drugnet IRELAND

Issue 34
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Alcohol and Drug Research Newsletter

Update on psychoactive head shop products

with pull-out chart

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Drugs come under new department

Following the reorganisation of government departments announced on 23 March 2010, the Office of the Minister for Drugs (OMD) is now located in the new Department of Community, Equality and Gaeltacht Affairs (DCEGA). Chief Whip Pat Carey TD, who was Minister of State with responsibility for drugs strategy and community affairs for 11 months between June 2007 and May 2008, was appointed Minister for Community, Equality and Gaeltacht Affairs, including responsibility for the National Drugs Strategy and the OMD.

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Children talk about living with problem drug and alcohol use

> 'She knew not to go near me in the morning 'til I had my foil, then 'mummy would play'. In the mornings the sickness was the worst… I'd just be telling her to get away. Once I had the gear [drugs] into me I'd be the best mother on the earth.'

These words were spoken by a mother of a four-year-old girl interviewed as part of a research study in Ireland published last year. It is quoted in a new EMCDDA thematic paper on European children's experiences and perceptions of drug and alcohol issues, published to mark International Children's Day on 1 June.[1]

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Drugs come under new department *(continued)*

Explaining the reconfiguration of the DCEGA, the Taoiseach said:[1]

> It is important, while addressing the priority issues in responding to unemployment and driving economic recovery, that we do not lose sight of the importance of social development, the targeting of the most vulnerable and support for those working to make a difference right across our communities. I have therefore decided that the Department of Community, Rural and Gaeltacht Affairs will become the Department of Community, Equality and Gaeltacht Affairs and will incorporate responsibility for social inclusion policy and family policy from the Department of Social and Family Affairs and for equality, disability, integration and human rights from the Department of Justice, Equality and Law Reform.

In the reorganisation, former Minister for Community, Rural and Gaeltacht Affairs, Eamon Ó Cuív TD, went as minister to the new Department of Social Protection, and the former minister of state with responsibility for drugs strategy and community affairs, John Curran TD, was appointed Government Chief Whip.

Mary White TD was appointed Minister of State at the departments of Justice and Law Reform, Community, Equality and Gaeltacht Affairs, and Education and Skills, with special responsibility for equality and human rights, and integration. It may be expected that the issue of drugs will come within her purview as well. In recent years, explicit policy commitments to recognise and address the human rights issues involved in drug control have been made at both UN and EU levels.[2] With regard to equality, *Drugnet Ireland* regularly reports on research highlighting how the drugs issue impacts on members of groups vulnerable to discrimination and provided for under Ireland's equality legislation, including young people, women, and members of the LGBT community, of new Irish communities and of the Traveller community.[3]

(Brigid Pike)

1. Cowen B (2010, 23 March) *Parliamentary Debates Dáil Éireann (Official report: unrevised): Nomination of members of government: motion.* Vol. 705, No. 1, p. 9. Available at http://debates.oireachtas.ie/Xml/30/DAL20100323.PDF
2. See Pike B (2009) *Development of Ireland's drug strategy 2000–2007.* Overview Series 8. Dublin: Health Research Board. pp. 99–101.
3. Under the Equal Status Acts 2000–2004, discrimination is prohibited on nine grounds, including gender, marital status, family status, sexual orientation, religion, age, disability, race, and membership of the Traveller community.

Children talk about living with problem drug and alcohol use *(continued)*

The purpose of the paper is to enhance drug policies and interventions for children and young people by highlighting children's and young people's perspectives and their needs. Comprising quotations selected from research studies and governmental and non-governmental reports in 14 EU countries, including Ireland, the thematic paper gives voice to four main issues:

- living with harmful parental drinking or drug taking (neglect, violence, abuse, stigma or shame),
- being separated from parents and looked after by relatives, foster carers or institutions,
- experiences and perceptions of alcohol and drug consumption, and
- experiences and perceptions of interventions to address alcohol and drug consumption.

The authors consulted three Irish sources[2] and used quotations from them to highlight issues associated with living with parents engaging in harmful substance use, and children's and young people's own experience of substance use. For example, an Irish child care worker is quoted on the effect of living with a parent engaging in harmful substance use:

> 'They become adults very young; they're like the carer to their parent. They actually know, you can see it in them, that they know when their parent isn't well… it seems to be a constant worry.'

Looking back, a young Irish woman who had been abused by a member of her extended family during her childhood recalled her teenage years:

> 'I turned 15 that January, I just went wild then you know after that like. I did have problems at home … Like when I was growing up, that would have been the start of it, but then I just used to go wild you know with the problems and the issues that I did have, I'd end up going drinking and taking drugs, you know, and not having any, no self-respect or anything for myself.'

In concluding the report, the authors make several observations:

- given the complexity and diversity of children's experiences, correspondingly flexible and holistic interventions need to be developed;
- more qualitative drug and alcohol research is needed if Europe is to understand the real needs of children and young people and to implement fully the United Nations Convention on the Rights of the Child (UNCRC);
- large numbers of parents with alcohol problems may generate more problems overall for children in the EU than the smaller number of children affected by parents with illicit drug problems;
- the quotations highlight children's extreme vulnerability, and yet also their desire and capacity to 'cope' with difficulties and to make rational judgements about their own situation based on objective information and personal experience;
- while quality care and other drug and alcohol interventions are needed to grant children in the EU their right to 'harmonious development and protection from harmful influences', abuse, neglect and exploitation, the root cause for many children facing both drug and alcohol problems are poverty and social exclusion.

(Brigid Pike)

1. Olszewski D, Burkhart G and Bo A (2010) *Children's voices: experiences and perceptions of European children on drug and alcohol issues.* Thematic paper. Luxembourg: The Publications Office of the European Union. Available at www.emcdda.europa.eu
2. The three Irish research studies used in the EMCDDA thematic paper were Bates T, Illback RJ, Scanlan F and Carroll L (2009) *Somewhere to turn to, someone to talk to.* Dublin: Headstrong – The National Centre for Youth Mental Health; Mayock P (2000) *Choosers or losers: influences on young people's choices about drugs in inner-city Dublin.* Dublin: Children's Research Centre, TCD; Mayock P and Carr N (2008) *Not just homelessness … A study of 'out of home' young people in Cork city.* Dublin: Children's Research Centre, TCD. These three research reports are available at www.drugsandalcohol.ie

Cuan Mhuire wins international quality improvement award

Cuan Mhuire, which has provided detoxification and residential rehabilitation services in Ireland since 1966, has won the prestigious CHKS Quality Improvement Award 2010. This international award recognises significant improvements in patient care and patient experience, as well as in staff welfare, safety and morale. Candidate institutions are evaluated by experts representing medical and nursing colleges, healthcare associations and national quality institutes. It is the first time that this award has been give to a rehabilitation service. Speaking at the award ceremony in London in May, Cuan Mhuire founder Sister Consilio Fitzgerald said: 'This Award shows how vocationally driven organisations such as Cuan Mhuire can deliver cost-effective services with the highest possible standards of care. The intrinsic value of each human being before God demands no less than our committed love.' Cuan Mhuire provides a range of services in its communities in Dublin, Kildare, Cork, Limerick, Tipperary, Galway, Monaghan and Newry. Between them the services had over 3,000 users in 2009. Cuan Mhuire is a voluntary body and a charitable trust.

Update on drug-related deaths

National Drug-Related Deaths Index (NDRDI) figures on drug-related deaths and deaths among drug users in 2006 and 2007 are now available on the web.[1] Previously reported figures for the years 1998–2005 have been updated to include data from the Coroner Service on late inquests. Similarly, figures for the years 2006 and 2007 will be revised when data relating to late inquests becomes available.

Between 1998 and 2007 a total of 3,465 drug-related deaths and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 2,120 were due to poisoning and 1,345 were due to traumatic or medical causes (non-poisoning) (Table 1). The annual number of deaths more than doubled in nine years, rising from 242 in 1998 to 491 in 2006. The number fell to 476 in 2007, but this figure may be revised upwards when data relating to late inquests becomes available. In 1998, almost three-quarters (73.6%) of drug-related deaths recorded in the NDRDI were poisonings. The percentage of such deaths decreased over the 10-year reporting period, with 57% of deaths in 2007 due to poisoning and 42% to other causes (non-poisoning).

Table 1 Drug-related deaths, by year of death, NDRDI 1998 to 2007 (N=3,465)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All deaths	242	271	261	277	338	297	365	447	491	476
Poisoning (n=2120)	178	187	182	178	211	185	207	248	270	274
Non-poisoning (n=1345)	64	84	79	99	127	112	158	199	221	202

Poisoning deaths

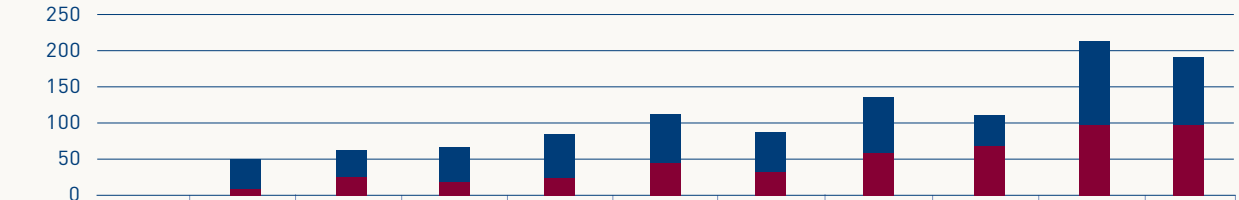
The annual number of deaths by poisoning increased from 178 in 1998 to 274 in 2007 (Table 1). The majority of cases in the 10-year period were aged between 20 and 40 years; the median age was 34 years. Males accounted for 68% of deaths in the 10 years.

Just over half of all deaths by poisoning involved more than one substance (polysubstance cases). Heroin and other opiates, including methadone, were implicated in over half (55.3%, 1,172) of all cases. Cocaine was implicated in 10% of all cases in the 10-year period, with the annual number rising from five in 1998 to 63 in 2007. Prescription and over-the-counter medication was implicated in many of the deaths by poisoning. Benzodiazepines continued to play a major role in polysubstance poisonings.

Since 2003, more deaths by poisoning occurred outside Dublin than inside Dublin (city and county). The number of poisoning deaths increased in all but two of the regional drugs task force (RDTF) areas between 1998 and 2007. The South Western RDTF area recorded the highest number of deaths (n=478) for the 10-year period.

Non-poisoning deaths

A total of 1,345 non-poisoning deaths among drug users was recorded between 1998 and 2007. Of the 1,183 cases with a known cause of death, 60.3% (714) were due to trauma and 40% (469) were due to medical causes (Figure 1).



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Trauma	39	41	51	60	67	55	85	113	116	87
Medical	11	27	18	23	45	29	55	65	98	98

Figure 1 Non-poisoning deaths among drug users, NDRDI 1998 to 2007 (N=1,183)

Deaths due to trauma

The annual number of deaths due to trauma increased from 39 in 1998 to 116 in 2006, but decreased to 87 in 2007 (Figure 1). These figures may be revised when data relating to late inquests becomes available. Half (50.4%, 360) of those who died from traumatic causes were aged between 20 and 29 years. The median age was 27 years. Almost all (90.1%, 643) of those who died were male. The most common causes of death due to trauma were hanging and road traffic collisions.

Deaths due to medical causes

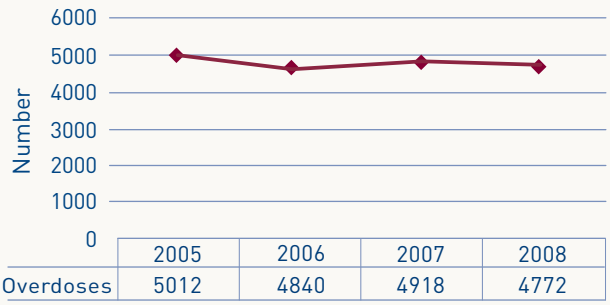
The annual number of deaths due to medical causes rose fairly steadily over the reporting period, increasing from 11 in 1998 to 98 in 2007, when it exceeded the number of deaths due to trauma (Figure 1). The majority of those who died from medical causes were aged between 30 and 44 years. The median age was 39 years. Three-quarters (75.0%, 352) of those who died were male. The most common medical causes of death were cardiac events (25.2%, 118), respiratory infections (17.7%, 83) and liver disease (10.2%, 48).

(Suzi Lyons and Simone Walsh)

1. Health Research Board (2010). *Drug-related deaths and deaths among drug users in Ireland, 1998 to 2007. Data from the National Drug-Related Deaths Index*. Available at www.drugsandalcohol.ie/13205

Non-fatal overdoses and drug-related emergencies

Data extracted from the Hospital In-Patient Enquiry (HIPE) scheme were analysed to determine trends in non-fatal overdoses discharged from Irish hospitals in 2008. There were 4,815 overdose cases in that year, of which 43 died in hospital. The 4,772 discharged cases are included in this analysis. The number of overdose cases decreased by 2.9% between 2007 and 2008 (Figure 1).



	2005	2006	2007	2008
Overdoses	5012	4840	4918	4772

Figure 1 **Overdose cases by year, 2005–2008 (N=19,542)**
Source: Unpublished HIPE data

Characteristics of cases

Gender

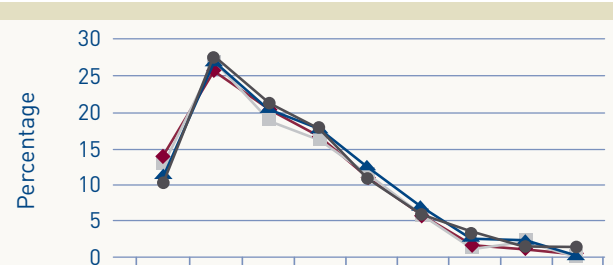
In the years 2005–2008 there were more overdose cases among females than among males (Figure 2), with females accounting for 55% of all overdose cases in 2008.

	2005	2006	2007	2008
Female	2794	2605	2691	2640
Male	2218	2235	2227	2132

Figure 2 **Overdose cases by gender, 2005–2008 (N=19,542)**
Source: Unpublished HIPE data

Age group

In the four-year period, one quarter of overdoses occurred in those aged 15–24 years, with the incidence of overdose decreasing with age (Figure 3). This pattern was similar for each of the years reported.

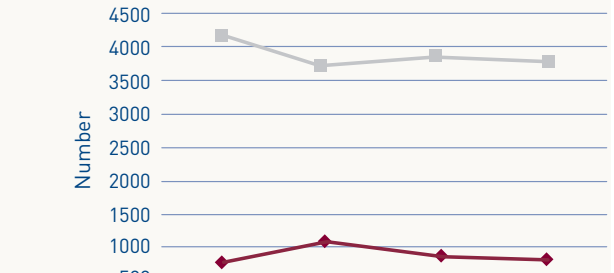


	0-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
2005	14.8	25.4	20.3	17.6	11.6	5.6	2.8	1.4	0.5
2006	14.5	26.2	19.5	17.3	11.9	5.6	2.6	2.0	0.4
2007	11.2	26.2	20.2	18.2	12.7	6.3	2.8	2.0	0.4
2008	11.7	25.8	21.5	18.2	11.4	5.7	3.1	1.9	0.6

Figure 3 **Overdose cases by age group, 2005–2008 (N=19,542)**
Source: Unpublished HIPE data

Area of residence

In 2008, 26 overdose cases were resident outside of Ireland and 10 cases were recorded as having no fixed abode; these 36 cases were excluded from this analysis. Figure 4 shows the area of residence of cases with an Irish address for the years 2005–2008. One fifth of cases in 2008 were resident in Dublin.



	2005	2006	2007	2008
Dublin (city and county)	862	1038	944	918
Outside Dublin	4109	3769	3941	3818

Figure 4 **Overdose cases by area of residence, 2005–2008 (N=18,510)**
Source: Unpublished HIPE data

Drugs involved

Table 1 presents the positive findings per category of drugs and other substances involved in **all cases of overdose** in 2008. Non-opioid analgesics were present in 34.8% (1,660) of cases. Paracetamol is included in this drug category and was present in 25% (1,198) of cases. Psychotropic agents were taken in 21.5% (1,025) and benzodiazepines in 20.8% (993) of cases. There was evidence of alcohol consumption in 14.0% (669) of cases. Cases involving alcohol are included in this analysis only when the alcohol was used in conjunction with another substance.

Non-fatal overdoses and drug related emergencies *(continued)*

Table 1 Category of drugs involved in overdose cases, 2008 (N=4,772)

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1660	34.8
Psychotropic agents	1025	21.5
Benzodiazepines	993	20.8
Alcohol	669	14.0
Narcotics and hallucinogens	599	12.6
Anti-epileptic / Sedative / Anti-Parkinson agents	569	11.9
Other chemicals and noxious substances	316	6.6
Systemic and haematological agents	169	3.5
Autonomic nervous system agents	117	2.5
Cardiovascular agents	110	2.3
Hormones	109	2.3
Systemic antibiotics	92	1.9
Anaesthetics	90	1.9
Gastrointestinal agents	65	1.4
Other gases and vapours	52	1.1
Muscle and respiratory agents	52	1.1
Anti-infectives / Anti-parasitics	40	0.8
Diuretics	38	0.8
Topical agents	24	0.5
Other and unspecified drugs	969	20.3

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.
Source: Unpublished data from HIPE

Overdoses involving narcotics or hallucinogens

Narcotic or hallucinogenic drugs were involved in 12.6% (599) of overdose cases in 2008. Figure 5 shows the number of positive findings of drugs in this category among the 599 cases. The sum of positive findings is greater than the total number of cases because some cases involved more than one drug from this category. Opiates were used in half of the cases, cocaine in one fifth and cannabis in 7%.

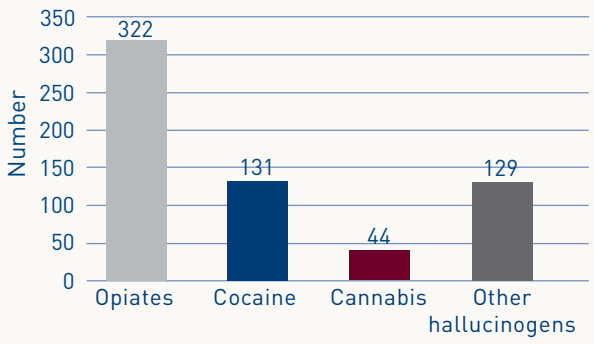


Figure 5 Narcotics and hallucinogens involved in overdose cases, 2008 (N=599)
Source: Unpublished data from HIPE

Overdoses classified by intent

In two-thirds (65.5%) of cases the overdose was classified as intentional (Figure 6).

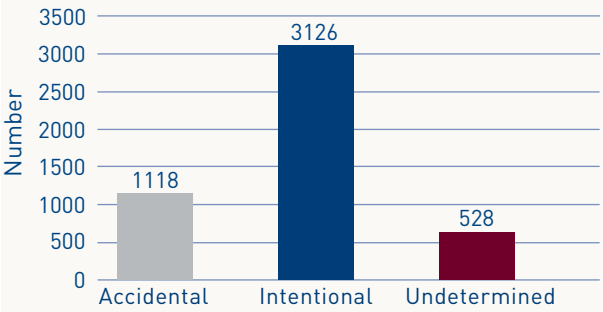


Figure 6 Overdose cases by classification, 2008 (N=4,772)
Source: Unpublished data from HIPE

Table 2 presents the positive findings per category of drugs and other substances involved in **cases of intentional overdose** in 2008. Non-opioid analgesics were involved in 43% (1,346) of cases, psychotropic agents in 26% (806) and benzodiazepines in 25% (772).

Table 2 Category of drugs involved in intentional overdose cases, 2008 (N=3,126)

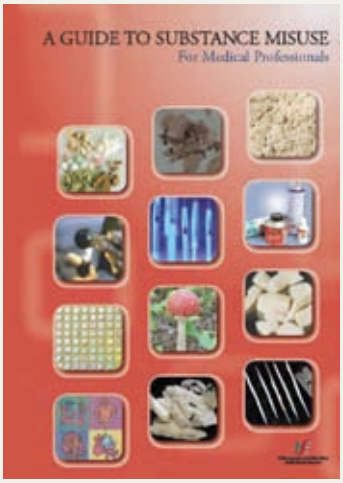
Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1346	43.1
Psychotropic agents	806	25.8
Benzodiazepines	772	24.7
Alcohol	476	15.2
Anti-epileptic / Sedative / Anti-Parkinson agents	461	14.7
Narcotics and hallucinogens	304	9.7
Systemic and haematological agents	96	3.1
Other chemicals and noxious substances	84	2.7
Autonomic nervous system agents	77	2.5
Cardiovascular agents	75	2.4
Hormones	70	2.2
Systemic antibiotics	69	2.2
Gastrointestinal agents	50	1.6
Anaesthetics	44	1.4
Muscle and respiratory agents	29	0.9
Anti-infectives / Anti-parasitics	28	0.9
Diuretics	22	0.7
Other gases and vapours	16	0.5
Topical agents	9	0.3
Other and unspecified drugs	576	18.4

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.
Source: Unpublished data from HIPE

(Mairea Nelson and Deirdre Mongan)

Drugnet digest

This new feature of the newsletter will contain short summaries of recent research reports and other developments of interest.



Guide to substance misuse for health professionals

Sinead O'Mahony Carey, drug education officer with HSE South, compiled a pocket-sized reference manual, *A guide to substance misuse for medical professionals*.[1] The first section of the guide presents drugs with potential for misuse by category and by type. The major categories of drugs covered include hallucinogens, opiates, stimulants and volatile inhalants. Details of individual drugs are presented under each category, described by street name(s), expected effects, negative or side effects, appearance, method(s) of use, dependency potential, withdrawal symptoms, overdose risk and effects of long-term use. The second section contains information on the signs of drug use. The third section presents an overview of the reasons people use drugs, while section four presents the dangers of drug use. The fifth section presents a summary of Irish law and drug use, and the final section covers the jargon related to drug use. This book is a useful guide for health professionals, counsellors, key workers and social workers who work with drug users.

White Paper on crime – discussion document

The Department of Justice and Law Reform has launched the second discussion document as part of the consultation process to develop a White Paper on crime. The White Paper, due to be completed in 2011, provides a high-level statement of government policy, its rationale and the strategies to give effect to that policy. The process of consultation involves the publication of thematic discussion documents. The first discussion document, published in July 2009, was entitled *Crime prevention and community safety* and invited submissions on a range of subjects such as: reducing opportunities for crime; developing locally based partnerships; preventing first-time criminality among those most at risk, and reducing re-offending. The process of consultation also involves regional seminars and meetings with key stakeholders. The second discussion document, *Criminal sanctions*, considers the purpose of sanctions, non-custodial sanctions, imprisonment, and sentencing policy and practice, and was published in February 2010. Written submissions are requested before the end of May 2010. www.justice.ie/en/JELR/Pages/White_Paper_on_Crime

First national report from sexual assault treatment units

There are currently six sexual assault treatment units (SATUs) in Ireland, located at the Rotunda Hospital (Dublin), South Infirmary Victoria University Hospital (Cork), Waterford Regional Hospital, Midlands Hospital (Mullingar), Letterkenny General Hospital and Galway (Ballybrit). Clinical reports from each of these units are combined in the first annual SATU report, for 2009.[2]

There were 529 attendances at the six units in 2009; 95% were female and the mean age was 24 years. Half (51%) of all patients who attended had consumed at least four units of alcohol in the 12 hours prior to the incident reported, 8% disclosed that they had taken illegal drugs and 3% were concerned that drugs had been used to facilitate sexual assault. Irish research has shown that alcohol consumption, especially drinking to intoxication, is a feature in a high proportion of rape and sexual abuse cases in Ireland,[3,4] and this report further corroborates those findings.

Prison-based needle exchange

A report assessing the need for prison-based needle exchange in Ireland[5] details the evolution of drug use, particularly injecting drug use, in Irish prisons in the years prior to 2001. It describes the association between injecting drug use and the spread of blood-borne viral infections among Irish prisoners, based on studies in 1999 and 2000. The authors acknowledge the development of harm reduction and drug treatment services in Irish prisons since 2001. However, they note that there are no recent Irish data on the prevalence of blood-borne viral infections and drug use among prisoners.

The authors describe the experience of prison needle exchange in six countries, where findings indicate that such programmes:

- reduced risk behaviours (such as sharing needles and syringes) and transmission of infection (such as hepatitis C and HIV);
- did not increase drug consumption or injecting drug use;
- did not endanger staff or compromise prison safety, and did, in fact, make prisons a safer place to live and work;
- had other positive outcomes for the prisoners' health;
- operated as part of a comprehensive harm reduction programme.

The authors note that the introduction of needle exchange would not present any ethical, legal or clinical issues which could not be addressed by the prison service.

In summary, prison needle exchange does work in other jurisdictions, but the need for this intervention requires up-to-date evidence. The NACD and the Irish Prison Service will commission a study to examine the prevalence of drug use, injecting drug use and drug-related blood-borne viral infections among prisoners in Ireland.

(Contributors: Jean Long, Deirdre Mongan and Johnny Connolly)

1. Sinead O'Mahony Carey (2008) *A guide to substance misuse for medical professionals*. Kilkenny: HSE South. Available at www.drugsandalcohol.ie/12899
2. Eogan M (2010) *First national sexual assault treatment unit (SATU) annual clinical report*. Dublin: Health Service Executive.
3. 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.
4. McGee H, Garavan R, de Barra M, Byrne J and Conroy R (2002) *The SAVI report: sexual abuse and violence in Ireland*. Dublin: The Liffey Press.
5. Forde C, Long J and Davey A (2009) An assessment of prison needle-exchange for Ireland. Unpublished report submitted to the Oversight Forum on Drugs.

HSE aims to strengthen drug services delivery

The Health Service Executive (HSE) National Service Plan 2010 sets out the agency's plans in the drugs and alcohol area for 2010.[1] HSE Drug and Alcohol Services are delivered as part of HSE Social Inclusion Services, which also include homeless services, services for minority ethnic communities, Traveller health services, community development, HSE RAPID and CLAR programmes, HIV/STI services, services for LGBT communities, and community welfare services.

Social Inclusion Services was part of the Primary, Community and Continuing Care (PCCC) directorate. However, in late 2009, as part of its Transformation Programme, the HSE merged the PCCC directorate and the National Directorate for Hospitals into a national Integrated Services Directorate (ISD). This directorate has responsibility for the delivery, reconfiguration, performance and financial management of all health and personal social services, including drug and alcohol services. A Quality and Clinical Care Directorate has also been established. This directorate is intended to strengthen clinical leadership and improve clinical performance, as well as support the working relationship between clinicians and managers across the organisation; the participation of clinicians in the management process is regarded as a key driver of service development at national, regional and local levels. Responsibility for implementation of this process lies with the ISD.

On foot of this realignment, a key focus for the HSE in 2010 is to integrate the recommendations in the national drugs and homeless strategies into the provision of mainstream health services, and to put in place a national framework for rehabilitation in addiction services. The key result areas and deliverables in relation to illicit drugs planned for 2010 are set out in the following table.

Key result area	Outputs 2009	Deliverables 2010	Due
Implementation of the National Drugs Strategy (NDS) 2009–2013	Input into preparation of NDS completed and strategy launched	National rehabilitation framework in place	Q2
	Planning undertaken for implementation of HSE components	National liaison pharmacist appointed	Q1
	Rehabilitation Co-ordinator appointed	Harm reduction and treatment services further developed, including needle-exchange and methadone services	Q1
	National Drug Rehabilitation Implementation Committee established		
	Recruitment of national liaison pharmacist under way		
	National Addiction Training Programme (NATP) developed from pilot stage		
Development of National Substance Misuse Strategy		Input into development of National Substance Misuse Strategy completed (co-led by Department of Health and Children)	Q4

Source: NSP (2010: 43–44)

Regarding drug treatment, in 2010 the HSE plans to increase its level of activity and performance as follows:

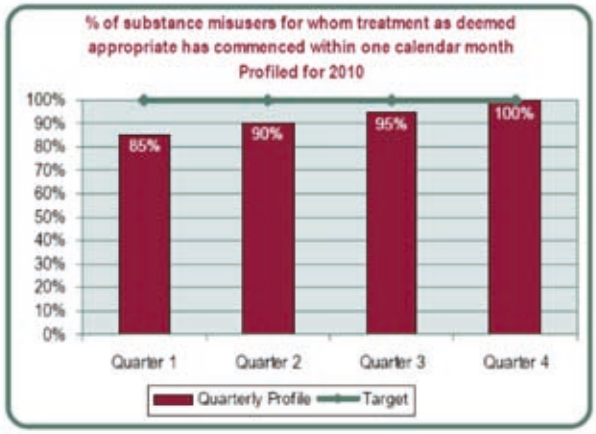
- *Average number of clients in methadone treatment per month per area* – in 2009 the HSE exceeded by 136 its target of having an average of 7,636 clients in methadone treatment per month per area; it plans to maintain this increased level of throughput in 2010, i.e. 7,762 clients in methadone treatment per month per area. In prisons, the HSE set a target of an average of 612 clients in methadone treatment per month in 2009; however, the projected outturn came in 115 below this target and the HSE has adopted this lower figure of 497 as the target for 2010.
- *Number of substance misusers under 18 years of age for whom treatment, as deemed appropriate, commenced within one calendar month* – in 2009 the percentage of substance misusers under 18 years of age for whom appropriate treatment was commenced within one calendar month exceeded the target of 88%, reaching 97%. For 2010 the HSE has sets its sights even higher, aiming to commence appropriate treatment within one calendar month for 100% of drug treatment clients aged under 18 years.

HSE aims to strengthen drug services delivery *(continued)*

- *Number and percentage of substance misusers for whom treatment, as deemed appropriate, commenced within one calendar month* – in 2009, 81% (1,365) of substance misusers aged 18 years and over entered appropriate treatment within one month, which was 3% below the target of 1,406 set for the year. In 2010 the HSE anticipates that 1,380 substance misusers will seek treatment for drug misuse and it is aiming to ensure that 100% of these clients commence appropriate treatment within one calendar month. The graph opposite shows how the HSE intends to work towards this target over the course of 2010.

(Brigid Pike)

1. Health Service Executive (2010) *National Service Plan 2010*. Dublin: HSE. Available at www.hse.ie



Source: HSE (2010: 45)

Guidebook on case management in homeless and drug services

The Homeless Agency has published a case management guidebook for those working in the area of homelessness and drugs.[1] The guide is intended as a companion to the Holistic Needs Assessment and Care Plan, the assessment tool developed by the Homeless Agency. The guide and its accompanying protocols were piloted among those working with the homeless, and their feedback was incorporated into the final document. The online version of the guide will be updated as necessary.

There are three sections in the guidebook: key support interventions, interagency protocols and a listing of services. Among the 12 key support areas covered in separate chapters are mental health, alcohol use and drug use. These three chapters are summarised in this article.

Mental health

Chapter 9 covers how to access mental health services, with a section on dual diagnosis (of both addiction and mental health problems). The role of the service provider outlined in the document is to make appropriate referrals, either to a GP or to the psychiatric services (within the addiction services). Other areas covered include how to make an application for involuntary admission to psychiatric care of a person deemed to be a risk to themselves or others, dealing with exclusion from the drug services because of mental health issues, and non-compliance with medication.

The second part of the mental health chapter deals with suicide and deliberate self harm, and how the service provider should handle such issues. The association between mental health problems and suicide is well known, and although self harm is not necessarily associated with suicide, it is an indicator of mental health issues.

Alcohol use

Chapter 10 cites evidence that alcohol, frequently combined with drugs, may be the most widely misused substance among homeless people. The key interventions identified are access to detoxification and access to rehabilitation and supports. This chapter also deals with the issue of a service user who is misusing alcohol while on prescribed methadone. The guide advises that in cases of polysubstance use an alcohol detoxification should be carried out before an opiate detoxification, but that problem use of cocaine or amphetamines may have to be addressed before that of either alcohol or opiates. Any interventions should be made with the support of the prescribing doctor, with aftercare in place, along with a relapse prevention plan, including social support from family and friends.

Drug use

Chapter 11 outlines key interventions in drug treatment services, stressing that they should be seen as a continuum of care across services (Figure 1). The interventions are: harm reduction services, methadone treatment, stabilisation services, detoxification, rehabilitation (day and residential), aftercare and support services. Some of these interventions are summarised below.

Harm reduction

The guide states that, as many problem drug users start injecting before accessing formal drug treatment, it is important that the service provider ensures that clients have access to harm reduction information and services in order to reduce drug-related harm. Such resources may be accessed through a client's own service or by referral to another appropriate service. This section summarises the types of intervention typically provided by harm reduction services.

Guidebook on case management in homeless and drug services *(continued)*

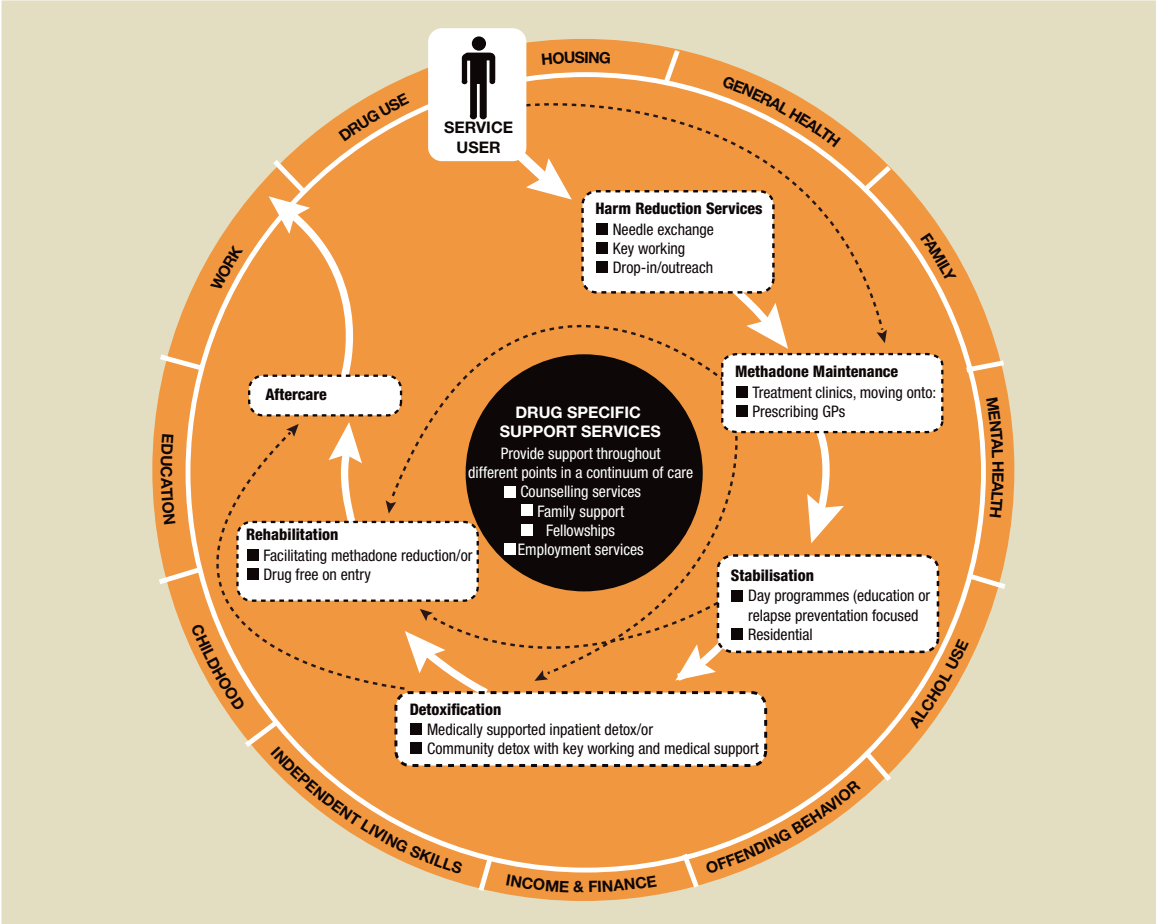


Figure 1 Example of the continuum of care within drug services
Source: Homeless Agency Partnership (2010: 82)

Methadone treatment

This section gives the service provider an overview of the issues around methadone treatment, including assessment, changing a prescription, take-aways and polydrug use. It includes practical advice, for example what documentation the client needs when attending an assessment of suitability for treatment.

Stabilisation services

Stabilisation in this context is taken to mean compliance with a methadone treatment programme. This process requires input from different services, such as counselling, relapse prevention or day programmes to assist and support the client. This section outlines some of the different options and how to access them.

Detoxification

In general, a person must have be on a reduced daily dose of to between 40mg and 60mg of methadone in order to qualify for residential detoxification, according to this guide. The criteria for other facilities vary, for example some require the person to be alcohol free or benzodiazepine free before entry. Inpatient facilities give priority to medical emergency cases (the type nature of the emergency is not specified), and to people who are pregnant, or are under the age of 18. While benzodiazepine detoxification can be carried out by a GP or by the doctor prescribing methadone, the guidebook notes that doctors are not obliged to carry out such detoxification in the community.

Interagency protocols and listings

The protocols presented in this section were developed to help multiple agencies work together and ensure that individuals did not fall through the gaps in service provision and also to improve the outcomes for those accessing the homeless services. The listings section provides information and contact details for all relevant services currently available.

(Suzi Lyons)

1. Homeless Agency Partnership and Progression Routes Initiative (2010) *Case management guidebook*. Dublin: Homeless Agency Partnership.

Using scientific knowledge to inform drug policy

Evidence-based, or more accurately, evidence-informed, policy is now an accepted norm, even if there is debate about how the evidence translates into policy. Equally important but not so widely debated are the questions (1) What is the evidence? and (2) How do policy makers know they are using the best evidence available?

For five years between 2004 and 2009, a group of 12 addiction scientists from different disciplines and with affiliations to academic institutions in Australia, Canada, Nigeria, Norway, Qatar, Sweden, the UK and the USA, collaborated to answer these two questions. The result is a 300-plus-page book *Drug policy and the public good.*[1]

To answer the second question first, what constitutes the 'best' evidence is determined by the purpose of the policy – 'policy for whom and for what?' – and the nature of the 'drug problem'. The authors regard securing the 'public good' as the purpose of drug policy. They suggest that the concept of the public good includes public health aspirations but is not restricted to them. Public health is defined as 'the management and prevention of adverse health conditions in groups of people, formally termed "populations".' It can benefit large numbers of people at the level of the community or country. The authors regard a public health approach as useful in managing the consequences of the use of psychoactive substances in a population as it emphasises the need to change both the environment and the behavior of the individual. However, the authors argue that this approach on its own is not enough: it focuses on health indicators to the exclusion of broader social indicators such as loss of self-esteem or increased anxiety or isolation caused by exposure to drug-related problems.

The purpose of drug policy therefore is seen by the authors as heavily influenced by public health concerns but not limited to them: '… concerns about justice, freedom, morality and other issues beyond the health domain have an important place in drug policy formation and should not be ignored by public health experts.'

The 'best' evidence is also determined by the nature of the drug problem, which is determined by the manner of use of the different substances and the various problems associated with their use. **In Figure 1 below**, the authors summarise how the three mechanisms by which harm may be inflicted – toxic effects, intoxication and dependence – are related to drug dose, use patterns and mode of drug administration, and how they mediate the consequences of drug use for the individual drug users. The impact of the harm mechanisms may also be affected by contextual factors such as the setting in which the drug is used and the user's expectations.

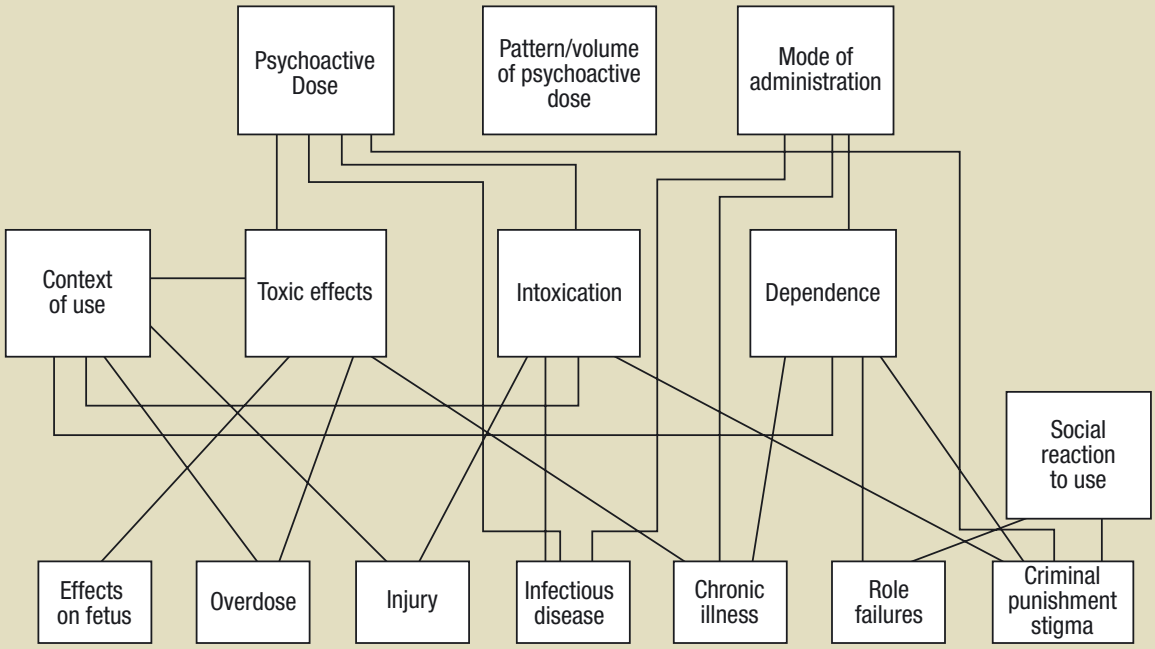


Figure 1 **How toxic effects, intoxication, and dependence are related to drug dose, use patterns, and mode of drug administration, and in turn mediate the consequences of drug use for the individual drug user.** Source: Babor *et al.* (2010: 19)

Using scientific knowledge to inform drug policy *(continued)*

The authors argue that classifying drugs according to their chemical composition alone, and using this as the basis for criminal penalties, policing, prevention, and treatment programmes, is not a sufficiently robust approach. The risks associated with different substances vary according to the drug's health effects, its safety ratio (i.e. how much constitutes a lethal dose), intoxicating effects, general toxicity, social 'dangerousness' (e.g. aggressive and uncontrolled behavior induced by or associated with the use of a drug), dependence potential, the environment/context of use, and social stigma. The authors conclude, 'Policies on substance use must reflect the social and pharmacological complexities of psychoactive substances as well as the relative differences among them.' They point out that using such a rating system indicates that legal substances such as tobacco and alcohol are at least as dangerous as many illicit substances.

Having established a conceptual basis for a 'rational drug policy', which provides a context within which the 'best evidence' may be more readily recognised, the authors provide a critical review of the cumulative scientific evidence in five general areas of drug policy:

- prevention
- supply reduction
- treatment and harm reduction
- criminal sanctions and decriminalisation
- control of the legal market through prescription drug regimes.

Acknowledging that policy making should not be solely a technocratic endeavour entrusted to scientists, the authors came to a consensus that the evidence reviewed in the book supported the following conclusions:

- There is no single drug problem, and neither is there a magic bullet that will solve 'the drug problem'.
- Many policies that affect drug problems are not considered drug policy, and many specific drug policies have large effects outside the drug domain.
- Once a drug is made illegal, there is a point beyond which increases in enforcement and incarceration yield little added benefit.
- Substantial investments in evidence-based services for opiate-dependent individuals usually reduce drug-related problems.
- School, family, and community prevention programmes have a collectively modest impact, the value of which will be appraised differently by different stakeholders. The drug policy debate is often dominated by four false dichotomies (law enforcement vs health services; targeting drug use vs damage caused by drug use; 'good' vs 'bad' drugs; the interests of heavy drug users vs the interests of the rest of society) that can mislead policy makers about the range of legitimate options and their expected impacts.
- Perverse impacts of drug policy are prevalent.
- The legal pharmaceutical system can affect the shape of a country's drug problem and its range of available drug policy options.

(Brigid Pike)

1. Babor T, Caulkins J, Edwards G, Fischer B, Foxcroft D, Humphreys K et al. (2010) *Drug policy and the public good.* Oxford: Oxford University Press.

Evaluating national drugs strategies

While evaluation is an accepted stage in the implementation of drug-related programmes and services, there has been slower progress in making it a routine part of the national policy or strategy cycle. In this regard, the EU Drugs Action Plan 2009–2012 includes two actions:

> 68: to develop analytical instruments to better assess the effectiveness and impact of drug policy (e.g. model evaluation tools, policy effectiveness indices, public expenditure analysis, etc.), and
>
> 70: member states to evaluate and fine-tune national drug policies on a regular or ongoing basis.

In its work programme for 2010, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) includes four activities 'to support Member States in evaluating their national strategies and action plans':

- develop European guidelines for the evaluation of national drug strategies,
- hold Reitox Academy[1] on the evaluation of national drug strategies,
- launch series of national policy case studies (Portugal to be first), and
- provide tailored support to member states if requested.

To date, Ireland's national drugs strategy has only ever been subjected to 'review', as distinct from evaluation. While noting that there had been evaluations of individual projects, the Steering Group that drafted Ireland's National Drugs Strategy 2009–2016 (NDS) observed that 'there is a need to evaluate services in a more comprehensive way that assesses not only services being developed and provided under the NDS framework, but also closely related services provided

Evaluating national drugs strategies *(continued)*

in the broader social inclusion context' (NDS: para. 6.40). Although this observation does not appear to have been followed up with an associated action regarding overall policy evaluation, the Steering Group did prioritise 'the development of an overall performance management framework across all relevant Departments and agencies to facilitate the effective assessment and monitoring of progress' (NDS: para. 6.101). Such a framework will help in undertaking an evaluation of the NDS at both its mid-term (2013) and its expiry (2016).

Policy evaluation was a theme of the recent annual conference of the International Society for the Study of Drug Policy (ISSDP). Presenters from Luxembourg, the Netherlands and Australia reported on recent evaluations of their national drugs strategies.[2] They made several salient points regarding strategy evaluation.

In all three countries, external evaluators were engaged, including in one instance an evaluator from another country, and sometimes in conjunction with an internal evaluator.

'Data triangulation' was acknowledged as essential to validate the conclusions drawn by the evaluators. In Australia relevant documentation and datasets were consulted and the relevant literature reviewed, stakeholders were consulted, and case studies of aspects of policy undertaken. The information gathered from all these sources was collated and compared and assessed. With a 'relatively small budget', the evaluators in Luxembourg were restricted to administering a questionnaire to stakeholders; holding follow-up interviews with survey respondents to develop a SWOT analysis; and convening focus groups to recheck information, resolve contradictory answers and discuss recommendations/ priorities for the new drug plan.

Finally, the choice of analytical framework to support the policy evaluation needs careful thought. The design will vary depending on whether it is an action plan or a strategy that is being evaluated. The Luxembourg evaluators recommended that a 'programme logic model' should be used 'to monitor and evaluate the implementation and achievements of the [Drug] Action Plan in an effective and transparent way'. While the logic may be applied in a simple linear manner – inputs à activities à outputs à outcomes – they proposed a matrix form, in which the intervention logic, underlying assumptions, and objectively verifiable indicators and the means of verification for each stage in the model are also evaluated.

In Australia the National Drug Strategy (NDS) was evaluated using a framework with four key components:

1. evaluate the NDS as a policy framework that informs stakeholders in the development of their respective drug-related policies and programmes;
2. evaluate the outcomes of programmes under the NDS;
3. evaluate the roles and workings of the advisory structures that inform the development and implementation of the NDS; and
4. monitor the performance of the NDS with regard to actual and potential drug issues and drug trends in Australia during the period 2006 – 2009.

These components were used to assess the overall effectiveness and the efficiency of the NDS, and to identify future needs and opportunities for future process or other improvements.

At the ISSDP conference the consultants who undertook the evaluation of the Australian NDS made a case for using an additional analytical framework based on policy theories.[3] They suggested that such a framework would provide evaluators with insights into the determinants of policy – how it is made, the drivers of implementation and its performance – which would strengthen the evaluation findings. In a similar vein, a recent overview of the development of Ireland's drug strategy between 2000 and 2007 focused on Ireland's NDS as a strategy process – how it was designed, developed and managed.[4] The objective was to gain insights into how the infrastructural elements might have influenced the outcomes of the strategy. Arguably, such an analytical lens would further strengthen a strategy evaluation.

(Brigid Pike)

1. Reitox is the European Information Network on Drugs and Drug Addiction, which is co-ordinated by the EMCDDA. The network is made up of National Focal Points (NFPs) in the 27 EU member states, Norway, the European Commission and the candidate countries. The EMCDDA holds 1–2-day seminars (academies) for network members to provide training on various topics relevant to the work of Reitox. Ireland's NFP is located in the Health Research Board.
2. See Trautmann F and Braam R (2009) *Evaluation of the National Drug Action Plan (2005–2009) of Luxembourg*. Utrecht: Trimbos-Institut; van Laar M and van Ooyen-Houben M (2010) Dutch drug policy evaluated. Paper presented at 4th annual conference of the ISSDP, Santa Monica, California, USA, 15–16 March 2010; McDonald D, Cleary G, Miller M, Hsueh-Chih Lai S, Siggins I and Bush R (2010) Using theories of policy processes in evaluating national drug strategies: the case of the 2009 evaluation of Australia's National Drug Strategy. Paper presented at 4th annual conference of the ISSDP, Santa Monica, California, USA, 15–16 March 2010.
3. The policy theories included the systems model, the stages heuristic, the rational/comprehensive model, the bounded rationality model, institutional rational choice frameworks, the incrementalism model, the punctuated equilibrium theory, the multiple streams model and the advocacy coalitions model.
4. Pike B (2009) *Development of Ireland's drug strategy 2000–2007*. Overview 8. Dublin: Health Research Board.

UN body reviews drug policy

The Commission on Narcotic Drugs (CND), the central policy-making body within the United Nations system dealing with drug-related matters, held its 53rd annual session in Vienna between 8 and 12 March 2010. The CND monitors the world drug situation, develops strategies on international drug control and recommends measures to combat the world drug problem.[1]

Thematic debate

The CND's annual thematic debate was on the subject of 'measures to enhance awareness of the different aspects of the world drug problem, including by improving understanding of how to tackle the problem'. Key points to emerge from the debate included the following:

- There is scientific evidence that drug use, even when occasional, poses serious risks to health.
- Long-term and frequent use of illicit drugs has lasting effects on the functioning of the brain, on physical and mental health and on behaviour.
- Drug use and drug dependence have a range of health-related, social and economic consequences for individuals, their families and the community.
- Use of drugs by young people is a major concern, as drug use during childhood and adolescence affects the healthy development of the brain.
- Female and male drug users have different histories and patterns of use. Female drug users are likely to have a co-morbid psychiatric disorder and a history of physical and sexual abuse and to make non-medical use of prescription drugs. The health and social consequences of drug abuse for female drug users, their families and the community require special consideration. Treatment and care services should address the special needs of women.
- Reliable information on drugs and training for drug prevention should be provided extensively to primary health-care workers, teachers, parents, media professionals and police officers.
- Prevention efforts should address all levels of risk (universal, selective and indicated), such efforts to include evidence-based interventions carried out in many settings (school, family, community and media), and should be tailored for the target population groups and be mainstreamed in national education and health policies.
- Evaluation of interventions to prevent drug use is not only possible but essential, and all drug abuse prevention efforts should have strong monitoring and evaluation components.
- There is an interplay of genetic, neurobiological and environmental factors that make individuals vulnerable to using drugs and becoming drug dependent.
- Practitioners, policymakers and the general public should be made aware of the changes in brain functions that are at the root of compulsive behaviour and uncontrollable cravings, and that because of these changes drug dependence is most accurately classed as a health disorder.
- Given that drug dependence is a health disorder, there is no justification for the stigma, ignorance and prejudice that persist and have adverse consequences for drug users, their families and the community.
- Care for drug addicts should be integrated into mainstream health-care services.
- Training of doctors, nurses and social workers should include an understanding of drug addiction as a chronic multi-factorial health disorder, and an understanding of evidence-based interventions.
- Prevention and treatment strategies should be based on scientific evidence and trials, as is the case with other chronic health disorders.
- Drug use and drug addiction are separate phenomena: while drug use is largely a function of access and availability, drug addiction is largely a function of genetic heredity.
- Non-governmental organisations often lead the way where no services are available. Their efforts should be included in the mainstream provision of health, education and social policies, building on the resources and the synergies of civil society and the public sector.

Resolutions

On foot of this debate and consideration of reports on the world situation with regard to drug abuse and drug trafficking, the Commission passed 15 resolutions related to, among other issues, strengthening awareness and prevention efforts; strengthening international co-operation in countering the covert administration of psychoactive substances related to sexual assault and other criminal acts; strengthening international co-operation in countering drug trafficking and related offences; achieving universal access to prevention, treatment, care and support for drug users and people living with or affected by HIV; measures to protect children and young people from drug abuse; promoting the sharing of information on the potential abuse of and trafficking in synthetic cannabinoid receptor agonists (synthetic cannabis); strengthening systems for the control of the movement of poppy seeds obtained from illicitly grown opium poppy crops; use of poppers as an emerging trend in drug abuse in some regions; and strengthening international co-operation and regulatory and institutional frameworks for the control of substances frequently used in the manufacture of narcotic drugs and psychoactive substances.

Ireland and the CND

The CND comprises 53 members elected from among the member states of the UN. Ireland is not currently a member of the CND, but an Irish delegation attended the 53rd session as observers. Delegates included Marita Kinsella (chief pharmacist) and Mary O'Reilly of the Department of Health and Children; Niall Cullen and John Garry of the Department of Justice and Law Reform; Dairearca Ní Néill of the Office of the Minister for Drugs; and John Francis Cogan (ambassador) and Niamh Neylon of the Permanent Mission to the United Nations, Vienna.[2]

(Brigid Pike)

1. For further information on the 53rd Session of the CND, visit www.unodc.org/unodc/en/commissions/CND/
2. For further information on Ireland and UN drug policy, see reports in *Drugnet Ireland*, Issues 8, 18, 22, 27, 30.

Update on psychoactive substances sold in head shops and on line

Legislation

On 11 May the Irish government moved to control the sale of psychoactive substances in head shops and on line using a two-fold strategy: amendments to the list of controlled substances under the Misuse of Drugs Acts 1977 and 1984, and the newly drafted Criminal Law (Psychoactive Substances) Bill 2010 which will prevent the sale of substances created to get around existing laws. As of 11 May, synthetic cannabinoids, benzylpiperazine derivatives and six named cathinones are banned substances under the Acts, with sentences of up to seven years and/or a fine for possession and up to a maximum of life imprisonment for supply. The new Bill, when enacted, will make it a criminal offence to sell or supply, for human consumption, substances which may not be specifically prohibited under existing Acts, but which have psychoactive effects. Further amendments to existing Acts towards the end of 2010 will regulate other head shop products.
www.dohc.ie/press/releases/2010/20100511.html
www.justice.ie/en/JELR/Pages/Press_releases

Additional head shop substances

The leading article in the spring issue of *Drugnet Ireland* (No. 33) described a range of head shop products; four additional substances are described below.

Fluorotropacocaine

Fluorotropacocaine, a drug derived from the organic compound tropane, acts both as a stimulant and as a local anaesthetic. It was first reported as a designer drug by the European Monitoring Centre for Drugs and Drug Addiction in 2008. The drug has been identified in two head shop products sold in Ireland: Whack and Stardust. On 9 June 2010 the Health Service Executive issued an emergency warning about 'Whack' after 40 people suffering side effects of the drug attended emergency departments or general practitioners over the preceding 10 days. The majority of these individuals were young males in their twenties. They lived in different parts of Ireland, with 20 presenting in Limerick, Clare or North Tipperary. They reported a range of symptoms, such as increased heart rate, increased breathing rates and raised blood pressure. The majority experienced varying levels of anxiety and at least seven cases experienced psychotic episodes. This psychosis was difficult to treat.

Pyrovalerone

Pyrovalerone is a psychoactive drug with stimulant effects that was developed in the late 1960s for the clinical treatment of chronic fatigue and as an appetite suppressant for weight loss purposes. Because of problems with abuse and dependence, it is now less frequently prescribed, but there are reports of its continued use in France and South-East Asia. Its side effects include loss of appetite, anxiety, sleep disturbance, and tremors. The user may become depressed when use is discontinued. Its use is controlled in Ireland, Australia, Britain and the US. Pyrovalerone is closely related in structure to a number of other stimulants, such as methylenedioxypyrovalerone (MDPV) (banned in Ireland under Order of 11 May 2010). Naphyrone (O-2482, NRG-1, Energy 1), also known as naphthylpyrovalerone, is a drug derived from pyrovalerone that has stimulant effects and has been reported as a novel designer drug. It is sold as a plant food on line. No safety or toxicity data are available on naphyrone.

Aminoindans

2-Aminoindan is an uncommon short-acting stimulant with effects that have been compared to those of 1-benzylpiperazine or methamphetamine. Little is known about its recreational use, but aminoindans are the active ingredient in at least one head-shop product, Pink Champagne pills, which also contain cola vera and caffeine. The pills may cause an increased heart rate and short-term insomnia. Online sellers of these products indicate that they should not be consumed in combination with alcohol or other drugs, particularly anti-anxiety or anti-depressant drugs, or by people with any medical condition (in particular, heart or liver disease), with mental illness, or who are pregnant or breast feeding.

1,3-dimethylamylamine (DMAA)

1,3-dimethylamylamine or DMAA, also known as methylhexaneamine, is a derivative of geranium oil and acts as a central nervous system stimulant. Methylhexaneamine is registered for use as a nasal decongestant. In combination with caffeine and other ingredients, it has been marketed as a dietary supplement under trade names such as Geranamine and Floradrene. Methylhexaneamine, at extremely low concentrations (less than 1%), is a component of geranium oil which is approved for use in foods. DMAA is emerging as an active ingredient in party pills in New Zealand, where the government has indicated its intention to schedule it as a restricted substance. Recreational drug users have reported adverse effects of DMAA, including headache, nausea, and stroke. Online user reports describe a desire to reuse the drug, episodes of profuse sweating, and feeling depressed and paranoid. Products containing DMAA are available in head shops and on line under names such as Iced Diamond, Vegas Nights and Blessed.

Active ingredients identified in products

Dr Pierce Kavanagh and colleagues (at Trinity College and the Drug Treatment Centre Board) identified the active ingredients and other constituents in 41 products sold in head shops in Dublin and illustrated their results in a poster,[1] reproduced on pages 16-17. This poster is useful for staff working in emergency departments and drug treatment centres. Eighteen of the products analysed contained cathinone derivatives, either in isolation or in combination: mephedrone (28% of cathinone products), flephedrone (17%), methylone (22%), butylone (17%) and MDPV (22%). Dr Kavanagh and his team are analysing other psychoactive products to determine their contents and will release the results when their research is completed.

The authors reported that the negative effects of cathinones were: dehydration, erectile dysfunction, discolouration of the knees attributable to vascular damage ('blue knees'), cardiac arrhythmias, and paranoia. They also said that mephedrone had been linked with at least one death in Europe and was suspected in other deaths. For further information, email id.lab.team@gmail.com

Head Shop 'Legal Highs' Active Constituents Identification Chart (May 2010, pre-ban)

•Mephedrone (66.1% as HCl salt, 54.8% as free base)
•Caffeine
•Benzocaine

•Mephedrone (82.2% as HCl salt, 68.1% as free base)

•Mephedrone (14.6% as HCl salt, 12.1% as free base)

•Mephedrone (39.9% as HCl salt, 33.1% as free base)
•Benzocaine

•Methylone

•Methylone

•Methylone

•Methylone
•MDPV

•Mephedrone

•Flephedrone
•Lignocaine
•Caffeine

•Flephedrone
•Lignocaine
•Caffeine

•MDPV

•Caffeine
•Dimethylamylamine (DMAA)

•Flephedrone
•Lignocaine
•Caffeine

•MDPV

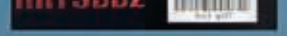
•MDPV
•Lignocaine

•MDPV
•Lignocaine

Pack 1
•Butylone
•A significant amount of what is believed to be an isomer of butylone was also found

Pack 2
•Butylone
•MDPV

•p-Fluorophenylpiperazine (pPFP)
•Caffeine



•Butylone
•Caffeine

•m-Trifluoromethylphenylpiperazine (mTFMPP)
•Caffeine

•Caffeine (100 %)

•Butylone

•Dimethylamylamine (DMAA)
•2-Phenylethylamine (2-PEA)
•Hordenine
•Caffeine

•m-Trifluoromethylphenylpiperazine (mTFMPP)
•1-Methyl-4-benzylpiperazine (Methyl BZP)
•Caffeine

•Mephedrone

•2-Aminoindane (2-AI, 2-indanamine)
•Caffeine

•MDPV

•Methylone

•Caffeine (99 %)

•Butylone

•Butylone

•m-Trifluoromethylphenylpiperazine (mTFMPP)
•p-Fluorophenylpiperazine (pPFP)

•MDPV

•Mephedrone

•Butylone
•Lignocaine

•Mephedrone

•2-Phenylethylamine (2-PEA)
•Dimethylamylamine (DMAA)
•Caffeine

•Caffeine
•Dimethylamylamine (DMAA)

•Caffeine
•Dimethylamylamine (DMAA)

These are the active constituents that we have found to date in the above products. It may be expected that Next Generation Compounds (NGC's) (i.e. new pharmacologically active compounds) will be used as active constituents in the above products following the banning of a number cathinone and piperazine derivatives on May 11, 2010 (www.dohc.ie/press/releases/2010/20100511.html). Recently NAPHYRONE has emerged as a replacement for mephedrone.

If you have any questions please contact us - id.lab.team@gmail.com

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Update on psychoactive substances sold in head shops and on line *(continued)*

1.Kavanagh P, McNamara S, Angelov D, Mc Dermott S and Ryder S (2010) Head shop 'legal highs' active constituents identification chart (May 2010, pre-ban). A modified version of this poster was presented at the All Ireland Joint Schools of Pharmacy Research Seminar (March 2010) and at the launch of the *Trinity Student Medical Journal* (April 2010).

Problem drug users' experiences of head shop products

Carol Murphy and colleagues presented an abstract of their survey, displayed a poster titled 'Head shop bath salts – not good clean fun',[1] at the College of Psychiatry of Ireland's spring meeting on 25 March 2010. This survey sought to estimate the extent, and describe the experience, of 'bath salts' use among problem drug users living in a hostel for homeless people in Dublin city centre. Nurses or key workers administered a questionnaire to a random sample of 20 clients during December 2009, of whom 17 participated in the survey. The researchers found that:

- Twelve of those surveyed had tried bath salts on at least one occasion.
- Some of the 12 had tried more than one product; 10 had taken 'Snow'; five had taken 'Blow'; three had taken 'Vanilla Sky'.
- The 12 respondents either snorted or injected the products.
- Ten respondents experienced a rush or euphoria similar to that of cocaine, ecstasy or crystal methamphetamine.
- The products were cheaper than cocaine.
- The unwanted side effects were: difficulty in sleeping, anxiety, agitation, hallucinatory experiences and paranoia.
- The 'come down' was associated with agitation, depression and paranoia.

1.Murphy C, McCarthy C, Harkin K and Keenan E (2010) Head shop bath salts – not good clean fun. Poster presentation at the College of Psychiatry spring meeting, Dublin, 25 March 2010.

Future research

The National Advisory Committee on Drugs has commissioned a review of products sold in head shops and other outlets in order to establish what the products contain, according to their labelling and on laboratory testing. The researchers will investigate availability of reference standards to facilitate the analysis of new psychoactive substances. They will update an inventory of head shops and other outlets (including internet sites) in order to assess geographical access to these substances. The users of products will be interviewed to determine products used, reason for use, expected effects, unexpected effects and preferred place or source of purchase. Problem drug users will be interviewed to identify specific risks associated with their use of these products. Data will be requested from hospital emergency departments to determine the negative health effects associated with head shop products. The research team will examine opportunities for legal and harm reduction interventions in Ireland and other countries. For further information, contact sscally@nacd.ie

Harm reduction

Ana Liffey Drug Project has developed a web page on legal highs which contains links to published harm reduction information. Peer workers at Ana Liffey have produced a booklet, Use your head, which provides some guidelines on how to minimise harm when taking drugs and how to intervene if someone experiences harm caused by drugs. www.aldp.ie/index.php?page=legal-highs

(Jean Long)

EMCDDA–Europol report on control of new psychoactive substances

A joint report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and European police agency Europol[1] concludes that 'the appearance of a large number of new unregulated synthetic compounds marketed on the Internet [and sold in head shops] as "legal highs" or "not for human consumption", and specifically designed to circumvent drug controls, presents a growing challenge to current approaches to monitoring, responding to and controlling the use of new psychoactive substances' (p.3). The report further states that a distinct feature of the 'legal highs' phenomenon is the speed at which suppliers target 'specific groups of recreational drug users', offering new unregulated alternatives in various guises, 'from room odorisers, through herbal incenses, to bath salts, and different patterns of use, including herbal smokable mixes, snorting powders, tablets and liquid preparations for oral consumption' (p.7).

The report is the fifth annual report from the two agencies on the information exchange, the Early-Warning System (EWS) set up by Council decision 2005/387/JHA. The joint report provides evidence-based advice to the Council and the commission on the need to request a risk assessment on a new psychoactive substance. In gathering information about new psychoactive substances, the EMCDDA and Europol also collaborate with national EWSs, Reitox National Focal Points (NFPs), Europol National Units (ENUs), the European Medicines Agency (EMA) and, where relevant, the World Health Organization (WHO).

During 2009, 24 new psychoactive substances were officially notified for the first time in the EU, the highest number ever reported. All substances were synthetic. The emergence of new, smokable herbal products laced with synthetic cannabinoids (also referred to as 'spice') and the growing popularity of various synthetic cathinones is seen as the main

EMCDDA–Europol report on control of new psychoactive substances *(continued)*

cause of 'significant new developments in the field of so-called "designer drugs"' (p.3).

The report also provides information recently gathered by the EMCDDA and Europol about mephedrone (4-methylmethcathinone) and about the piperazine derivative *m*CPP, reported as being present in an increasing proportion of ecstasy tablets while the availability of MDMA on the market appears to be decreasing. Although the reason for the apparent decline in MDMA is unclear, the finding 'corresponds with the growing number of legal alternatives to controlled drugs ... such as mephedrone' (p.3). Mephedrone is sold as a legal high, an alternative to cocaine or ecstasy. A number of member states – Ireland, Denmark, Germany, Estonia, Romania, Sweden and the UK – as well as Croatia and Norway, have recently introduced measures to control this substance. The report adds a note of caution in this respect: 'In view of the growing popularity and sales of mephedrone, it is important to consider the threat that this may pose by creating momentum for an undesirable transition, from a mostly online "legal-highs" market, originally driven by individual entrepreneurship, to one that involves organised crime' (p.15).

The report concludes with a review of the EWS achievements and also identifies some of the challenges which it may encounter during the coming years. Such challenges include 'issues that relate to identifying, monitoring and understanding the nature of various new substances, which increasingly appear on the internet and on the European drug markets, as well as the innovation and sophistication of their marketing' (pp.3–4). The EMCDDA is currently piloting an 'internet snapshot', or 'multilingual audit of on-line shops which are EU-based or dispatch to EU Member States' (p.7). In early 2010, the EMCDDA audited websites in 14 EU languages.

One challenge highlighted in the report relates to the importance of forensic and toxicology laboratories having access to reference materials (reference substances or seized substances), especially if they are to be able to identify new synthetic drugs about which limited scientific literature is available. Although the EWS has high reporting capabilities, the report concludes that 'despite its speediness and capacity to triangulate information from different sources, it has no mandate or resources to anticipate and research the future market by actively purchasing, synthesising and studying new compounds' (p.15).

(Johnny Connolly)

1. EMCDDA, Europol (2010) *EMCDDA-Europol 2009 annual report on the implementation of Council Decision 2005/387/JHA.* Lisbon: EMCDDA. Available at www.emcdda.europa.eu

Legal responses to new psychoactive substances in Europe

The current controversy over so-called 'head shops' has highlighted the challenge to policy makers of controlling and regulating new psychoactive substances which emerge in the licit or illicit market.[1] For public health reasons, legislators may need to bring new substances under control rapidly. A recent publication by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) describes the systems and procedures available in the European Union, Norway and Croatia.[2]

The comparative study finds that there is a variety of control methods available in the different countries, including the *generic* and *analogue systems* (see below), as well as temporary emergency and rapid permanent scheduling procedures. The procedures may be effective immediately, within several days, or they may need up to a year to process. The risk assessment systems that are used to inform these procedures also vary widely, with some countries having no formal procedures while others include full consultation with independent scientists.

The 'principle of legality' is a core value which underpins the criminal law. This holds that, 'no one shall be guilty of any criminal offence on account of an act or omission which did not constitute a criminal offence under national or international law at the time when it was committed'.[3]

Following this principle, controlled psychoactive substances need to be clearly identified in any legislation that makes their possession or supply a criminal offence. Substances are generally defined individually or in tightly defined groups. A challenge which can arise, however, is that illicit drug producers or traffickers can adjust a chemical compound so that it falls outside the definition of a controlled substance, or find a new substance that has similar psychoactive effects. The challenge then facing policy makers, as highlighted in this study, is that they will need to decide 'if they need to bring this new substance under control – and in cases of immediate risk to public health, they will need to act quickly' (p.4). Similarly, countries that are parties to the UN drug treaties or within the EU may be obliged to add substances to their lists within a certain deadline.

This study, an update of a similar study conducted by the EMCDDA in 2004,[4] looks at the formal systems used by member states and by Norway and Croatia to control new psychoactive substances (synthetic and otherwise), the legal procedures involved and an estimate of the time such procedures might take. It also describes the risk assessments involved in the various procedures. The methodology used for the study involved a questionnaire sent to the ELDD's Legal Correspondents Network and contributions from correspondents to the Early-Warning System.

Legal responses to new psychoactive substances in Europe *(continued)*

Countries generally follow the individual listing system whereby national lists of controlled substances follow the UN Conventions, which may also extend the list to a substance's 'isomers, esters, ethers and salts' (p.5). New substances may be added by means of an emergency procedure, which is an accelerated procedure whereby new substances are controlled for a limited period, or a rapid procedure where new controls on new substances are permanent.

In some countries, the individual list system may be supplemented by definitions of groups of substances under either a generic or an analogue system. A **generic system** is defined in the study as referring to the inclusion within the list of individual substances under control of a 'precise definition of a group of substances' sharing the same compounds or molecular structure (p.6). An example of such a definition might be 'any compound structurally derived from fentanyl' by modification in a number of ways, which are then described. An **analogue system** is based on more general aspects of similarity in the chemical structure of substances. An analogue definition of a compound might be 'a substance – the chemical structure of which is substantially similar to the chemical structure of a controlled substance…which has a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than' the effect of an already controlled substance (p.6).

The report then describes the national systems and procedures and the legal practice in each country. In Ireland, new substances are controlled both by individual listing and by a generic system. In practice, a memorandum is drafted and submitted to the relevant government departments for comment. A Declaration Order is then issued and the Minister for Health and Children sends a draft to the Cabinet. Once approved, the Order is signed by the Minister and then laid before both houses of the Oireachtas within 21 days, together with any regulations and exemption orders. Notification of the Order is then published in the Irish State Gazette (Iris Oifigiúil). The procedure can take approximately six weeks, but may take longer if there are drafting delays or if the Oireachtas is not in session. This procedure is the same regardless of the source of the instructions for placing a new substance under control (whether the UN or the EU). The study finds that all countries use the individual listing system, in addition to which Ireland and the UK use the generic system, and Latvia and Norway the analogue system.

The speed with which changes are introduced can be affected by the formalities involved in each jurisdiction. The faster procedures are found to be those that require final approval of the legal text by one minister, rather than by an entire government, or those that shorten the duration of the consultations with experts.

The study also considers the risk assessment procedures available in different countries. Three questions are addressed in this review:

- Is the risk assessment procedure part of the general legal procedures for bringing new substances under control?
- Do the harm levels detected by the risk assessment influence the speed of the legal procedure?
- Is the risk assessment performed by experts within the public administration or by independent scientific experts?

In Ireland, although there is no legally-based requirement for risk assessment, the Early Warning and Emerging Trends sub-committee of the National Advisory Committee on Drugs (NACD) was established to carry out risk assessments, as well as to contribute to risk assessments carried out at the European level. To date, no instances of risk assessment outside UN/EU proposed substances have been reported.

(Johnny Connolly)

1. Long J (2010) Conference on psychoactive drugs sold in head shops and on line. *Drugnet Ireland* (33): 1–3.
2. Hughes B and Blidaru T (2009) *Legal responses to new psychoactive substances in Europe*. Lisbon: European Legal Database on Drugs. http://eldd.emcdda.europa.eu/
3. European Convention on Human Rights, Art. 7(1)
4. EMCDDA (2004) *Legal responses to new synthetic drugs 2000–2004*. Lisbon: European Legal Database on Drugs. http://eldd.emcdda.europa.eu

Pompidou Group celebrates its first 30 years

The Pompidou Group (PG) consists of 35 member states, including Ireland, which work together to develop drug policies to combat illicit trafficking in drugs and drug abuse. The PG was formed at the instigation of the French President Georges Pompidou in 1971, and incorporated into the Council of Europe in 1980.[1]

In celebrating its first 30 years, the PG states that its unique contribution has been to provide the only forum of open discussion on the drugs issue that is not constrained by ideological or political considerations. Because of this, the PG has been able to develop and promote effective drug-related policies, i.e. policies that have actually reduced supply and demand. Among its achievements over the past three decades, the PG lists the following:

1. The concepts of monitoring trans-national drug abuse and indicator development were introduced by the PG, and then taken over by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Methods to measure the use of alcohol, tobacco and drugs were developed by the PG, and the European School Survey Project on Alcohol and other Drugs (ESPAD) is now an independent programme that serves governments in 51 countries as the principal data source in drug-use trends.
2. Control of drug trafficking in civil aviation through co-operation between customs and law enforcement agencies across member states has been supported by the PG's Airports Group, which regularly updates member states on the *modus operandi* of drug traffickers in civil aviation.
3. The PG has sought to develop effective approaches to drug prevention. It compiled the *Prevention Handbook* for policy managers and practitioners, and school-based life-skills training modules developed by the PG are widely used in Europe.
4. Effective involvement of civil society in reducing drug use and the associated negative social and health consequences owes much to two PG initiatives, the European Consultative Forum and the European Drug Prevention Prize, which have engaged young people, particularly those in at-risk groups, in preventing drug use among their peers.
5. Targeted drug treatment policies leading to the re-integration of drug users into society have been the result of the PG's integrated approach to linking policy with practice and research. Achievements include treatment as an alternative to prison, treatment standards for young drug users and women, drug addiction treatment in prisons, and principles and guidelines for reducing drug-related HIV/AIDS infections.
6. The PG was the first body to develop and promote policies for effectively dealing with open drug scenes in cities. The significant reduction of open drug scenes in Europe over the past 15 years can be attributed to a great extent to the PG's work.
7. The PG is the only body to address ethical and human rights issues related to drug control policies. Attention to such issues has been identified by the International Narcotics Control Bureau (INCB) as key to effective implementation of drug policies. The PG has already provided member states with guidance on the conduct of drug screening.
8. The MedNET network, which is supported by the PG, has made it possible to measure for the first time the scope of the drug problem in Algeria, Morocco and Lebanon and has informed the development of drug strategies in these countries based on risk-reduction policies. Under MedNet the PG has organised training for medical staff in drug addiction treatment, including opiate substitution treatment taking into account the right to health of the drug user.

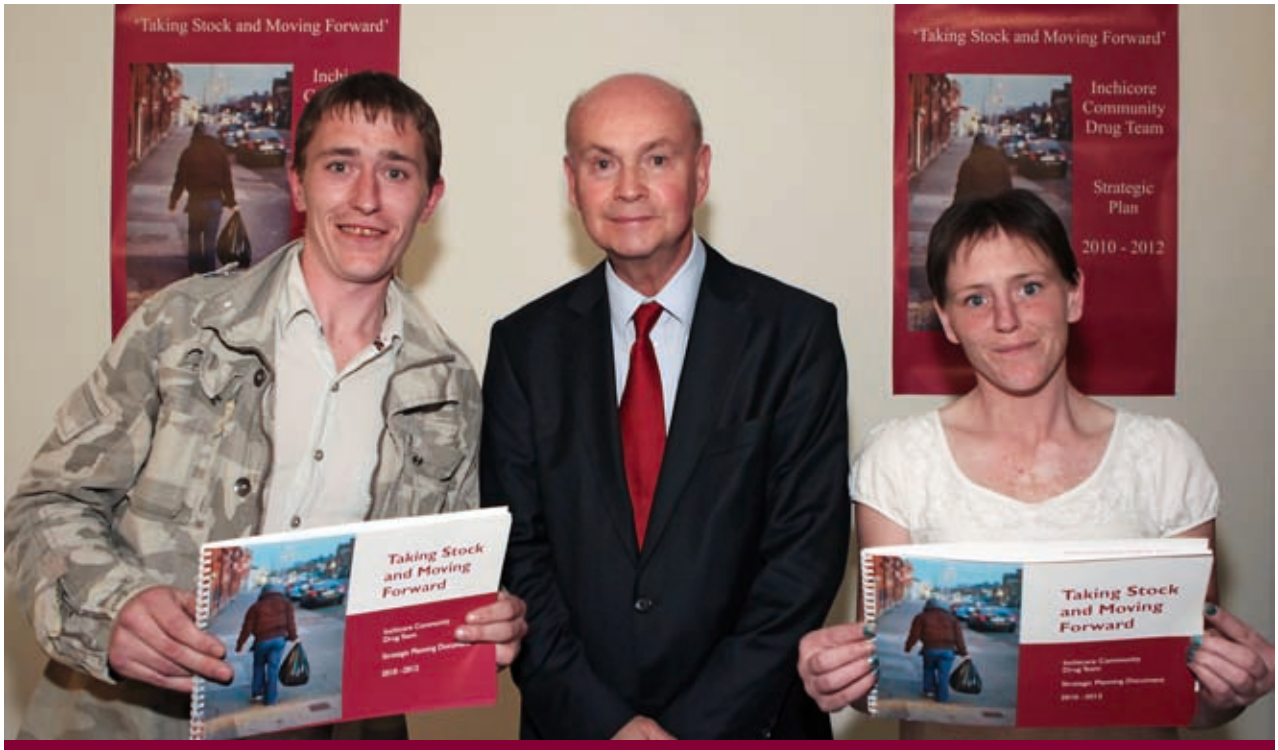
Looking to the future, the PG has announced its intention to concentrate on three main themes:

1. involving target groups in developing, implementing and reviewing drug demand reduction policies,
2. combining policy with research and practice in order to overcome barriers to policy implementation and increase efficiency and effectiveness, and
3. bringing the human rights dimension to the forefront in tackling drug problems, and in particular,
   - the human rights and ethical aspects concerning vaccinations against cocaine use
   - human rights as a key factor to better balance repression and prevention
   - the ethics of using developments in neuro-science to influence behaviour
   - the crucial role and added value of human rights in drug treatment and rehabilitation.

(Brigid Pike)

1. The Social Inclusion Unit of the Department of Health and Children is Ireland's Permanent Correspondent to the Pompidou Group. For further information on the Pompidou Group, visit www.coe.int/t/dg3/pompidou/AboutUs/default_en.asp

ICDT launches three-year strategic plan



Attending the launch of the ICDT Strategic Plan, (l to r) Terence Murphy, Minister Pat Carey and Kiera Keogh (photo courtesy ICDT)

The Inchicore Community Drug Team (ICDT) launched its strategic plan for 2010–2012, T*aking stock and moving forward*, in April 2010.[1] The plan was officially launched by Mr Pat Carey, Minister for Community Equality and Gaeltacht Affairs.

The vision set out in the strategic plan is 'that all those living with drug addiction in Inchicore will have access to a holistic addiction service locally'.

Six strategic goals were identified for the three-year period of the plan:

- To provide a safe environment where people affected by drug addiction can explore in a non-judgemental way the issues affecting their lives.
- To promote opportunities for individuals to move out of the cycle of drug addiction.
- To develop opportunities for children and young people to reach their full potential.
- To identify gaps in service provision and initiate local responses.
- To promote a better understanding of how the drug problem affects the local area, and to increase the community awareness of drug issues.
- To develop ICDT structures, roles and responsibilities in accordance with the strategic plan.

The plan also outlines a number of actions to be undertaken by ICDT:

- Develop a minimum service level for those on low-threshold programmes.
- Develop a needle exchange in Inchicore in partnership with the Canal Communities Local Drugs Task Force and the Health Service Executive.
- Develop holistic interventions in response to drug-use trends among service users.
- Develop programmes to meet the needs of children aged 10–14 years who have outgrown the Children's Project.
- Develop an inter-agency youth programme targeted at those involved in drug dealing.
- Establish a working group and develop a local strategy in response to benzodiazepine dependency.
- Establish an inter-agency response to meet the mental health needs of service users.
- Develop a family welfare forum in conjunction with local agencies, with the aim of improving the quality of life of children living in vulnerable families.
- Develop the ICDT website and publish a regular newsletter.

(Anne Marie Carew)

1. Inchicore Community Drug Team (2010) *Taking stock and moving forward: strategic planning document 2010–2012*. Dublin: Inchicore Community Drug Team.

Guidelines for peer-led family support groups

The Family Support Network (FSN) launched its long-awaited good practice guidelines for peer-led family support groups[1] in Dublin Castle on 7 April 2010. The audience was welcomed by FSN chairman Mr Tony Hickey, and the guidelines were formally launched by Mr Eamonn Quinn of the Quinn Family Trust, who part-funded the project. Ms Sadie Grace, co-ordinator of FSN, gave a brief overview of the guidelines.

Geraldine Hanlon, Marian Davitt, Tiffany Bourke, Gwen McKenna, Brendan Doyle, Breda Fell and Bernie Howard, all members of family support groups, spoke about their own experiences, about the benefits of such groups, and about issues such as starting up, confidentially and respite care. Minister Pat Carey, Department of Community, Equality and Gaeltacht Affairs, also spoke at the launch.

Developed after consultation with a wide range of interested stakeholders, the guidelines are intended to be used by all members of family support groups, with the following objectives:

- To assist family support groups to develop good practice in all areas of the work of the group.
- To identify training and other resources required to support good practice.
- To ensure consistency in the practice of family support groups throughout the country.
- To provide a basis for affiliation to the FSN.

The document has six sections:

1. **Introduction** includes items on who the guidelines are for and how best to use them;
2. **Starting a peer-led family support group** includes items on the composition of groups, code of ethics and practice advice for convening meetings;
3. **Providing support in a group** examines aspects of confidentiality, identifying the needs of members, and group development;
4. **Facilitation** outlines the role and attributes of a good facilitator;
5. **Seeking external support** deals with identifying information, self-development and training needs of a group;
6. **Setting up a family support network** outlines the benefits and issues involved in setting up a network of support groups.

Each section concludes with reflective exercises and 'top tips', which are also available in the form of a separate resource pack.

As well as being very comprehensive, this document clearly draws on a wealth of personal experience among the families themselves and those working with them. It is intended that the guidelines will be reviewed and updated over time.

(Suzi Lyons)

1. Family Support Network (2010) *Good practice guidelines for peer-led family support groups*. Dublin: Family Support Network.

Mr Eamonn Quinn of the Quinn Family Trust formally launched the FSN guidelines (photo courtesy FSN)

Attitudes towards alcohol: Special Eurobarometer

Europe is the region with the highest per capita consumption of alcohol in the world. In the European Union (EU), harmful and hazardous alcohol consumption is the third largest risk factor for ill health, and is responsible for 195,000 deaths each year. The economic cost to the EU each year is estimated at €125 billion.[1] Against this backdrop, the European Commission recently commissioned a survey of respondents in each of the 27 member states, with the aim of analysing EU citizens' alcohol consumption patterns, their awareness of the adverse health and social effects, and opinions regarding policy options to reduce alcohol-related harm.[2] Fieldwork took place in October 2009 and respondents were interviewed face-to-face in their own homes. In Ireland, 1,008 respondents were interviewed. A similar survey was conducted in 2006.[3]

Main findings

The majority of the EU population drink alcohol, with 76% reporting that they had consumed alcohol in the year prior to the survey. Although Irish people drink on fewer occasions, they are the most likely of EU citizens to consume more drinks on a drinking occasion and to binge drink (defined as consuming at least five drinks on a singe drinking occasion) (Table 1). Just 34% of Irish respondents consume two drinks or less per drinking occasion, compared to 69% of Europeans. The survey also found men more likely to engage in weekly binge drinking than women (36% vs. 20%).

Table 1 Selected drinking patterns in Ireland and EU27

	Ireland %	EU27 %
Abstainer	24	24
Drinks 4+ times per week	7	21
Drinks 5+ drinks per drinking occasion	26	10
Weekly binge drinker	44	29

Irish respondents reported high levels of support for drink-driving countermeasures (Table 2). Although Irish respondents were largely uninformed about the legal blood alcohol concentration (BAC) limit, just 4% stated that it would be safe to drive after consuming more than two drinks, compared to 14% of Europeans. Among Irish people there is widespread support for reducing the permitted BAC for young and novice drivers. The level of support for drink-driving countermeasures among Irish people may be attributed to the introduction of random breath testing in 2006, which has been credited with reducing road deaths and the work of the Road Safety Authority.

Table 2 Drink driving – awareness of risk and support for countermeasures

	Ireland %	EU27 %
Knows the relevant legal BAC limit	8	27
Believes it safe to drive after consuming more than two drinks	4	14
Random police checks would reduce people's alcohol consumption before driving	93	83
BAC levels for young and novice drivers should be decreased to 0.2g/l	82	73

The survey also investigated opinions regarding the responsibility for and prevention of alcohol-related harm. In Ireland, 53% consider individuals to be mainly responsible for protecting themselves from alcohol-related harm (Table 3). There is strong evidence that alcohol is price sensitive, with consumption increasing as price decreases and vice versa.[4] Young people and heavy drinkers are the two groups of people who are most likely to be affected by price changes. One third (31%) of Irish respondents believe that young and heavy drinkers would buy less alcohol if prices increased by 25%. One third state that they themselves would buy less alcohol if the price increased, and 18% would buy more alcohol if the price decreased. This demonstrates that there is a lack of awareness among Irish people of what policies are effective in reducing alcohol consumption.

Table 3 Support for public policies on alcohol

	Ireland %	EU27 %
Individuals are responsible enough to protect themselves from alcohol-related harm	53	53
Young and heavy drinkers would buy less alcohol if prices increased by 25%	31	26
Respondent would buy less alcohol if prices increased by 25%	34	35
Respondent would buy more alcohol if prices decreased by 25%	18	14

All European countries are strongly in favour of prohibiting the selling and serving of alcohol to people under the age of 18. There is strong support for measures that restrict young peoples' exposure to alcohol, with 81% of Irish respondents in favour of the banning of alcohol advertising that targets young people (Table 4). Not surprisingly perhaps, young people aged 15–24 years were least likely to favour controls that tighten regulations concerning their age group. There is broad support for putting warning labels on alcohol bottles in order to inform pregnant women and drivers of the dangers associated with drinking alcohol, with 86% of Irish respondents in favour of such an initiative.

Attitudes towards alcohol: Special Eurobarometer *(continued)*

Table 4 Support for measures to protect young people and pregnant women

	Ireland %	EU27 %
Selling and serving of alcohol to under-18s should be banned	91	89
Alcohol advertising targeting young people should be banned	81	77
Alcohol containers should carry labels warning pregnant women and drivers of the dangers of alcohol	86	79

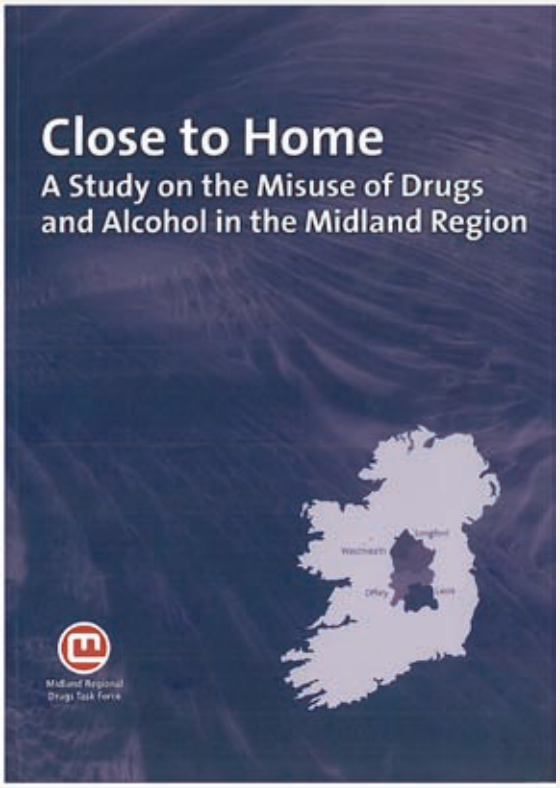
Conclusion

While this survey shows that the proportion of Irish respondents reporting weekly binge drinking has decreased since 2006, drinking patterns in Ireland are still problematic. More encouragingly, there is widespread support for drink-driving countermeasures and for measures aimed at protecting young people from premature exposure to alcohol.

(Deirdre Mongan)

1. Anderson P and Baumberg B (2006) *Alcohol in Europe: a public health perspective*. London: Institute of Alcohol Studies. Available at http://ec.europa.eu/health-eu/doc/alcoholineu_content_en.pdf
2. TNS Opinion & Social (2010) *EU citizens' attitudes towards alcohol. Special Eurobarometer 331*. Brussels: European Commission. Available at http://ec.europa.eu/public_opinion
3. TNS Opinion & Social (2007) *Attitudes towards alcohol. Special Eurobarometer 272*. Brussels: European Commission.
4. WHO Regional Office for Europe (2009) *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen: World Health Organization. Available at www.euro.who.int/

Report on drug and alcohol use in the Midland region



Minister Pat Carey of the Department of Community, Equality and Rural Affairs launched the report of a study on drug and alcohol use in the Midland region on 7 May.[1] Commissioned by the Midland Regional Drugs Task Force, the aim of the study was to establish an evidence base for drug-related issues in the Midland region to inform the development of appropriate response strategies. The study used information from several different sources, including national drug prevalence data, the National Drug Treatment Reporting System (NDTRS) and the Central Statistics Office. Interviews and focus groups were also conducted with key informants (e.g. service providers, drug users, family members) in four selected communities in the region.

Many of the issues identified were common to all four communities and could be generalised to the whole of the Midland region. The report highlights these issues and makes some key recommendations:

Expand and improve existing addiction services to cope with increasing numbers of individuals requiring treatment for drug and alcohol problems.

- **Facilitate access to addiction services** by reducing waiting lists and by addressing issues of distance and adequate transportation when locating new or expanded services.
- **Expand harm reduction programmes** and set up additional ones as needed.
- **Improve access to methadone treatment** and reduce waiting lists by increasing the number of general practitioners providing methadone in the community and by expanding and improving existing services.
- **Improve access to detoxification, rehabilitation and aftercare services** in line with the recommendations of the report of the HSE Working Group on Residential Treatment and Rehabilitation.[2]

Report on drug and alcohol use in the Midland region *(continued)*

- **Address problem alcohol use in a more comprehensive way**, not only by providing adequate treatment facilities but also by adopting broader strategies, including education, increased taxation and regulation.
- **Address the lack of adequate services for under-18s** by providing adolescent-specific services offering a complete, integrated range of services, in line with the recommendations of the Department of Health and Children.[3]
- **Improve drug awareness education** for all age groups.
- **Reduce drug-related deaths** by using strategies such as providing education in overdose prevention and training in basic life support.
- **Provide social reintegration services to** recovering and former drug users through accommodation, re-training and employment supports.
- **Evidence of drug crime**, such as drug markets, was found in the region. A partnership approach involving all the key stakeholders is one strategy to tackle this problem.

(Suzi Lyons)

1. Lyons S, Robinson J, Carew AM, Gibney S, Connolly J, Long J *et al.* (2010) *Close to home: a study on the misuse of drugs and alcohol in the Midland region.* Tullamore: Midland Regional Drugs Task Force.
2. O'Gorman A and Corrigan D (2008) *Report of the HSE working group on residential treatment and rehabilitation (substance users).* Dublin: HSE.
3. Working Group on treatment of under 18 year olds (2005) *Report of the working group on treatment of under 18 year olds presenting to treatment services with serious drug problems.* Dublin: Department of Health and Children.

From *Drugnet Europe*

Enhancing the quality and effectiveness of services for drug users

Article by Roland Simon in Drugnet Europe *No. 70, April–June 2010*

Enhancing the quality and effectiveness of drug prevention, treatment, harm reduction and rehabilitation interventions is one of the key objectives of the current EU drugs action plan (2009–12). In order to translate this goal into concrete action, the plan foresees developing, implementing and exchanging quality standards and guidelines for services and interventions in these areas. The European Commission (DG–JLS) is supporting an EU-funded research project to develop 'minimum quality standards and benchmarks' in the four fields. The project will take stock of standards already existing in Europe and develop a mechanism of consensus-building between the EU Member States.

The EMCDDA has been working in this domain for over a decade. In 2008, it launched its Best Practice portal, designed to help those working in these fields take evidence-based decisions when planning interventions. More recently it has conducted a review of national treatment guidelines[1] and is currently collaborating in another EU-funded research project to produce evidence-based drug prevention standards for use in the EU.[2] In the light of its experience, the EMCDDA will work closely with the Commission on this initiative, participating in the project steering group and offering technical support as required.

1. A Selected Issue report on the implementation of the treatment guidelines will be published in 2011.
2. www.emcdda.europa.eu/publications/drugnet/online/2010/69/article8

New EMCDDA monograph focuses on harm reduction

Article in Drugnet Europe *No. 70, April–June 2010*

EMCDDA Monograph No 10, entitled *Harm reduction: evidence, impacts and challenges,*[1] was released in April. In 16 chapters authored by over 50 European and international experts, the monograph provides a comprehensive overview of the harm reduction field. Part I looks at the emergence of harm reduction approaches and their diffusion as part of the new public health movement of the mid-1980s. It explores the concept from several perspectives (e.g. international organisations, academic researchers and drug users). Part II is dedicated to current evidence and impacts of harm reduction and illustrates how the concept has broadened to cover a wide range of behaviours and harms, including those related to alcohol, tobacco and recreational drug use. Part III addresses challenges and innovations and the requirement to integrate and match interventions to individual and social needs.

1. Available at www.emcdda.europa.eu/publications/monographs/harm-reduction

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), available at www.emcdda.europa.eu.

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

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Online course in evidence-based practice for drug prevention workers

Participants on the NDC's elearning course in evidence-based drug prevention practice (photo JJ Berkeley)

The National Documentation Centre is piloting a course in evidence-based practice in drug prevention and education work. The course, which lasts for 12 weeks, was launched in early March. The 12 participants on the course are from a variety of backgrounds, but most work in the drug prevention and education field. The aim of the course is to teach the participants a range of information-literacy skills which will help them understand how evidence in their field is produced, how this evidence can be found and how research-based knowledge can be used to shape policy and bring about better health outcomes.

The course participants bring to it considerable knowledge of their own specialist field and experience of planning and delivering educational and instructional programmes. They already have some research and information-retrieval skills and some understanding of the role of evidence in the formation of policy in this area. The course draws heavily on the participants' conceptual, technical and communication abilities.

The course comprises seven modules covering the following topics: the policy context; the research infrastructure; the evidence for drug prevention interventions; evidence-based medicine; searching the scientific literature; critical appraisal; and data sources.

A successful outcome will depend on participants' capacity to make logical links between the production of evidence, finding evidence, and the role of evidence in policy development. It is intended that the outcome will be of direct benefit to the participants' daily practice and will enable them to contribute to the adoption of evidence-based approaches to policy decisions. A problem-based learning approach encourages the type of enquiry, discourse and collaborative effort which will be needed to make full use of the newly acquired information-literacy skills.

Assessment is based on performance in a group presentation, and on participation in online discussion throughout the course. The presentation is the group's response to a problem they identified at the beginning of the course. There are three face-to-face sessions, but most of the course is delivered online. Content and learning activities are supported by the Moodle course management system. The decision to deliver the course online was based on the following considerations:

- The participants work and live in diverse locations and a distance learning element will provide the flexibility for those with limited opportunity to travel.
- As it is an information literacy course, it will require the participants to engage with online resources and develop an awareness of the potential of the internet for research, communication and collaborative working.
- The emergence of the evidence-based medicine movement is closely linked to the rapid development of electronic scientific publishing. An understanding of EBM will require an awareness of the virtual environment which has fostered it.

Following completion of the pilot course, an evaluation report will be prepared and submitted to an appropriate accreditation body. The course will be repeated in the future, when details will be advertised in *Drugnet Ireland* and on the NDC website at www.drugsandalcohol.ie.

(Brian Galvin)

Brian Galvin and Louise Farragher (NDC) with Paul Gormley and Catherine Bruen (Vista eLearning Consultancy) during the first session of the new course (photo JJ Berkeley)

In brief

On 19 January 2010 **Revenue Cutter Service** was the subject of a response by Minister for Finance, Brian Lenihan TD, to a Parliamentary Question (PQ). He stated that the Revenue Commissioners have two cutters involved in the patrol and monitoring of the State's maritime jurisdiction and adjacent waters. The aim is to prevent, detect, intercept and seize prohibited and restricted goods (including narcotics) smuggled into or out of the State/EU. The cutters also co-operate with other national enforcement agencies and with international customs agencies in combating drugs trafficking by sea. www.oireachtas.ie

On 2 February 2010 **prescription drugs** were the subject of a PQ. Minister for Health and Children, Mary Harney TD, stated: 'Certain prescription medicines have been declared controlled drugs in accordance with the Misuse of Drugs Act 1977 — for example, products containing morphine, methadone, flunitrazepam and possession of these products, in contravention of the Act, is an offence. Under the Misuse of Drugs (Exemption) Order 1988, it is not an offence for a person to possess prescription medicines containing certain benzodiazepines.' www.oireachtas.ie

On 2 February 2010 **Policing Priorities 2010** were announced by the Minister for Justice, Equality and Law Reform, Dermot Ahern TD. In addition to the continuing fight against gangland crime (including targeting drug trafficking and low-level street dealing), the Minister has prioritised security; policing communities (including adopting a low tolerance to alcohol- and drug-related anti-social behaviour and youth crime); customer service; roads policing and human trafficking. The policing priorities set by the Minister are reflected in the Garda Síochána Policing Plan for 2010. www.garda.ie

On 25 February 2010, at the **Irish Youth Justice Service's** 2nd biennial conference, Barry Andrews TD, Minister for Children and Youth Affairs, launched the online learning community **YJforum** for those working on Garda Youth Diversion Projects. This web-based forum provides an opportunity for practitioners working in the youth justice system to share their experiences and work together to strengthen the system. Copies of the presentations made at the conference, together with a Conference Report, are available on the IYJS website. www.iyjs.ie

On 18 February 2010 the **Dial to Stop Drug Dealing campaign** was the subject of a PQ. Minister of State at the Department of Community, Rural and Gaeltacht Affairs, John Curran TD, stated: 'Due to the success of the campaign, I have again made funding available in 2010 to keep the phone line open. Over the coming months, I will be reviewing various options for further promotional campaigns, perhaps through a more centralised approach or through potential linkages with other campaigns and fora.' www.oireachtas.ie

On 23 February 2010 **drug policy in the European Union** was the subject of a public hearing, when approximately 40 representatives of European civil society organisations from 15 countries came together to formulate their recommendations to members of the European Parliament, the European Commission and the European Council on the approach that the European Union should take regarding criminalised drugs. The main issue on the agenda was the *Report on Global Illicit Drugs Markets 1998–2007,* that was financed by the European Commission in 2008.[1] The hearing resulted in recommendations to the EU institutions, including calls for (1) the organisation of a EU Summit to discuss innovative drug strategies not based on prohibition, with delegations of national and local authorities, parliamentarians and civil society organisations present, and (2) the strengthening of the 'harm reduction' approach, promoting drug policies that respect human rights, individual freedoms and social cohesion. www.encod.org

On 25 February 2010 an **Internal Security Strategy for the European Union** (5842/2/10) was approved by the Council for Justice and Home Affairs. The strategy lays out a European security model, which integrates action on law enforcement and judicial co-operation, border management and civil protection, with due respect for shared European values, such as fundamental rights. It identifies the main threats and challenges the EU is facing, including organised crime, cyber-crime, and drug and arms trafficking. The Council also adopted the decision to set up the **Standing Committee on Operational Cooperation on Internal Security (COSI)** (16515/09 and 5949/10). COSI's co-ordination role will concern, among other things, police and customs co-operation, external border protection and judicial co-operation in criminal matters relevant to operational co-operation in the field of internal security. The committee shall regularly report on its activities to the Council which, in return, shall keep the European Parliament and national parliaments informed. COSI will also be responsible for evaluating the general direction and efficiency of operational co-operation. www.consilium.europa.eu

On 9 March 2010 **Cosc – the National Office for the Prevention of Domestic, Sexual and Gender-based Violence** published a national strategy on domestic, sexual and gender-based violence for 2010–2014. The report states: 'Although the relationship between substance use and domestic and sexual violence is complex, there are clear indications that alcohol use, particularly heavy drinking and binge drinking, not only complicates the extent and nature of violence against women, particularly among intimate partners, it also increases the likelihood of re-assault and reduces the likelihood of perpetrators of domestic violence completing treatment.' www.cosc.ie

On 23 March 2010 the **Social, Personal and Health Education (SPHE)** programme was the subject of a PQ. Minister for Education and Science, Batt O'Keeffe TD, stated: 'Although the Walk Tall Support Service will no longer exist in its current guise, it is my intention that the support for substance misuse prevention be further integrated into SPHE support. It is widely acknowledged that while a strand of SPHE can be taught in isolation, it should be linked to each of the other strands of the SPHE curriculum in order to be at its most effective.' www.oireachtas.ie

On 31 March 2010 Ireland's proposed **National Substance Misuse Strategy** was mentioned by the Minister for Tourism, Culture and Sport, Mary Hanafin TD, during Question Time in Dáil Éireann: 'The Department [of Tourism, Culture and Sport] is also represented on a steering group developing proposals for an overall national substance misuse strategy. The group is chaired by the Department of Health and Children and the office of the Minister of State with responsibility for drugs. Part of the strategy will relate to preventative measures and the subjects of sports and arts activities are expected to be included within this framework.' www.oireachtas.ie

(Compiled by Brigid Pike)

1. For a summary of the report, see Connolly J and Donovan AM (2009) A report on global illicit drug markets. *Drugnet Ireland,* (30): 23–24.

Recent publications

Journal articles

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

Head shop compound abuse amongst attendees of the Drug Treatment Centre Board

MacNamara S, Stokes S and Coleman N
Irish Medical Journal 2010; 103 (5)
www.drugsandalcohol.ie/13185

The use of 'Head shop' compounds has received much media attention lately. There is very little research in the current literature with regard to the extent of the usage of these substances amongst the drug using population in Ireland. We conducted a study to examine the extent of the usage of Mephedrone, Methylone and BZP amongst attendees of Methadone maintenance programs at the DTCB. Two hundred and nine samples in total were tested. The results showed significant usage of these compounds amongst this cohort of drug users, with 29 (13.9%) of samples tested being positive for Mephedrone, 7 (3.3%) positive for Methylone and 1 (0.5%) positive for BZP.

Factors predicting completion in a cohort of opiate users entering a detoxification programme

Mullen L, Keenan E, Barry J, Long J, Mulholland D, Grogan L and Delargy I
Irish Journal of Medical Science (In press, published online 21 February 2010)
www.drugsandalcohol.ie/12940

Aim; To determine the outcome and factors influencing outcome among a cohort of drug users commencing detoxification from opiate use.
Methods: National cohort study of randomly selected opiate users commencing methadone detoxification treatment in 1999, 2001 and 2003 (n=327).
Results: One quarter 62 (25.6%) of opiate users had a successful detoxification within the three-month study criteria. Receiving some inpatient treatment as part of detoxification programme resulted in completion by 56.3% drug users compared to treatment at outpatient only (21%). The factors independently influencing detoxification are as follows: having some inpatient treatment (AOR 5.9, 2.63–13.64) and never having injected (AOR 2.25, 1.20–4.25). An additional 31 (9%) opiate users had a detoxification between 3 months and 1 year and 27 (8%) moved into methadone maintenance.
Conclusions: This study finds that having some inpatient treatment increases the likelihood of a successful opiate detoxification within three months. Offering an opiate detoxification early in a drug using career, pre-injecting drug use, should be considered for suitable and motivated patients.

Sex, drugs and STDs: preliminary findings from the Belfast Youth Development Study

McAloney K, McCrystal P, and Percy A
Drugs: education, prevention and policy (In press, published online 2 April 2010)
www.drugsandalcohol.ie/13061

Young people's participation in sexual risk behaviours is commonly linked with participation in a range of other risky behaviours, and in particular with substance use behaviours. This cross-sectional analysis of the sixth sweep of the Belfast Youth Development Study aimed to examine associations between substance use and sexual activity and related risks among 17–19-year olds in Northern Ireland. Being sexual activity and participating in sexual risk behaviours was associated with the use of a range of licit and illicit substances particularly alcohol and ecstasy. Additionally, females were more likely to have been tested for a sexually transmitted disease (STD).

The findings add to the existing research body suggesting that substance misuse and sexual risk behaviours tend to co-occur in adolescence, and highlight a need to develop appropriate interventions and initiatives for school-aged young people.

Emergencies related to cocaine use: a European multicentre study of expert interviews

de Millas W, Haasen C, Reimer J, Eiroa-Orosa, FJ and Schaefer I
European Journal of Emergency Medicine 2010; 17 (1) 33–6

Illicit drug use can lead to acute reverse reactions leading to admission to emergency departments. Cocaine-related emergencies have been monitored in the USA, but not in Europe so far.

The study investigates patterns of cocaine emergencies in eight European cities in a multicentre cross-sectional study conducted in Barcelona, Budapest, Dublin, Hamburg, London, Rome, Vienna and Zurich. The reported frequency differs from city to city, with some emergency centres having less than one case per half year, and some centres having more than one case per month. Patterns of complaints among cocaine users are associated with the psychomotor-stimulant or cardiovascular effects of cocaine. Urine screens and referrals to the addiction services are infrequent.

A closer link between emergency departments and addiction services would help in guiding problematic drug users towards appropriate treatment at an earlier stage in the addiction process.

Prevalence of psoriasis in patients with alcoholic liver disease

Tobin AM, Higgins EM, Norris S and Kirby B
Clinical and Experimental Dermatology 2009; 34(6): 698–701

Background: Excessive alcohol use has been implicated as a risk factor in the development of psoriasis, particularly in men. Despite this, little is known of the incidence or prevalence of psoriasis in patients who misuse alcohol. Objective: To assess the prevalence of psoriasis in patients with alcoholic liver disease. Methods: In total, 100 patients with proven alcoholic liver disease were surveyed for a history of psoriasis and a full skin examination was performed if relevant.
Results: Of the 100 patients, 15 reported a history of psoriasis and another 8 had evidence of current activity, suggesting a prevalence (past or present) of 15% in this group of patients. Conclusion: It would appear that the prevalence of psoriasis in patients who misuse alcohol is much higher than the 1–3% variously quoted in the general population.

Recent publications *(continued)*

Maze and minefield — a grounded theory of opiate self-detoxification in rural Ireland
McDonnell A and Van Hout MC
Drugs and Alcohol Today 2010; 10 (2) 24–31
www.drugsandalcohol.ie/13146

Opiate use is no longer confined to the greater urban context in Ireland, with scant detoxification services present in rural areas (Carew et al, 2009; National Advisory Committee on Drugs, 2008). This exploratory research aimed to yield an illustrative account of opiate users' experiences of self-detoxification by adopting a grounded theory approach (Glaser & Strauss, 1967). Data emerging from 21 in-depth interviews (n=12 heroin users, n=9 drug service providers: statutory, community and voluntary) were analysed using the constant comparative method. The study generated a substantive theory of self-detoxification as a subjective process of seeking heroin abstinence. Self-detoxification emerged as a frequent and reactive or proactive process in collaboration with others (heroin users, family and drug service providers). The study has implications for drug service delivery in rural Ireland in terms of increasing information provision and access to opiate detoxification through the development of low threshold services and community-based detoxification.

Primary medical care in Irish prisons
Barry JM, Darker CD, Thomas DE, Allwright SP and O'Dowd T
BMC Health Services Research 2010; 10:74
www.drugsandalcohol.ie/13086

Background: An industrial dispute between prison doctors and the Irish Prison Service (IPS) took place in 2004. Part of the resolution of that dispute was that an independent review of prison medical and support services be carried out by a University Department of Primary Care. The review took place in 2008 and we report here on the principal findings of that review.
Methods: This study utilised a mixed methods approach. An independent expert medical evaluator (one of the authors, DT) inspected the medical facilities, equipment and relevant custodial areas in eleven of the fourteen prisons within the IPS. Semi-structured interviews took place with personnel who had operational responsibility for delivery of prison medical care. Prison doctors completed a questionnaire to elicit issues such as allocation of clinician's time, nurse and administrative support and resources available.
Results: There was wide variation in the standard of medical facilities and infrastructure provided across the IPS. The range of medical equipment available was generally below that of the equivalent general practice scheme in the community. There is inequality within the system with regard to the ratio of doctor-contracted time relative to the size of the prison population. There is limited administrative support, with the majority of prisons not having a medical secretary. There are few psychiatric or counselling sessions available.
Conclusions: People in prison have a wide range of medical care needs and there is evidence to suggest that these needs are being met inconsistently in Irish prisons.

(Compiled by Louise Farragher)

Upcoming events

(Compiled by Joan Moore; email jmoore@hrb.ie)

June

30 June 2010

Sharps – Best practice in needle exchange and harm reduction
Venue: 28 Portland Place, London, W1B 1DE
Organised by / Contact: Royal Society for Public Health, Jennifer Tatman
Email: jtatman@rsph.org.uk; tel: 020 3177 1614
www.rsph.org.uk

Information: This conference will allow best practice and new initiatives in the provision of needle exchange services to be publicised, with the practitioners responsible available for questions and comments. Speakers will include experts in the area of needle exchange and drug misuse, with speakers from the Joseph Rowntree Foundation, the National Treatment Agency and the NHS. The conference will also look to the future. New challenges for needle exchange programmes will always appear, whether they are caused by new drugs, changes in injecting habits, or different clients.

July

8 July 2010

Alcohol 2010: public health, policy and personal responsibility
Venue: Central London
Organised by / Contact: Westminster Forum Projects
Email: info@westminsterforumprojects.co.uk
www.westminsterforumprojects.co.uk

Information: This seminar will take a current look at the effectiveness of alcohol strategies and media campaigns and consider what more could be done to reduce alcohol misuse and alcohol-related harm. The agenda will include discussion on proposals for minimum pricing and changes to current licensing laws. Keynote presentations will be made by expert speakers from a range of organisations, including Diageo GB, NICE, BMA, Alcohol Concern, Drinkaware, and the advertising industry.

Upcoming events *(continued)*

15 July 2010

Masterclass: Beyond mephedrone – the continued rise of new psychoactive 'internet' drugs
Venue: Vauxhall, London SW8
Organised by / Contact: Drink and Drugs News / CJ Wellings Ltd
Email: charlotte@cjwellings.com
www.drinkanddrugsnews.com/ListDiary.aspx

Information: As mephedrone joins the legion of illegal drugs, drug users who don't wish to break the law are moving further into unknown territory than ever before. A vast array of RCs (research chemicals) are being sold and bought over the internet – Move over m-cat, here comes naphyrone (NRG-1), 5-IAI, sub-coca dragon 3, Benzo- fury (6-APDB), AMT, MDAI and of course NRG-2. Come and join the people who predicted the mephedrone phenomenon and join us as we look into the future of drug use in the UK.

20–22 July 2010

Intoxicants and intoxication in historical and cultural perspective
Venue: Christ's College Cambridge
Convenors: Dr Phil Withington; Dr Angela McShane
Email: pjw1003@cam.ac.uk a.mcshane@vam.ac.uk
www.hist.cam.ac.uk/academic_staff/projects/

Information: This three-day conference is hosted by the network of the same name, funded by the Economic and Social Research Council (ESRC) and supported by the Victoria & Albert Museum and the University of Cambridge. The aim of the network and of the conference is to gain some perspective on the nature and scope of intoxicants and intoxication as enduring and ubiquitous social and cultural phenomena, by bringing together scholars whose interests and expertise range across disciplines, geographies and time periods.

September

23 September 2010

Social work and substance use: evidence-based practice?
Venue: Resource Centre, Holloway Road, Islington, London N7
Organised by / Contact: Tilda Goldberg Centre, Institute of Applied Social Research, University of Bedfordshire
Email: kerry.lapworth@beds.ac.uk
www.beds.ac.uk/research/iasr/

Information: This collaborative event includes expert speakers from the fields of social work and substance use. There will be plenary presentations and interactive workshops including the following topics: What does the evidence say?; Working with children, parents and family members; Domestic violence; Mental health, Older alcohol users; Hep C and HIV; Service user involvement; Adolescent substance use; Family drug and alcohol courts; Supervising social workers in drug and alcohol work; Working partnership with specialist services.

30 September – 2 October 2010

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

Information: Twenty ESSD conferences have been held to date, in 16 European countries. The 21st conference will be held this year in the Centre for Advanced Academic Studies at the University of Zagreb in Dubrovnik, Croatia. Themes to be covered include: new drugs; polydrug use; drug-using lifestyles and music; drug markets; methodological perspectives in drug research; and theories, concepts and analysis.

At the first ESSD conference in 1990, nearly all the participants took an active role and presented their own research. This active participation has remained a characteristic feature of ESSD conferences and means that participants can actively and effectively share their experiences with their colleagues across Europe. There are no parallel sessions nor workshops and all presentations last for 15 minutes. After each two presentations, there are 15 minutes for discussion. This conference format has clearly enhanced the quality of discussions and facilitated the exchange of ideas and experiences. Such an atmosphere is also less threatening for participants new to the field, especially young and new researchers.

October

4–7 October 2010

12th annual ISAM conference: Bridging the gap between science and practice in the addiction field
Venue: University of Milano-Bicocca, Italy
Organised by / Contact: International Society of Addiction Medicine (ISAM)
Email: isam2010@unimib.it
www.isam2010.medicina.unimib.it

Information: ISAM Milan 2010 aims to give physicians and allied health professionals who treat patients with substance use a comprehensive overview of all evidence-based findings currently available. The conference will focus on the latest scientific developments in addiction medicine and addiction psychiatry. The meeting is structured to encourage international interaction between clinicians from multiple disciplines, schools of thought, and settings. Conference events include plenary lectures, symposia, workshops, and poster sessions showcasing new research in the field.

7–8 October 2010

National conference on injecting drug use (NCIDU)
Venue: The Sage, Newcastle, UK
Organised by / Contact: Exchange Supplies
Email: info@exchangesupplies.org
www.exchangesupplies.org

Information: A packed and varied programme with over 30 parallel sessions, meetings, poster presentations and films to inform practice, disseminate research, explore policy and develop skills. What can you present? If you would like to present a paper or workshop session on a subject relevant to the conference themes, please see full abstract submission details, event information and online booking on our website, or call 01305 262244.

Upcoming events *(continued)*

November

3 November 2010

Facing the future: tackling drugs in the new decade
Venue: NCVO HQ, Regent's Wharf, London N1 9RL
Organised by / Contact: DrugScope
Email: cherylf@drugscope.org.uk
www.drugscope.org.uk

Information: We have entered a changed economic and political landscape. Cuts in public spending are under way, with the expectation that services will need to do more for less. The 'localism' agenda will likely see a shift in decision making from central government to local communities. The rise in the use of legal highs has led to calls for a review of legislation and for faster responses to new and emerging drugs. Speakers at DrugScope's annual conference will explore the effects of these changes. How will wider economic and political changes impact on drug policy? Will we see more attention paid to tackling alcohol misuse? Will drug and alcohol crime and health policies draw closer together? What are the risks and potential opportunities for the drug sector?

4–5 November 2010

National Drugs Conference: Continuum of care within drug services
Venue: Radisson Blu Royal Hotel, Dublin 8
Organised by / Contact: Irish Needle Exchange Forum (INEF) and others
Email: conference2010@inef.ie
http://inef.ie

Information: It was clear that the INEF conference in November 2009 benefited from the range of disciplines within the delegate group. Building on this experience, and under the guidance of the INEF Advisory Group (made up of members of the voluntary and statutory sectors), the INEF has come together with the Irish Association of Alcohol and Addiction Counsellors (IAAAC), Ana Liffey Drug Project and Coolmine Therapeutic Community to hold a National Drugs Conference. The conference will include national and international speakers from across the spectrum of service provision and policy development, i.e. this is not a harm-reduction conference or an abstinence-based conference; this is an all-inclusive drugs conference.

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