part of 2008 some 15 prisoners a week were waiting for admission to the Central Mental Hospital (CMH). In November 2008 the HSE agreed to provide 10 extra beds in the CMH, and although these beds were not solely for the use of the prisons, they have gone some way to reducing the waiting list for this service.

In-reach services

In-reach medical services are available in a number of the prison sites:

- Dental services from the Dublin Dental Hospital – in seven Dublin prisons
- Consultant-led psychiatric services from the CMH – in all Dublin prisons and in Portlaoise/Midlands
- Consultant-led addiction services – in Cloverhill/Wheatfield and in the Mountjoy complex.

Deaths in custody

In 2008 there were 11 deaths in custody, an increase of five on the 2007 figure. The inquests were not closed in any of these cases so exact cause of death was not known. Every death in custody is examined by a multi-disciplinary group, and significant findings are shared with other sites. The report states that there are strategies in place to help prevent self-harm and suicide.

Drug treatment services

Merchants Quay Ireland completed the implementation of its national prison-based addiction counselling service in 2008. This service is available to all prisoners who require it, and provided in excess of 1,000 counselling hours per month to a total of 440 prisoners in 13 prisons in 2008.

Methadone maintenance treatment was available in eight of the 14 prisons (covering 80% of the prison population). The report notes that in 2008 the IPS was the largest single provider of methadone maintenance treatment, treating an average of 650 patients per month, and a total of 2,014 in the year (Table 1). This represents a 28% increase on 2007 figures. Of these, 241 had never been in treatment before (Table 1).

The IPS published a *Drug treatment clinical policy* in January 2008 to provide guidance to health professionals when treating addiction in prison.[2]

Irish Prison Service annual report 2008 *(continued)*

Table 1 Numbers of individuals receiving methadone treatment* in Irish prisons in 2008

Prison	Total patients during 2008	New patients in 2008	Patients at 31 December 2008
Cloverhill Prison	827	168	71
Dóchas Centre	245	27	25
Limerick Prison	37	6	12
Midlands Prison	110	5	50
Mountjoy Main Prison	464	12	171
Mountjoy Medical Unit	89	5	19
Portlaoise Prison	4	1	1
St Patrick's Institution	28	5	8
Wheatfield Prison	210	12	95
Total	2014	241	452

*Methadone treatment in this context is either substitution or detoxification.
Source: IPS (2009)

Reintegration – homelessness
The report refers to homelessness among ex-prisoners as an ongoing problem; 894 prisoners accessed the in-reach community welfare service provided by the Homeless Persons Unit of the HSE in 2008, an increase of 304 on the 2007 figure. A pilot service run by Focus Ireland in Cloverhill prison has provided a case management and pre-settlement service for 68 homeless remand prisoners since it started in September 2007.

Drug offenders in custody
On 5 December 2008 there were 567 people (550 males and 17 females) serving sentences for drug offences – 15% of the total number (3,695) in custody on that date, and 20% more than the comparable figure of 472 in 2007.

During 2008, 637 people (595 males and 42 females) were committed under sentence for drug offences, representing 8% of total committals under sentence in the year, compared to 8.2% in 2007. Thirty-six drug offenders were committed under sentence of more than 10 years, an increase on the 2007 figure of 22. Table 2 shows the numbers in custody on 5 December 2008 and the numbers committed during 2008, by sentence length.

Security measures
The roll-out of a package of enhanced security measures in closed prisons to prevent access to contraband items, primarily mobile phones, drugs and weapons, began in May 2008. The new measures include operational support (dedicated search teams), security screening (airport-style detectors and scanners) and drug-detection dog teams (16 teams came into operation in 2008). Some 2,047 mobile phones were seized by prison authorities in 2008. The first module of a pilot project to install technology to prevent the use of mobile phones was completed in the Midlands prison in November 2008, and a second module was started in Portlaoise prison.

There were 759 incidents of violence among prisoners, some of them very minor. According to the report, 'Attacks by prisoners on prisoners are often related to matters on the outside – such as drug debts or gang rivalry, or perceived co-operation with Gardaí.'

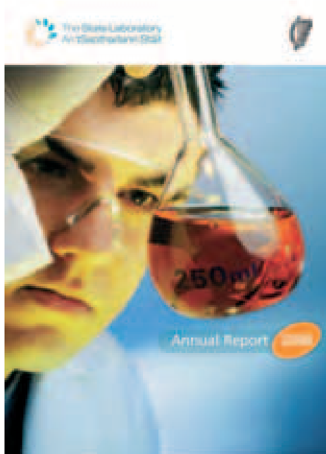
(Suzi Lyons and Joan Moore)

1. Irish Prison Service (2009) *Irish Prison Service annual report 2008*. Longford: Irish Prison Service.
2. This document can be found at www.irishprisons.ie/Healthcarepolicies060209.doc

Table 2 Numbers serving sentences for drug offences, by sentence length, 2008

Drug offenders	<3 months	3–6 months	6–12 months	1–2 years	2–3 years	3–5 years	5–10 years	10+ years	Total
In custody on 5 December 2008	4	3	22	33	60	133	220	92	567
Committed under sentence in 2008	139	61	133	53	59	77	79	36	637

The State Laboratory annual report 2008



'The State Laboratory provides an analytical and advisory service to Government departments and offices to support their policies, regulatory programmes and strategic objectives'.[1] The laboratory's annual report for 2008 outlines the progress made in achieving its objectives in four strategic areas: agriculture and food, Revenue, the Coroner Service and other departments, and the modernisation agenda and operational capacity.[2]

The human toxicology department of the laboratory provides services to the Coroner Service, the Department of the Environment, the Department of Agriculture and other bodies such as the Irish Medicines Board. Between 2007 and 2008 the laboratory saw a 6% increase in the number of samples received for analysis. The laboratory extended its analytical capacity in 2008 with the development of a number of new methods of analysis.

The number of post-mortem samples analysed for the Coroner Service which were positive for cocaine remained high, indicating the widespread use of the drug. Requests for post-mortem analysis of benzylpiperazine (BZP) were encountered for the first time by the laboratory. BZP (also known as legal ecstasy) is an amphetamine-type drug which, until March 2009, could be purchased legally in Ireland in the form of party pills. In 2009, legislation was passed making BZP and related compounds illicit substances under the Schedule of Controlled Substances in the Misuse of Drugs Act.

The goal of the laboratory with regard to the Coroner Service remains that of providing a timely, high-quality service and to meet present and future demands in areas such as forensic toxicology, health and safety compliance, and environment and heritage protection.

(Simone Walsh)

1. The State Laboratory (2008) *Annual report 2007*. Kildare: The State Laboratory.
2. The State Laboratory (2009) *Annual report 2008*. Kildare: The State Laboratory. www.statelab.ie/PDF/AnnRep2008.pdf

Anthrax outbreak in heroin users in the UK and Germany

Since early December 2009, public health authorities in Scotland have identified 27 cases of anthrax in heroin users, of whom 10 have died. In England, there were three cases of anthrax among heroin users, one of whom died. In Germany, one heroin user died of an anthrax infection. Anthrax is a very rare but serious infection caused by the bacterium *Bacillus anthracis*. If the bacterium enters the bloodstream or the brain and is not treated early, it is usually fatal. Important symptoms of anthrax are marked redness and swelling around an injection site and/or a very high temperature. There have been no cases of anthrax infection identified in Ireland.

Further information is available on the following websites:

www.hps.scot.nhs.uk/anthrax/index.aspx

www.hpa.org.uk/HPA/Topics/InfectiousDiseases/InfectionsAZ/1191942145749/

http://ndsc.newsweaver.ie/epiinsight/1of2s8hqbmy1trn9tg2qo4

The Irish Needle Exchange Forum conference

The Irish Needle Exchange Forum (INEF) held its inaugural conference at the Malton Hotel, Killarney, Co Kerry, on 5 November 2009. The INEF is the first dedicated resource for those working in the field of harm reduction and needle exchange (NX) in Ireland and is linked to the main national and international harm reduction organisations. The forum aims to provide those working in the field with a platform to initiate open, informed discussion and debate, and to raise concerns and move issues forward, to identify and promote good practice in the development and delivery of needle exchange services. The INEF believes that harm reduction complements abstinence-based approaches by providing service users with the knowledge and tools to stay safe until they can achieve and maintain abstinence.

The INEF conference was well attended. Speakers in the morning session included Dr Shane Butler, who spoke about extending needle-exchange provision across the Irish healthcare system; Tony Duffin, director of Ana Liffey, who discussed harm reduction within the continuum of care approach, and Tony Geoghan, director of Merchants Quay Ireland (MQI), who presented a profile of service users at the needle-exchange facility in MQI. International speakers included Rick Lines, who presented evidence on the effectiveness of needle- and syringe-exchange programmes in prisons, and Jamie Bridges, who explored the concept of harm reduction; both Rick and Jamie work for the International Harm Reduction Association (IRHA).

The afternoon session included three workshops: needle and syringe provision for adolescent users; working with women drug users who engage in risky sexual behaviour; and blood-borne viruses. The workshops were very well attended and covered many practical issues that were relevant to front-line workers. The afternoon session also included presentations from Martin Chandler (UK), who presented on research that examined the risks of taking performance and image-enhancing drugs (PIEDS), and Lloyd Belcher (UK), who presented on research into secondary peer needle exchange programmes. John Craven from the HSE East Coast Area Addiction Services presented a profile of the needle exchange back-packing service that is delivered locally.

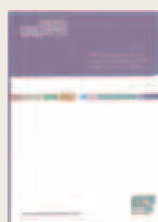
Dr Denis O'Driscoll, chief pharmacist at HSE Addiction Services Dublin Mid-Leinster, and Mr Rory Keane, Regional Drug Co-ordination Unit HSE Mid-West, presented an overview of plans to provide additional needle exchange-services through community pharmacies in 65 new locations across the country. It is envisaged that the services will be targeted to areas outside Dublin and the former Eastern Regional Health Authority. The services proposed will come from a new partnership between the Irish Pharmacy Union (IPU), the Health Service Executive (HSE) and the Elton John Aids Foundation (EJAF). The service will be part-funded by the EJAF for three years, with matching funding by the HSE.

The HSE will take responsibility for funding in year four. It is envisaged that in the first year a national pharmacy co-ordinator will be appointed and regional pharmacy liaison staff and participating pharmacies will be recruited. These actions will be supported by developing a training programme for participating pharmacists. Needle-exchange services will be provided free in pharmacies and will include both custom-made and standard packs. It is envisaged that the service will exchange new injecting equipment for old, provide sharps bins and advice on safe disposal of used equipment, information on safer-injecting and safe sex practices, and advice on drug use and other health-related issues.

The INEF is chaired by Mr Tim Bingham. More information about the forum and its activities can be found on the website www.inef.ie

(Martin Keane)

2010 Directory of training courses



The National Documentation Centre on Drug Use has published a new edition of the Directory of courses and training programmes on drug misuse in Ireland. Forty-two providers sent us information about 102 courses for this fifth edition. We would like to thank all of those who made contributions.

Most courses refer directly to drugs or addiction, though others aim to develop broad skills, such as supervision, facilitation and counselling techniques, which may be of interest to those working in this area. A wide variety of training standards, methods and approaches are represented.

We do not assess the quality of courses listed; we present information as supplied by the course co-ordinators on course length, assessment, qualifications and accreditation. Course providers are based in Dublin (60%), Cork, Donegal, Kildare, Galway, Leitrim, Limerick, Mayo, Meath, Roscommon, Tipperary, Waterford and Westmeath. Although many cater specifically for people in their locality, some also offer courses on a regional or national basis.

A small number of task forces offer financial assistance for those living or working in their area to attend specified courses. We provide information on their application criteria. Course co-ordinators who wish to revise an existing entry or include a new course in the 2011 edition of the Directory may request an application form from mdunne@hrb.ie

(Mary Dunne)

From *Drugnet Europe*

EMCDDA and Europol step up information collection on mephedrone

Extract from article by the Action on new drugs team printed in Drugnet Europe *No. 69, January–March 2010*

Synthetic cathinones are increasingly being reported to the EMCDDA and Europol via the EU early-warning system (EWS). These 'designer' compounds, structurally related to amphetamine, are derivatives of the parent compound cathinone, one of the psychoactive ingredients found in khat (*Catha edulis)*. In 2008, six of the 13 psychoactive substances reported via the EWS were synthetic derivatives of cathinone.

Some 15 synthetic cathinones are currently being monitored through the EWS, among these mephedrone (4-methylmethcathinone). Now apparently more popular among drug users as a 'legal high' — legal alternative to amphetamine, cocaine and ecstasy — the substance has recently attracted considerable media attention. To date, there has been one confirmed mephedrone-related death in Sweden and others suspected in the UK.

A rapid audit on the availability of mephedrone on the Internet at the end of 2009 showed that at least 31 websites were selling the substance, around three-quarters of them being dedicated mephedrone sites. ...

... the EMCDDA and Europol agreed to launch a formal procedure to collect further information on the substance. This will lead to the production of an EMCDDA–Europol Joint report to be presented to the Council of the EU, the European Commission and the European Medicines Agency. On the basis of this report, a decision can be taken on whether or not to launch a formal risk-assessment procedure on the substance.

Health and prisons in Europe

Cited from article by Linda Montanari, Dagmar Hedrich and Lucas Wiessing in Drugnet Europe *No. 69, January–March 2010*

Prisoners are entitled to the same level of medical care as persons living in the community. Prison health services should therefore be able to provide treatment for drug problems in conditions comparable to those offered outside prison. This general principle of equivalence is recognised within the EU by a 2003 Council recommendation on the prevention and reduction of health-related harm associated with drug dependence. The current EU drugs action plan (2009–12) calls for its implementation. The issue of health in prisons was the focus of two European conferences held in October and November in Madrid and Oslo.

Several issues regarding prison health and drug use were raised at these events, including the high proportion of drug users in prison, the spread of infectious diseases and the high risk of drug-related deaths after release from prison. The events resulted in specific recommendations covering topics such as the prevention of post-release mortality, notably via the continuation of substitution treatment in prison. Also stressed was the need to boost evidence-based treatment in prison and to strengthen the link between prison and public health services.

Madrid conference: The Madrid recommendation: Health protection in prisons as an essential part of public health, www.prisonhealthconference2009.com

Oslo conference: www.ndphs.org/?mtgs,prison_health_public_health

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

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

Health Research Board
Knockmaun House
42–47 Lower Mount Street
Dublin 2
Tel: 01 2345 127
Email: drugnet@hrb.ie

In brief

On 10 September 2009 the **European Communities (Road Haulage and Road Passenger Transport Operator's Licences) Regulations 2009 (SI No 318 of 2009)** came into effect. In the Dáil on 5 November, Minister for Transport Noel Dempsey TD explained that this regulation automatically disqualifies from holding a road transport operator's licence any operator who has serious convictions in a number of specific areas, including drug-trafficking, money laundering and firearms offences. Any licensee continuing to operate while disqualified risks receiving a maximum fine of €500,000 or three years in prison, or both. www.attorneygeneral.ie

On 4 November 2009 the **Independent Monitoring Commission (IMC)** published its 22nd report. In assessing current activities by republican paramilitary groups the IMC reported, 'we note that a factor behind the increase in the number of attacks in some nationalist areas appears to have been the growth of vigilante organisations which claim to want to "clean up" (their term) anti-social behaviour. Two such groupings are Concerned Families Against Drugs in Belfast and Republican Action Against Drugs in Derry. We believe that both these groups have undertaken attacks, including the use of pipe-bombs.' With regard to loyalist paramilitary groups, the IMC reported in relation to the Ulster Defence Association (UDA) that, 'notwithstanding the efforts of some in the leadership to reduce criminality [including drug dealing, robbery, extortion and the supply of contraband cigarettes], some senior figures remain directly involved or give their personal approval.' www.independentmonitoringcommission.org

On 13 November 2009 the **British–Irish Council (BIC)** held its thirteenth Summit meeting in Jersey. The meeting heard that the Sectoral Group on the Misuse of Drugs had held three Senior Official meetings in 2009. (1) In March, Guernsey briefed the group on the introduction of their new legislation to ban Spice and other psychoactive substances. (2) In May, Dr Suzi Lyons of the Alcohol and Drugs Research Unit of the Health Research Board gave a presentation to the group on the development and the content of Ireland's National Drug-Related Deaths Index. (3) The September meeting focused on prevention and on how Scotland was raising awareness in the overall population of the dangers of drug use through their national Know the Score campaign. www.britishirishcouncil.org

On 19 November 2009 the **Defence Forces policy** on drugs was the subject of a Parliamentary Question. Minister for Defence Willie O'Dea TD stated: 'A Compulsory Random Drug Testing (CRDT) programme aimed at deterrence was introduced in October 2002. Since then, 10,178 tests have been conducted with 41 tests yielding a positive result (4.0%). To date, a total of 25 members have been discharged as a result of a positive test result.' www.oireachtas.ie

On 2 December 2009 the **numbers employed by drugs task forces** were the subject of a Parliamentary Question. Minister of State John Curran TD responded that in 2009 the number of people employed in the task forces and receiving funding from the Department's Drugs Initiative was 34 in the local drugs task forces at a cost of €1.583 million, and 20 in the regional drugs task forces at a cost of €926,000. The Minister noted that some of these people worked in a part-time or job-sharing capacity; that in some instances, the task forces employed the people directly, while in others a task force project or other local organisation acted as a host employer; and that the task force co-ordinators were employed by the HSE. www.oireachtas.ie

On 9 December 2009 the Board of the **Homeless Agency Partnership** acknowledged significant advances in addressing homelessness in Dublin, including a decline in rough sleeping, implementation of a new model of homeless services, and localisation of homeless services across city and county. Cathal Morgan, director of the Homeless Agency, commented, 'This decline coincides with the intensive collaborative working that has taken place between all statutory and voluntary members of the Homeless Agency Partnership in identifying and securing long-term tenancies for people who currently reside in temporary forms of accommodation in homeless services.' www.homelessagency.ie

On 15 December 2009 the **Children's Mental Health Coalition (CMHC)** was launched in central Dublin. Comprising more than 35 organisations, the coalition will lobby the government on four key demands in relation to mental health services and the education, care and criminal justice systems. Its aim is to bring to life the vision as set out in the State's mental health policy – *A vision for change*. www.childrensmentalhealth.ie

On 1 January 2010 the **Spanish EU Presidency** commenced. In its programme for the first six months of the year, the Spanish Presidency endorses the new Stockholm Programme, which provides the framework for EU police and customs co-operation, including tackling drug trafficking, for the period 2010–2014. This programme replaces the Hague Programme, which similarly addressed the issue of drug trafficking at EU level, and which expired at the end of 2009. www.eu2010.es/en/

On 25 January 2009 the **Children's Rights Alliance (CRA)**, a coalition of over 90 NGOs working to secure the rights and needs of children in Ireland, launched its second annual 'report card', *Is the government keeping its promises to children?* With regard to protecting children from the negative consequences of alcohol use, the government was given an 'F' – 'a fail, and a significant drop from last year's "D"'. The report card states that the government has failed to move on recommendations made by the Strategic Task Force on Alcohol in relation to 'protecting children', and its decision to reduce the price of alcohol in Budget 2010 was a step that will 'undermine children's wellbeing'. The CRA called on the government to introduce a legislative ban to protect children from unnecessary exposure to alcohol marketing; the current voluntary advertising code is not seen as effective. www.childrensrights.ie

(Compiled by Brigid Pike)

Recent publications

Journal articles

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

Lifetime history of substance misuse in first-episode psychosis: Prevalence and its influence on psychopathology and onset of psychotic symptoms

Kamali M, McTigue O, Whitty P, Gervin M, Clarke M, Browne S, Larkin C and O'Callaghan E
Early Intervention in Psychiatry 2009; 3(3): 198–203
www.drugsandalcohol.ie/12822/

Introduction and aims: Substance misuse (drug/alcohol dependence or abuse) in psychotic illness is an increasingly recognised problem. We aimed to estimate the prevalence and examine the influence of substance misuse on age at onset of psychosis and psychopathology among patients with first-episode psychosis.

Method: One hundred seventy-one consecutive patients with first-episode psychosis were assessed. Substance misuse, age of onset of psychosis and psychopathology were determined using valid instruments.

Results: Seventy-seven (46%) patients had a lifetime history of substance misuse and were predominately males, had more positive symptoms, and in the majority of cases (84%), started misusing substances before the onset of psychosis (SM-BP). There was no difference in age of onset between patients with SM-BP and the rest of the sample.

Conclusion: Lifetime history of substance misuse is common and may influence psychopathology, but does not appear to influence or bring forward the age at onset of psychotic symptoms.

The functional outcome and recovery of patients admitted to an intensive care unit following drug overdose: a follow-up study

O'Brien BP, Murphy D, Conrick-Martin I and Marsh B
Anaesthesia and Intensive Care 2009; 37(5): 802–806
www.drugsandalcohol.ie/12823/

Patients who have overdosed on drugs commonly present to emergency departments, with only the most severe cases requiring intensive care unit (ICU) admission. Such patients typically survive hospitalisation. We studied their longer term functional outcomes and recovery patterns, which have not been well described. All patients admitted to the 18-bed ICU of a university-affiliated teaching hospital following drug overdoses between 1 January 2004 and 31 December 2006 were identified. With ethical approval, we evaluated the functional outcome and recovery patterns of the surviving patients 31 months after presentation, by telephone or personal interview. These were recorded as Glasgow outcome score, Karnofsky performance index and present work status. During the three years studied, 43 patients were identified as being admitted to our ICU because of an overdose. The average age was 34 years, 72% were male and the mean APACHE II score was 16.7. Of these, 32 were discharged from hospital alive. Follow-up data was attained on all of them. At a median of 31 months follow-up, a further eight had died. Of the 24 surviving there were 13 unemployed, seven employed and four in custody. The median Glasgow outcome score of survivors was 4.5, their Karnofsky score 80. Admission to ICU for treatment of overdose is associated with a very high risk of death in both the short and long term. While excellent functional recovery is achievable, 16% of survivors were held in custody and 54% unemployed.

Empirically defined subtypes of alcohol dependence in an Irish family sample

Sintov ND, Kendler KS, Young-Wolff KC, Walsh D, Patterson DG and Prescott CA
Drug and Alcohol Dependence 2009; (In press)
www.drugsandalcohol.ie/12825/

Alcohol dependence (AD) is clinically and etiologically heterogeneous. The goal of this study was to explore AD subtypes among a sample of 1,221 participants in the Irish Affected Sib Pair Study of Alcohol Dependence, all of whom met DSM-IV criteria for AD.

Variables used to identify the subtypes included major depressive disorder, antisocial personality disorder, illicit drug dependence (cannabis, sedatives, stimulants, cocaine, opioids, and hallucinogens), nicotine dependence, the personality traits of neuroticism and novelty seeking, and early alcohol use. Using latent class analysis, a 3-class solution was identified as the most parsimonious description of the data.

Individuals in a mild class were least likely to have comorbid psychopathology, whereas a severe class had highest probabilities of all comorbid psychopathology. The third class was characterised by high probabilities of major depression and higher neuroticism scores, but lower likelihood of other comorbid disorders than seen in the severe class.

Overall, sibling pair resemblance for class was stronger within than between classes, and was greatest for siblings within the severe class, suggesting a stronger familial etiology for this class. These findings are consistent with the affective regulation and behavioral disinhibition subtypes of alcoholism, and are in line with prior work suggesting familial influences on subtype etiology.

Alcohol usage and associated treatment outcomes for opiate users entering treatment in Ireland

Stapleton RD and Comiskey CM
Drug and Alcohol Dependence 2010; 107(1): 56–61
www.drugsandalcohol.ie/12642/

Evidence has shown that frequency and quantity of drug usage are reduced after treatment but the effect of opioid addiction treatment on alcohol consumption remains unclear. As part of the national Research Outcome Study in Ireland Evaluating drug treatment effectiveness (ROSIE, see www.nuim.ie/rosie) comprehensive drug and alcohol data on 404 opiate users were collected. This study recruited and followed up at 1 and 3 years a prospective cohort of 404 users entering a new treatment episode. Descriptive and inferential statistics were computed and logistic modelling was used to identify key factors effecting outcomes. The

Recent publications *(continued)*

cohort represented 8.2% of all new treatments. Follow-up interview rate at 3 years was 88%. Analysis revealed that those who abstained from alcohol use at 3 years were less likely to be using heroin at 3 years than non-abstainers. In addition, those who abstained from alcohol use at 3 years were also less likely to be using methadone, benzodiazepines and cocaine at 3 years than alcohol users. Outcomes for medium and heavy drinkers were found not to be as good as alcohol abstainers. Finally males tended to reduce the frequency and level of alcohol usage after entering treatment more than females. Results demonstrate to clinicians that an alcohol strategy is a key component of opiate treatment planning and a comprehensive and regular assessment of the client's alcohol and drug use profile is essential if treatment interventions are to have maximum impact on outcomes.

(Compiled by Louise Farragher)

Upcoming events

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

April

13 April 2010

Towards multi-level co-operation against drug trafficking in Europe
Venue: Renaissance Hotel, Brussels
Organised by/Contact: Centre for Parliamentary Studies
Email: bookings@publicpolicyexchange.co.uk
www.publicpolicyexchange.co.uk/events/AD13-PPE.php

Information: Since the launch of the EU Drugs Action Plan for 2009–2012, hopes are high that a renewed commitment to address the gaps in capacity building across the EU will have a positive impact. This special international symposium provides a timely opportunity for practitioners and stakeholders across the EU to discuss the latest challenges and consider the steps needed to revitalise the triple 'C' approach of Cooperation, Collaboration and Coordination in the fight against illicit drug trafficking through multi-level and cross-border approaches in Europe.

The Centre for Parliamentary Studies welcomes the participation of all key partners, responsible authorities and stakeholders. The symposium will support the exchange of ideas and encourage delegates to engage in thought-provoking topical debate.

May

24–26 May 2010

2nd World Forum Against Drugs
Venue: Stockholm, Sweden
Organised by/Contact: World Federation Against Drugs
www.wfad.se

Information: More than 600 representatives from 82 countries attended the first World Forum Against Drugs in Stockholm, Sweden, in September 2008. The Forum resulted in a Declaration that has been signed by a large number of organisations and individuals. The World Federation Against Drugs (WFAD) was formed in 2009 in Vienna, Austria, with a board representing all continents.

The 2010 World Forum will focus primarily on:

- New research on cannabis
- Drugs in Sub-Saharan Africa
- Adult drug abuse and its influence on children

June

24–25 June 2010

Drugs, alcohol and criminal justice: ethics, effectiveness and economics of interventions
Venue: Friends House, London
Organised by/Contact: Conference Consortium and supported by Drink and Drugs News and Napo
www.connectionsproject.eu/conference2010

Information: The University of Kent is delighted to announce the Second European Conference of the Connections Project. The conference takes place at a time of unprecedented competition for scarce resources everywhere. To be able to demonstrate 'value for money' is critical and nowhere is this more so than in drug and alcohol treatment. Following previous conferences where we have examined the various treatment models and interventions available, this event will seek to tease out how different modalities can be delivered and combined to construct a comprehensive treatment system, offering accessible and effective options to those requiring help, demonstrating value for money.

The conference will look at a range of interventions and treatments, from harm reduction to drug free 'recovery'. The premise is that no one treatment modality can deal effectively with the complex range of presented need. The task of the conference is to discuss and debate how best the different components can be combined most effectively.

September

22 September 2010

30th Annual EAP Conference & Learning Institute. Drugs and alcohol at work: health and safety implications in the workplace
Venue: Ashling Hotel, Parkgate Street, Dublin 8
Organised by/Contact: EAP Institute
www.eapinstitute.com/conference.asp

Information: This conference will feature presentations from health and safety professionals, EAP practitioners, employee relations specialists and policy makers which will assist delegates in developing policies and procedures that will comply with the Safety, Health and Welfare at Work Act 2005. The programme will also include three presentations on the US experience of the Drug-Free Workplace Act which was implemented in 1988. At the end of this conference those attending will be in a position to:

Upcoming events *(continued)*

- Have full knowledge of the general duties of employers and of employees to comply with Section 80 and Section 13 of the Safety, Health and Welfare at Work Act 2005.
- Acquire information on the development of workplace drug and alcohol policies, procedures and developing workplace drug and alcohol case law.
- Learn how to carry out risk assessments and develop control measures for workplace drugs and alcohol.

23 September 2010

EAP post-conference training seminar: procedures for the collection and processing of employee drug and alcohol tests
Venue: Ashling Hotel, Parkgate Street, Dublin 8
Organised by/Contact: EAP Institute
www.eapinstitute.com/conference.asp

October

30 September – 3 October 2010

21st Annual ESSD Conference
Venue: Dubrovnik, Croatia
Organised by/Contact: ESSD: European Society for Social Drug Research
www.essd-research.eu/en/index.html

Information: It has been an ESSD tradition to hold a conference in a different European country each year, preferably alternating between North, South, East and West Europe. Twenty conferences have been held to date, in 16 countries. The 21st conference will be held this year in Dubrovnik, Croatia. Further details will be posted on the website in due course.

December

5–7 December 2010

Thematic meeting: Policies for reducing problems associated with alcohol availability
Venue: Washington Marriott Wardman Park, Washington DC
Organised by/Contact: Silver Gate Group
www.silvergategroup.com/ap15/index.htm

Information: The US federal administration has signalled a renewed interest in science and public health. Meanwhile, states and localities are facing increased demand for public services in the face of declining revenues. Evidence-based alcohol policy can reduce alcohol problems and resultant social costs, simultaneously generating revenue (alcohol excise taxes and other user fees) to promote public health and safety.

This 15th conference in the Alcohol Policy series will explore, develop, and advance public policy approaches to the prevention of alcohol problems in order to promote evidence-based strategies and to bring focus to the need for alcohol policy reform at all levels – local, regional, national, and international. Specific objectives are to:

Strengthen the understanding of sound, evidence-based public policy in preventing and reducing alcohol-related problems.

Illuminate policy-making processes at local, state, regional and national, and international levels.

Influence international, national, regional, state and local agendas to consider rational alcohol policy, with an emphasis on offsetting the public costs of alcohol use.

Expand the coalition of individuals, organisations and agencies committed to public policy approaches to the prevention of alcohol problems.

Promote public discussion on specific alcohol policy issues, including sales, service, products, marketing, and other conditions of availability.

Do we have your correct contact details?

The form enclosed with this issue invites you to confirm that the contact details we have for you are correct, or to update them if necessary, and to subscribe to receive *Drugnet Ireland* by email rather than in hard copy. We would appreciate your taking the time to complete the form and return it to us at the address below.

***Drugnet Ireland* is published by:**

Health Research Board
Knockmaun House
42–47 Lower Mount Street
Dublin 2

Tel: + 353 1 2345 127
Email: drugnet@hrb.ie

Managing editor: Brian Galvin
Editor: Joan Moore