

Further update on psychoactive head shop products

with pull-out chart
See pages 15–18

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- How does evidence feed into Ireland's drug policy?
- Drug projects and local democracy
- The burden of alcohol-related morbidity
- Adulterants in illicit drugs
- Finglas Addiction Support Team reports
- Drug-related deaths among recently released prisoners
- HSE drug awareness campaign
- Study of drug use in the Canal Communities area
- 'What's the point?' Report of conference on suicide

National Drugs Conference 2010

The first Irish National Drugs Conference will be held on 4–5 November 2010 at the Radisson Blu Royal Hotel, Dublin 8. It is being organised by the Irish Needle Exchange Forum (INEF) in association with the Irish Association of Alcohol and Addiction Counsellors, Ana Liffey Drug Project and Coolmine Therapeutic Community. The theme of the conference is 'A continuum of care within drug services'.

The keynote speaker will be Dagmar Hedrich of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Academics, practitioners and policy makers working in the drugs field in Ireland and abroad will present papers and contribute to plenary sessions, workshops and other fora. Speakers will include Minister Pat Carey, Rowdy Yates (University of Stirling), Stephen Bamber (Liverpool Hope University), Dr David Best (University of Western Scotland), Dr Scott Kellogg (New York University), Mat Southwell (INPUD), Dr Brion Sweeney, Dr Joe Barry, Professor Pat O'Hare, and Austin Prior (Rutland Centre).

A number of Health Research Board (HRB) research staff will present papers at the conference. Delphine Bellerose will report on an analysis of data from both the National Drug Treatment Reporting System (NDTRS) and the Drug-Related Deaths Index (NDRDI) used to describe trends in treatment for problem benzodiazepine use and to develop a profile of benzodiazepine users. Anne Marie Carew will describe a study of treated problem substance use in the Traveller community, based on cases recorded on the NDTRS. Simone Walsh will describe the work of the NDRDI in providing a complete and accurate reporting of drug- and alcohol-related deaths and deaths among drug users and among those who are alcohol dependent. Dr Suzi Lyons will present an analysis of data from the NDRDI showing the incidence of drug-related death among individuals who have been released from prison.



HRB researchers Simone Walsh and Dr Suzi Lyons, who will speak at the conference

(Brian Galvin)



Dagmar Hedrich of the EMCDDA will give the keynote speech at the conference



HRB researcher, Anne Marie Carew

Martin Keane will report on a qualitative synthesis of research on methadone treatment programmes which seeks to identify obstacles to progression faced by clients on such programmes. Brigid Pike's paper will analyse the National Drugs Strategy 2001–2008 (NDS) as a policy instrument. It will explore how the NDS was designed and developed, and the strategic management processes and governance arrangements put in place to support implementation.

The National Drugs Conference 2010 is an excellent opportunity to bring together policy developers and practitioners from right across the drug treatment spectrum to share knowledge and develop networks. A limited number of delegate places remain. If you would like to attend the conference, consult the INEF website at www.inef.ie or email 2010@inef.ie

contents

- 1 National Drugs Conference 2010
- 2 NESF's final reports focus on policy implementation
- 3 How does evidence feed into Ireland's drug policy?
- 4 Drug projects and local democracy
- 5 An ethnographic study of drug use in the Canal Communities area
- 6 Drug awareness initiatives in Fingal county
- 7 Drugnet digest
- 9 The burden of alcohol-related morbidity on hospital services
- 12 Sponsorship of sports events by the alcohol industry
- 13 'What's the point?' A conference on understanding suicide and supporting life
- 13 Reconnecting with life: recovering from mental health problems
- 15 Further update on psychoactive substances sold in head shops and on line
- 18 Adulterants, bulking agents and contaminants in illicit drugs
- 21 HSE awareness campaign on legal and illegal highs
- 21 Lapse and relapse following inpatient treatment of opiate dependence
- 22 Reintegration of prisoners in Ireland
- 23 Drug Treatment Court to continue operating
- 24 Drug Tests in Irish prisons
- 25 Drug-related deaths among recently released prisoners
- 26 Finglas Addiction Support Team launches two reports
- 27 National Registry of Deliberate Self Harm annual report 2009
- 28 From *Drugnet Europe*
- 28 Pharmacy guidelines on safe supply of codeine-based products
- 29 In brief
- 30 Recent publications
- 31 Upcoming events

NESF's final reports focus on policy implementation

In March 2010, following a recommendation by the Special Group on Public Service Numbers and Expenditure Programmes (McCarthy report), the National Economic and Social Forum (NESF) was wound up. During its 16½ years the NESF, a government-appointed social partnership body, provided advice on economic and social policies, especially those intended to achieve greater equality and social inclusion in Irish society.

Many of the NESF's investigations influenced thinking with regard to policies to tackle the illicit drug problem, particularly in the areas of drug use prevention and rehabilitation. Relevant investigations included studies of early school leavers, lone parents, the long-term unemployed, prisoners, social housing, mental health, arts and cultural inclusion, and the policy implications of social capital. A number of these studies were reported on in *Drugnet Ireland*.

In recent years the NESF also began to explore issues around the implementation of policy and delivery of services, again with relevance to illicit drugs policy. With its diverse membership and experience of policy processes across institutional and departmental boundaries, the NESF was considered well positioned to identify innovations and reforms that would ensure that public services better met individual needs and were delivered more effectively.

In 2007 NESF Report No 34, *Improving the delivery of quality services*, put the citizen at the centre of public services reform, recommending a new 'public value' approach for delivering quality public services. This approach would ensure people's needs are better met and assist in the implementation of the 'lifecycle' approach to the future development of public services. The links between better public service delivery and equality, social inclusion and the rural/urban dimensions were strongly emphasised.

Published in late 2009 and early 2010, the NESF's last three reports – on implementing the Home Care Package scheme (Report No 38); child literacy and social inclusion policies (Report No 39); and a discussion report on community participation in the delivery of public services – addressed the issues associated with policy implementation. This body of work highlighted how good policies have had mixed success when implemented, because of the way policy actors think about risk and accountability, how they frame their own role and the role of others involved in the process, and how organisational cultures of defensiveness militate against learning.

The reports on implementing home care and child literacy policies proposed a 'policy implementation template' comprising the following items:

1. Strategy plans with agreed outcomes
2. Delivery plans and delivery on the ground (including standards, competition, co-ordination of organisations and procedures and tailored universalism)
3. Monitoring, evaluation and measurement of inputs, outputs and outcomes
4. Links between outcomes and budget
5. Good accountability and incentive structure
6. Equity in provision
7. Cultural elements (including values, beliefs and tacit assumptions, leadership, attitudes and quality of collaborative relationships)

The discussion report on local participatory governance provides a framework within which to understand the range of community participation/governance arrangements currently in operation. A separate article on page 4 discusses this report in the context of the ongoing national debate on how to strengthen local democracy.

The activities of the NESF have been absorbed by the National Economic and Social Council (NESC), a constituent body of the statutorily-based National Economic and Social Development Office (NESDO). To date, the function of the NESC has been to analyse and report to the Taoiseach on strategic issues relating to the efficient development of the economy and the achievement of social justice and the development of a strategic framework for the conduct of relations and negotiation of agreements between the government and the social partners. The NESC is chaired by the secretary general of the Department of the Taoiseach and includes representatives of trade unions, employers, farmers' organisations, NGOs, key government departments and independent experts.

The NESF was the largest of the social partnership bodies. It comprised 60 social partners, representing employer, trade union and farming organisations, the community and voluntary sectors, members of the Dáil and Seanad, representatives of central and local government, and independent experts. In the final newsletter of the NESF (February 2010), NESF Chairperson, Dr Maureen Gaffney, asserted that a unique feature of the NESF was its 'strongly independent, consultative and participative ethos. It was open in a routine way to other actors in the system and to those working directly with people experiencing poverty and social exclusion. This way of working facilitated the early identification of emerging trends in social exclusion, and of the glitches and failures in policies designed to address them.'

(Brigid Pike)

For further information on the NESF and the NESC, and access to the reports, visit www.nesdo.ie

How does evidence feed into Ireland's drug policy?

The last issue of *Drugnet Ireland* reported on a recent study that sought to identify what constitutes the 'evidence' relating to the drugs problem and how one decides what is the 'best' evidence?¹ Another recent publication explores the process rather than the content – how does evidence feed into policy?² It draws together the lessons from six European countries, including Ireland. The authors of the article on the Irish experience identify four mechanisms that serve to 'feed' evidence into Ireland's social policy development process in the health care sector:³

1. social partnership,
2. research producers for government, e.g. National Economic and Social Council (NESCC), National Economic and Social Forum (NESF) and Combat Poverty Agency (CPA),
3. academic research, and
4. professional associations.

This list provides a useful starting point for considering the range and nature of 'knowledge exchange' mechanisms in the drug policy domain.

Ireland's two national drugs strategies were developed using the social partnership approach, depending on public consultation meetings held throughout the country, written submissions, meetings with departments, statutory agencies, sectoral groups, organisations and focus groups, and engaging with the Oireachtas. Kennedy and colleagues³ comment that, in the current economic climate, the social partnership model is under strain and whether or how it will continue to serve as a defining characteristic of policy development in Ireland is uncertain.

'Research producers for government' have been another casualty of the current recession, with the work of the NESF and the Combat Poverty Agency being absorbed into the work of other entities. Notwithstanding the contribution that research published by both these bodies made to increasing understanding of the issues associated with problem drug use, an independent study of the overall impact of state agencies such as these concluded that their performance appeared 'less than optimal, in terms of both their perceived effectiveness and the level of duplication and overlapping responsibilities' (p. 130).⁴

With regard to academic research, Ireland has only one drug-related research centre – the Irish Focal Point (IFP) of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), located in the Health Research Board (HRB). Funded by the EMCDDA, the IFP compiles an annual report on the drug situation in Ireland and responses to it, and participates in EMCDDA-led data-gathering, analysis and dissemination projects in conjunction with focal points in other member states. The IFP draws on the drug-related epidemiological databases located in the HRB – the National Drug Treatment Reporting System (NDTRS) and the National Drug-Related Deaths Index (NDRDI) – for much of its work. While there is a paucity of dedicated drug-related research infrastructure, individuals in tertiary institutions across the island of Ireland, in academic disciplines ranging from medicine to pharmacology to criminology and sociology, undertake drug-related research. The database of current research and evaluation projects on the website of the National Documentation Centre on Drug Use indicates that a significant proportion of drug-related research projects are

funded either through state funding bodies such as the HRB, or commissioned by state agencies such as the Health Service Executive or the National Office on Suicide Prevention.⁵

Finally, practitioners in specific callings relating to drugs and addiction have come together to form professional associations in Ireland, for example the Drug Education Workers Forum and the Irish Association of Addiction and Alcohol Counsellors (IAAAC). However, there is no umbrella organisation that brings together professionals and non-professionals, academics, policy makers, public officials, and members of organisations under the social partnership pillars, to debate, discuss and contribute to developing thinking on drug policy in Ireland. A national conference on drugs, organised by a group of voluntary sector bodies, will be held in Dublin on 4–5 November 2010 (see article on p. 1). Such an event could be an opportunity to form an independent forum.

One formal knowledge-exchange mechanism not described by Kennedy and colleagues but used in Ireland's drugs policy domain is the National Advisory Committee on Drugs (NACD). Appointed by the Minister with responsibility for the National Drugs Strategy, the NACD includes representatives from academic disciplines, professional practitioners, civil and public servants, and representatives of the voluntary and community sectors. It advises the government on problem drug use in Ireland in terms of prevalence, prevention, consequences and treatment, based on its analysis and interpretation of research findings; where it finds gaps in knowledge, it may commission research. While stipulating that the independence of the NACD's research work would be 'fully maintained', the National Drugs Strategy 2009–2016 brought the NACD within the ambit of the new Office of the Minister for Drugs. The intention was 'to better address the issue of linkages between policy development and research' (para. 6.74).⁶

(Brigid Pike)

1. See report on T Babor, J Caulkins J, G Edwards, B Fischer, D Foxcroft, K Humphreys et al. (2010) *Drug policy and the public good* (Oxford: Oxford University Press) in *Drugnet Ireland*, (34): 11–12.
2. Nutley S, Morton S, Jung T and Boaz A (2010) Evidence and policy in six European countries: diverse approaches and challenges. *Evidence & Policy*, 6(2): 131–144. The issue includes articles on evidence-based policy and practice in Iceland, Ireland, the Netherlands, Norway, Scotland and Sweden.
3. Kennedy P, de Brun T, O'Reilly-de Brun M and MacFarlane A (2010) An exploration of evidence-based policy in Ireland: health and social inclusion. *Evidence & Policy*, 6(2): 255–268.
4. Quinn O (2008) *Advisers or advocates? The impact of state agencies on social policy*. Dublin: Institute of Public Administration.
5. www.drugsandalcohol.ie accessed on 30 June 2010
6. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009 – 2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. Available at www.drugsandalcohol.ie/12388

Drug projects and local democracy

The decision-making relationships between national, local and community-level bodies, i.e. the governance framework, have attracted considerable attention in recent years. Following its establishment in 2002 the Department of Community, Rural and Gaeltacht Affairs undertook a 'cohesion process', whereby it significantly reduced the number of community-based bodies involved in providing local and community development and social inclusion programmes while seeking to maintain service provision across the country. Most recently, in January 2010, the Department merged its own two social inclusion programmes into one integrated programme – the Local and Community Development Programme (LCDP). In the drugs area, in the course of 2009, the work of the National Drugs Strategy Team, comprising representatives of relevant departments, state agencies and the voluntary and community sectors which supported the work of the local and regional drugs task forces, was absorbed into the Office of the Minister for Drugs, which is located in the Department of Community, Equality and Gaeltacht Affairs.¹

The assumptions underpinning these cohesion and rationalisation processes have recently been challenged in the National Economic and Social Forum's final report.² Exploring local participatory governance in Ireland, the authors argue that a certain level of seeming duplication is necessary to ensure that the complex array of needs and circumstances can be accommodated, and that 'different opportunities for participation and, most importantly, for the realisation of social inclusion' are provided. Mapping the landscape of participatory processes, they have divided it into four 'zones':

1. in-house participatory government, e.g. strategic policy committees;
2. moving towards governance 'out there', e.g. county/city development boards, RAPID;
3. participating governance 'out there', e.g. area-based/ community partnerships, local and regional drugs task forces; and
4. civil society organisations, e.g. community platforms.

Rather than streamlining structures, collapsing the range of governance frameworks into a one-size-fits-all, the authors argue that greater attention should be given to supporting participation and to strengthening performance within each of the zones. In Zone 3, where the authors locate the drugs task forces, they suggest that participation could be enhanced by strengthening co-operation between the entities and elected local representatives, by promoting an approach to problem-solving based on reference to organisational values, such as social inclusion and finding a voice, rather than stressing rules and procedures, and by ensuring that the local development culture is not weakened.

The authors of the NESF report expressed the hope that their analysis might feed into deliberations leading to the development of the government's White Paper on stronger local democracy. In the Green Paper published as a preliminary step towards this White Paper,³ the government has suggested that community participatory structures could be strengthened by giving local authorities the leadership role on the county/city development boards. Unlike single-focus agencies, local authorities are regarded as having

the flexibility to be creative about new services they might provide.

In a separate study, looking at how to promote innovation generally, Ireland's National Economic and Social Development Office (NESDO) organised a project, FuturesIreland, to investigate how to develop a capacity for foresight and innovation both in the Irish economy and society and in the nation's decision-making processes – in short, how to turn Ireland into a 'learning society'.⁴ The project reached four conclusions:

1. Cross-fertilisation between the economy, society and public governance enhances the ability to learn and innovate.
2. Innovation and learning are systematic, almost always combining initiative, disciplined review and a willingness to confront challenges – institutional, inter-personal and personal.
3. Systematic review provides the basis for both innovation and accountability.
4. Organisational systems, particularly systems of control and accountability in the public sector, need to be completely changed in order to promote innovation and learning.

SAOL – Service Provision for Women with Addiction Problems – based in inner-city Dublin was one of several case studies undertaken by FuturesIreland that led to the fourth conclusion. The authors described how the rapid change from heroin to crack cocaine use rendered many of SAOL's services ineffective, causing the project to refocus its services very quickly. This was done following extensive consultations with colleagues in the Netherlands who were engaged in drug treatment services and had already dealt with this problem. SAOL piloted, tested and reviewed the new approach with women in their rehabilitation project. Notwithstanding this thorough review process, SAOL found it difficult to have the shift in focus accepted by their statutory funding body. FuturesIreland suggested that, 'To a large degree, the difference between the staff delivering the service and the people in the funding body centred on the willingness, ability and familiarity with data and methods of review' (p. 41).

(Brigid Pike)

1. Department of Community, Rural and Gaeltacht Affairs (2009) *National drugs strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
2. McNerney C and Adshead M (2010) *The challenge of community participation in the delivery of public services: exploring local participatory governance in Ireland*. Dublin: National Economic and Social Forum.
3. Department of the Environment, Heritage and Local Government (2008) *Stronger local democracy – options for change. Green Paper on Local Government*. Dublin: Department of the Environment, Heritage and Local Government.
4. FuturesIreland (2009) *Ireland at another turning point: reviving development, reforming institutions and liberating capabilities*. Dublin: National Economic and Social Development Office. Available at www.nesdo.ie/futuresireland/futuresireland_finalreport0909.pdf

An ethnographic study of drug use in the Canal Communities area

In 1997, in response to the heroin problem, the Government set up 14 local task forces in the areas most affected. Task forces are partnerships between all interested stakeholders looking to bring a multi-agency response to the issue. The Canal Communities Local Drugs Task Force (CCLDTF) covers Rialto, Bluebell and Inchicore communities in the Dublin 8 area.

The CCLDTF undertook a study to improve knowledge and understanding of the nature of illicit drug use in their area.¹ The researchers used an ethnographic method, which the authors state 'can be defined as a perspective as well as a means of data collection' (p. 12). Ethnographic studies aim to describe and explain how specific groups of people experience their lives and environment.²

Data for the CCLDTF study were collected by means of participant observation (in service facilities, estates, homes) and through interviews. Fifty-one interviews were conducted, of which 24 were life histories and eight were group discussions (with 29 young people). Six of those who were initially interviewed had a subsequent interview. Additionally, there were 24 formal and informal interviews with service providers. The authors note that many other people interacted with the research at all the different sites. Interviewers also administered a survey to a target population of 100 opiate or methadone users; some of the results of that survey appear in the text and the appendix (and will be discussed in more detail in a future CCLDTF publication).

The report of the study begins with a discussion on the nature of drug use and the difficulties in relation to the categorisations used within the field. In relation to patterns of use, the authors use the term 'styles' as this can help convey how '...at any one moment, populations that overlap certain institutional categories (disorganized heroin-users, for example, can be found both in and out of treatment, often using both methadone and heroin simultaneously), while presenting different challenges to various intervention strategies' (p. 19). This is followed by a chapter which discusses experiences of the combined use of heroin and methadone in the CCLDTF area.

Subsequent chapters deal with the history and the issues around drug use in the area, the emergence of crack cocaine and the changing patterns of drug use. Data from the Central Treatment List (CTL) pertaining to people living in the CCLDTF area were analysed. One finding from this analysis was that the area had a relatively high rate of registration on the CTL in 2007, at 20 per 1,000 of the population, compared to 2 per 1,000 of the population nationally.

The quantitative data collected from 98 valid responses to the survey are summarised in an appendix to the report. The main results include:

- 63% were male;
- 98% were prescribed methadone;
- Average number of days on methadone was 86;
- 63% reported current use³ of heroin;
- 46% reported current use of street benzodiazepine;
- 30% reported current use of crack;
- 22% reported current use of powder cocaine;
- 17% reported current use of street methadone;
- 60% of those who injected reported sharing a needle or syringe;
- 36% reported spending between €60 and €119 on drugs in the average week;
- 88% reported ever having been involved in crime;
- 57% reported having had a custodial sentence.

While the authors concede that the methodology used made it difficult to summarise the report, they identify findings that they felt were important (illustrated for the purposes of this article with extracts from the field notes and interview transcripts).

- Most of those interviewed were polydrug users, often using combinations of illegal and legal drugs (whether obtained legally or not). *Louise is on methadone and prescribed sleeping tablets and an antidepressant. She smokes a couple of bags of heroin every few days. Recently, she has been smoking crack every day. This is her main problem drug at the moment. Her weight loss is noticeable.* (Field notes, p. 18)
- Many of those in treatment for problem opiate use had a range of unmet needs.
- Many of those who took part in the study and who were in treatment for opiates also used cocaine, with the use of crack cocaine emerging as a problem. *I got a pipe off someone and I says, ah that's not doing me any harm, [be]cause it was really the needles [to inject cocaine] that was doing the harm, the blood poisoning, septicaemia, so I says ah I'll have a pipe [of crack] and then I went to have another one, ...going half with someone, and when I was going well, I would get one for meself. 'Just one', I'd say, 'and I'll go down and have a nice smoke at the end of the night,' to meself. ...and I was smokin' every morning and all.* ('Sandra', p. 42)



An ethnographic study of drug use in the Canal Communities area *(continued)*

- Individuals who dealt drugs often continued to do so after entering treatment.
 - Heroin use was viewed unfavourably by younger drug users. *You know what I mean, when you hear about new drugs coming out and all these mad trips and you'd say oh I have to try this, it's an experience, but we never turn round and say, 'I have to try heroin and see what that's like', d'ya know what I mean? ('Kim', p. 53)*
 - While terms and categories used in government policy such as 'drug user' and 'treatment' appear to be clearly defined, particularly as used in relation to funding, their application at local level is less clear, causing a 'divide [that] needs to be bridged'.
1. Saris A J and O'Reilly F (2010) *A dizzying array of substances: an ethnographic study of drug use in the Canal Communities area*. Dublin: CCLDTF. Available at www.drugsandalcohol.ie/13503
 2. Robson C (2002) *Real world research*. 2nd edition. Padstow: Blackwell Publishing.
 3. Current use is defined as use in the past three months.

(Suzi Lyons)

Drug awareness initiatives in Fingal county



Prizewinners at the 'Let's Talk About Drugs' 2010 media awards ceremony, pictured with the mayor of Fingal, Councillor Ken Farrell, and GBRD personnel

A combined launch and award ceremony in Wynne's Hotel on 30 June illustrated the strong commitment and support for educational initiatives to tackle drug-related issues in the Blanchardstown and Fingal communities.

The event featured the two initiatives described below.

'Let's Talk About Drugs' media awards

Greater Blanchardstown Response to Drugs (GBRD) presented the 'Let's Talk About Drugs' 2010 media awards, with Councillor Ken Farrell, mayor of Fingal, attending. Now in their fourth year, these awards are organised by the GBRD in partnership with the Dublin People newspaper group, Blanchardstown Local Drugs Task Force, and County Dublin Vocational Education Committee (CDVEC).

Phillip Keegan, co-ordinator of GBRD, briefly described the media awards initiative: young students and adults with an interest in journalism are invited to research and write articles about one of two drug-related topics that are chosen each year. The aim is to trigger discussion, and therefore raise awareness, about drug-related issues in the community. The initiative also rewards sensitive and well-informed

reporting on drugs and encourages budding journalists. Sean Mullan, chairperson of GBRD, pointed out that there is no better way to raise awareness than by using the media.

The two topics for 2010 were 'Head shops – legal but potentially fatal?' and 'Tackling drugs – the real cost of budget cuts'. The head shop topic was the most popular; all articles were written prior to the new legislation on legal highs. Phillip Keegan, along with many of the winners and other speakers on the day, reiterated that, despite the recent developments in the head shop debate, it is extremely important to remain vigilant to prevent head shops from going underground and to prevent new potentially dangerous substances from being made available in the community.

Jim McVeigh, youth development officer with CDVEC, presented some of the awards and emphasised the important educational aspect of the programme, by which students get hands-on experience in researching a topic and writing an article, and also learn and inform others about the important issue of drugs.

Jack Gleeson, news editor for Northside People West, stressed the overall good quality of all articles entered in the competition and congratulated the winners on their well-researched and well-written pieces of work. He mentioned that the media's responsibility with regard to drugs and addiction is to change perceptions and challenge preconceived ideas.

Winners and runners-up in the youth categories got prizes of laptops and digital cameras. The winning articles are being published in the Northside People and Southside People newspapers throughout the summer, and are available on the GBRD website at www.gbrd.ie. The winners described the programme as an excellent experience, a great incentive to pursue their interest in writing and journalism, and a real eye-opener on drug issues.

The 2010 award winners were:

12–14-years: Rebecca Murphy, Rockford Manor Secondary School

15–17-years: Lisa Murphy, Cabinteely Community School; Uzair Saif Qureshi, Institute of Education

Drug awareness initiatives in Fingal county *(continued)*

18–20-years: Sehreen Qureshi, Trinity College Dublin; Ian McFarlane, St Kevin's College, Finglas

21 years and over: Emer Halpenny, Independent College; Majella Twomey, Independent College

Special Merit Award: Stuart Lerner, Catholic University School

Endeavour Award: Eoin Harty, Catholic University School

'Stay onside – say no to drugs' initiative

The GBRD awards event was held in conjunction with the official launch of a new drug awareness campaign by Sporting Fingal Community Trust, the charitable arm of Sporting Fingal Football Club (www.sportingfingal.ie).

One of a series of projects being delivered jointly by the Club and the Community Trust, the 'Stay onside – say no to drugs' initiative is a drugs education 'trading card' scheme.

It includes sets of collectable cards featuring player profiles with anti-drugs messages from members of the Sporting Fingal squad. The cards were produced by the Trust in conjunction with CDVEC. Sets of cards are being distributed to young people through schools and summer camps and at matches. The idea behind the scheme is that young people are more likely to be influenced by their local sporting heroes' endorsement of healthy lifestyles.

Councillor Ken Farrell, mayor of Fingal, and Brian Gannon, Sporting Fingal defender representing the squad, both emphasised the importance of sport as a powerful way to reach out to young people, to help people affected by drugs and, more generally, as 'an excellent tool for building communities'.

(Delphine Bellerose)

Drugnet digest

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

Clinical audit of the ICGP Methadone Treatment Protocol

The findings of the general clinical audit of the operation of the ICGP Methadone Treatment Protocol (MTP) between July and December 2009 are summarised in the most recent Methadone Treatment Protocol Newsletter.¹ The audit found the most common issues that required a review were: vaccination and virology, record keeping and supervision of dispensing. The newsletter gives examples of discrepancies found between the standard expected and the actual practice among a small proportion of the GPs who participate in the MTP scheme, and suggests ways to improve practice in these areas.

- On transfer between Level 1 and Level 2 doctors, not all clients had their virology screening or vaccination completed, as required by the protocol. In some cases, screening or vaccination history was not documented.
- Some cases transfer summaries were difficult to find or were missing, and not every consultation record was complete.
- In some cases where at least one supervised dose per week in the pharmacy was the expected standard, no request for such supervision was found in the file. In some cases, 'supervised dispensing did not appear to be responsive to clinical conditions', for example in failing to provide for increased supervision if a client appeared to be destabilising.

Irish Prison Service annual report 2009

The Irish Prison Service (IPS) annual report for 2009² states that drug treatment continues to be one of the biggest issues facing the Irish prison health services. Those who present with a history of problem opiate use are offered detoxification if it is clinically indicated, or methadone maintenance treatment. Those who are already on methadone when committed can continue to receive this treatment for the duration of their sentence.

The number of prisoners on methadone treatment increased by 20% between 2008 and 2009. There was a 10% increase in the number of people new to treatment. Over 20% of those

on the Central Treatment List (CTL) of methadone clients in 2009 were treated within the IPS, and 31% of all new entrants on the CTL for 2009 were treated within the IPS. Since 2008, pharmacists have provided the methadone treatment in Mountjoy and in the Dóchas Centre. The report states that in 2009 the service continued to face challenges in securing places in methadone clinics in the community for prisoners who were due to be released.

Detoxification treatment was provided to 1,130 prisoners in 2009, and the addiction counselling services recorded approximately 1,500 prisoner contacts per month. The report notes the benefit of the multidisciplinary approach to the care of drug-using prisoners in Mountjoy prison, which aims for a personalised therapeutic relationship.

The IPS offers a range of care and rehabilitation services to inmates, including those with drug and alcohol problems. These services include education, vocational training, and psychological and spiritual services, which aim to improve re-integration into the community. The IPS works through partnership with voluntary and statutory services to enable prisoners at risk of homelessness to access appropriate accommodation on release.

In a section on prison in-reach services (p. 40), the report states:

A consultant-led Infectious Disease Service has been contracted from St. James Hospital to provide treatment to prisoners who suffer from infectious diseases, including Hep C and HIV. The development of this service has demonstrably decreased the number of prisoners transferred to St. James Hospital Guide Clinics for screening and treatment. It has also been effective in increasing compliance with complicated drug regimes and improving patient outcomes. The IPS in collaboration with St. James's Hospital are finalising arrangements to introduce a Hepatitis C Virus treatment service to selected Dublin prisons.

According to the report, 760 people were serving sentences for drug offences on 4 December 2009, an increase of 34% on the 2008 figure of 567. The IPS continued to roll-out various security measures introduced in 2008, and has continued to test technology for the inhibition of mobile phone signals within prisons.

Poisons Information Centre of Ireland annual report 2009

The Poisons Information Centre, located in Beaumont Hospital, provides a service to doctors and healthcare professionals throughout Ireland in the diagnosis and management of poisonings.

The Centre’s annual report³ outlines the number and type of enquiries handled in 2009:

- The Centre received 9,838 calls in the year: 9,647 (98.1%) concerned cases of poisoning in humans, 89 (0.9%) concerned poisoning in animals, and 102 (1%) were non-emergency requests for information.
- Of the 9,838 enquiries, 5,044 (52.3%) were in relation to children under 10 years of age, the majority relating to the 1–4-year age group.
- Of the human poisoning incidents, 90.8% occurred in a domestic setting; 59.4% were reported as accidental; 23.2% were suspected to be intentional, or the result of recreational abuse; 11.1% were therapeutic errors; and 6.3% were of unknown intent.
- As in other years, the largest number of enquiries made to the Centre concerned paracetamol, followed by ibuprofen, codeine and diazepam.
- The most common household products involved in poisoning were laundry products, and the majority of these cases were in children under 10 years of age.

In 2009 the Centre saw an increase in the incidence of poisoning with alcohol-based hand-gel products. In the past, this type of poisoning was seen mainly in hospitals, but an increasing number of enquiries in 2009 related to children in the home. The report suggests the increase in children’s exposure to hand gels is due to their increased availability in the home and improper storage.

Europe 2020: a strategy for smart, sustainable and inclusive growth

On 17 June 2010 the European Council adopted *Europe 2020: A strategy for smart, sustainable and inclusive growth* (EUCO 13/10),⁴ the EU’s strategic framework for sustainable and job-creating growth over the next 10 years.

By setting targets in relation to employment, research and development, greenhouse gas emissions and education, the strategy aims to promote social inclusion and remove at least 20 million people from the risk of poverty and exclusion by 2020. The European Commission has designed seven ‘flagship initiatives’ to ‘catalyse progress’ towards the five strategic targets, including a ‘European platform against poverty’ which has particular relevance to the social inclusion target. The aim of this initiative is to ensure economic, social and territorial cohesion by raising awareness and recognising the fundamental rights of people experiencing poverty and social exclusion, thereby enabling them to live in dignity and take an active part in society.

At EU level, the Commission will work to:

- transform the open method of co-ordination on social exclusion and social protection into a platform for co-operation, peer review and exchange of good practice, and into an instrument to foster commitment by public and private players to reduce social exclusion, and take concrete action, including through targeted support from the structural funds, notably the European Social Fund (ESF);
- design and implement programmes to promote social innovation for the most vulnerable, in particular by providing innovative education, training, and employment opportunities for deprived communities, to fight discrimination, and to develop a new agenda for migrants’ integration to enable them to develop their potential;
- undertake an assessment of the adequacy and sustainability of social protection and pension systems, and identify ways to ensure better access to health care systems.

At national level, member states will need to:

- promote shared collective and individual responsibility in combating poverty and social exclusion;
- define and implement measures addressing the specific circumstances of groups at particular risk (such as one-parent families, elderly women, minorities, Roma, people with a disability and the homeless);
- fully deploy their social security and pension systems to ensure adequate income support and access to health care.

(Contributors: Suzi Lyons, Jean Long, Simone Walsh and Brigid Pike)

1. Irish College of General Practitioners (2010) General clinical audit findings for Methadone Treatment Protocol. *Methadone Treatment Protocol Newsletter*, (2): 2. Available at www.icgp.ie/go/courses/substance_misuse
2. Irish Prison Service (2010) *Irish Prison Service annual report*. Longford. Irish Prison Service. Available at www.drugsandalcohol.ie/13615
3. Poisons Information Centre of Ireland (2010) *Annual report 2009*. Dublin: Poisons Information Centre. Available at www.poisons.ie/downloads/Annual_Report_2009.pdf
4. European Council ‘Conclusions on a New Strategy for Jobs and Growth’. 17 June 2010. EUCO 13/10; European Commission ‘Europe 2020: A strategy for smart, sustainable and inclusive growth’. 3 March 2010. COM (2010) 2020.

Correction: The article on p. 9 of Drugnet Ireland Issue 34 should have been titled ‘Guidebook on case management in homeless services’. The authors of the guidebook are the Homeless Agency Partnership and Progression Routes Initiative.

The burden of alcohol-related morbidity on hospital services

The Economic and Social Research Institute (ESRI) manages the Hospital In-Patient Enquiry (HIPE) scheme. This is a computerised health information system designed to collect clinical and administrative data on discharges from over 60 acute hospitals in Ireland.

This article reports on an analysis of HIPE data on discharges, including deaths in hospital, of cases with an alcohol-related diagnosis in the years 2005–2008, in order to assess the burden of alcohol-related morbidity on Irish hospitals. It is important to note that, because the HIPE scheme does not record attendances at emergency departments, using HIPE data to assess the impact of alcohol use on acute hospital services can lead to an under-estimation of the true extent of the burden.

Number of alcohol-related discharges

Between 2005 and 2008 the number of alcohol-related discharges increased by 22% (Table 1). Changes in the classification of alcohol-related diagnoses introduced in the tenth version of the International Classification of Diseases – ICD-10, may explain the low number of discharges in 2005. Males accounted for 74% and females for 26% of all discharges. In 2008 the average length of stay was nine days and alcohol-related discharges accounted for 3.6% (161,016) of all bed days. According to the Health Service Executive (HSE), the average cost per bed day in 2008 was €889.¹ We can therefore deduce that alcohol-related discharges cost €143,143,224 in 2008.

Table 1 Number and length of stay of alcohol-related discharges, 2005–2008 (N=68,565)

	2005	2006	2007	2008
Number of discharges	15,088	17,053	18,024	18,400
Male	10,971	12,629	13,344	13,579
Female	4117	4424	4680	4821
Average length of stay (days)	7.86	8.11	8.04	8.75
% of all bed days	2.9	3.2	3.3	3.6

Discharges by age

The mean age of discharges was 48 years, and the median was 49 years. There was little difference in the age profile of males and females, although male discharges tended to be older, with 51% aged 50 years or over, compared to 43% of women (Figure 1). One explanation for this may be that health complications arising from alcohol tend to manifest themselves earlier in the drinking careers of women than in men. Alternatively, these trends may be attributable to the fact that middle-aged and older women in Ireland drink less than men and are also more likely to abstain from alcohol altogether.² Those aged under 18 accounted for 3% (2,083) of all discharges. Males accounted for 55% and females for 45% of discharges aged under 18.

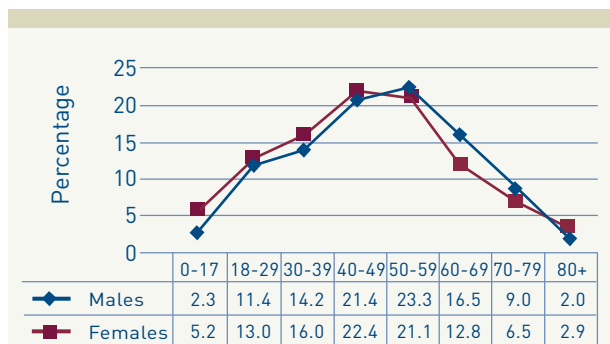


Figure 1 Percentage of alcohol-related hospital discharges by gender and age, 2005–2008

Discharges by diagnosis

Alcohol-related discharges were categorised according to diagnosis into one of the following groups: acute conditions, chronic diseases and other chronic conditions (Table 2 overleaf). Twenty-seven discharges with a diagnosis relating to fetal alcohol syndrome are not presented in this analysis.

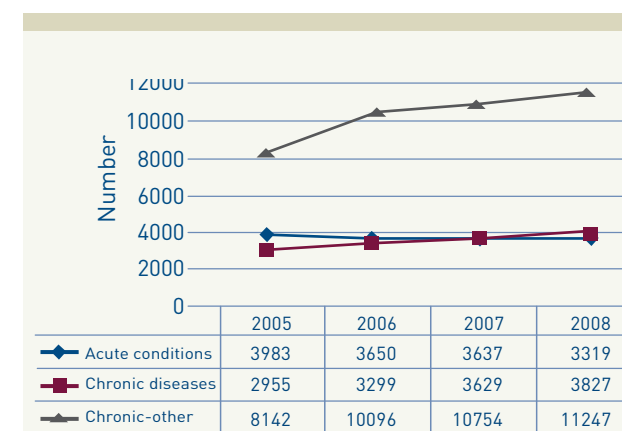


Figure 2 Number of alcohol-related discharges by year and diagnosis, 2005–2008 (N=68,538)

For the purposes of this analysis, cases with both an acute and a chronic diagnosis were recorded in the chronic category, and cases with both a chronic disease and a chronic condition were recorded in the chronic disease category. Acute conditions accounted for 18%, chronic diseases for 21% and other chronic conditions for 61% of alcohol-related discharges in 2008 (Figure 2).

The burden of alcohol-related morbidity on hospital services *(continued)*

Table 2 Classification of alcohol-related discharges by diagnosis

Acute conditions		Chronic diseases		Other chronic conditions	
ICD code	Description	ICD code	Description	ICD code	Description
F10.0	Acute intoxication	E24.4	Alcohol-induced pseudo-Cushing's syndrome	F10.1	Harmful use
T51.0	Ethanol	G31.2	Degeneration of nervous system due to alcohol	F10.2	Dependence syndrome
T51.1	Methanol	G62.1	Alcoholic polyneuropathy	F10.3	Withdrawal state
T51.2	2-Propanol	G72.1	Alcoholic myopathy	F10.4	Withdrawal state with delirium
T51.3	Fusel oil	I42.6	Alcoholic cardiomyopathy	F10.5	Psychotic disorder
T51.8	Other alcohols	K29.2	Alcoholic gastritis	F10.6	Amnesic syndrome
T51.9	Alcohol unspecified	K70.0	Alcoholic fatty liver	F10.7	Residual and late onset psychotic disorder
X45	Accidental alcohol poisoning	K70.1	Alcoholic hepatitis	F10.8	Other mental and behavioural disorders
X65	Intentional alcohol poisoning	K70.2	Alcoholic fibrosis and sclerosis of liver	F10.9	Unspecified mental and behavioural disorder
Y15	Alcohol poisoning – undetermined intent	K70.3	Alcoholic cirrhosis of liver	Z50.2*	Alcohol rehabilitation
R78.0	Finding of alcohol in blood	K70.4	Alcoholic hepatic failure	Z71.4*	Alcohol abuse counselling and surveillance
Y90.0 – Y90.9	Evidence of alcohol involvement determined by blood alcohol level	K70.9	Alcoholic liver disease, unspecified	Z72.1*	Problems related to lifestyle – alcohol
Y91.0 – Y91.9	Evidence of alcohol involvement determined by level of intoxication	K86.0	Alcohol-induced chronic pancreatitis	Z86.41*	Personal history of alcohol use disorder

*These conditions indicate the presence of an underlying alcohol disorder

Alcoholic liver disease accounted for three-quarters of all alcohol-related chronic diseases (Table 3). Alcoholic gastritis and alcohol-induced chronic pancreatitis each accounted for 9% of chronic diseases. Between 2005 and 2008, 71 discharges had a liver transplant during their hospital stay.

Table 3 Alcohol-related discharges by disease type, 2005–2008 (N=13,710)

	Number	%
Alcoholic liver disease	10349	75.5
Alcoholic gastritis	1295	9.4
Alcohol-induced chronic pancreatitis	1198	8.7
Alcoholic cardiomyopathy	483	3.5
Degeneration of nervous system due to alcohol	272	2.0
Alcoholic myopathy	58	0.4
Alcoholic polyneuropathy	55	0.4

Acute conditions were more prevalent among younger people, while chronic diseases and other chronic conditions were more common among older age groups (Figure 3). The numbers admitted with chronic diseases or other chronic conditions increased steadily with age and peaked in the 50–59-year age group; the numbers of discharges for both types of condition decreased steadily among those aged 60 years or over. Acute conditions accounted for 59% of discharges aged under 30. However, it is somewhat worrying that in the four years 2005–2008 there were 4,129 discharges aged under 30 with chronic conditions or diseases, given that these conditions usually develop after a number of years of harmful drinking and are normally seen in much older people.

The burden of alcohol-related morbidity on hospital services (continued)

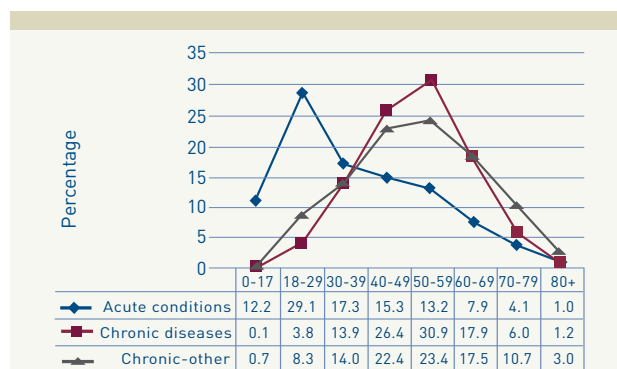


Figure 3 Percentage of alcohol-related discharges by age and diagnosis, 2005–2008

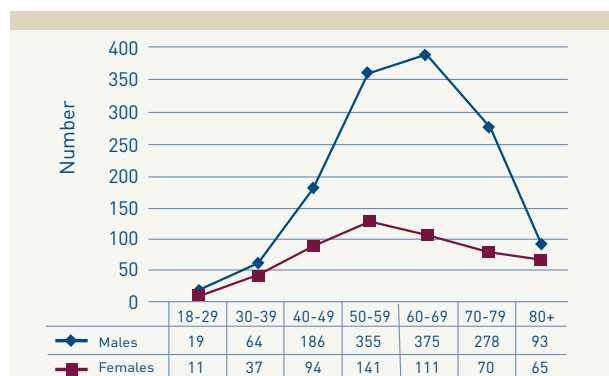


Figure 5 Number of hospital deaths with an alcohol-related diagnosis by age and gender, 2005–2008 (N=1,899)

Deaths in hospital of cases with an alcohol-related diagnosis

In the period 2005–2008, 1,899 (2.8%) cases died while still in hospital; 1,001 (53%) had an alcohol-related disease, 813 (43%) had a chronic condition and 85 (4%) had an acute condition. Males accounted for 72% of deaths (Figure 4).

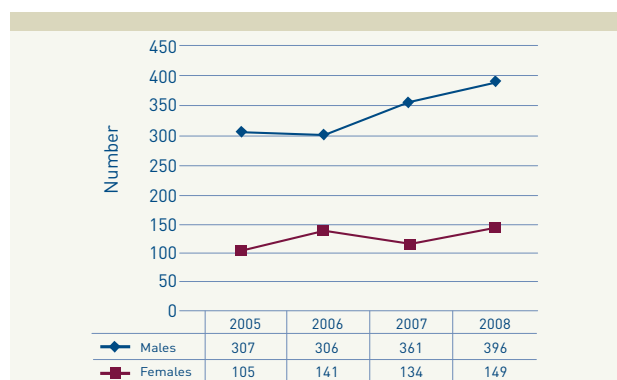


Figure 4 Number of hospital deaths with an alcohol related diagnosis by year and gender, 2005–2008 (N=1,899)

Over half (52%) of deaths occurred among those aged 50–70 years. Male deaths peaked in the 60–69-year age group and female deaths peaked in the 50–59-year age group (Figure 5).

Those aged under 65 accounted for 61% (1,156) of deaths, highlighting the link between alcohol-related conditions and premature mortality. As these people were of working age, these deaths represent a considerable economic loss to the country and contribute to the wider, intangible human costs associated with premature mortality due to alcohol.

Discharges with additional mental health, drug or trauma diagnoses

There is a close relationship between alcohol problems and mental health. People with mental health problems are at increased risk of alcohol problems, and vice versa. One in ten male and one in five female cases discharged in the four-year period had a mental health diagnosis in addition to an alcohol-related diagnosis (Table 4). Eleven per cent of discharges had an additional drug-related diagnosis, and half of these were aged 15–34 years. Female discharges (18%) were twice as likely as males (9%) to have a drug-related diagnosis. A large number of the female cases were related to intentional poisoning by analgesics or psychotropic agents in conjunction with alcohol.

Acute consequences of alcohol use such as road traffic accidents and assaults were experienced primarily by males, and three-fifths occurred among those aged 15–34 years. One in ten discharges had experienced a fall, with one in five falls occurring among those aged 65 or over. Alcohol problems among the elderly can be hard to detect and often go undiagnosed. The clinical presentation of harmful use of alcohol in elderly people may differ from that in younger people, with elderly people more likely to present with non-specific complaints, including falls, which may mask the underlying problem alcohol use.

Table 4 Discharges with additional mental health, drug or trauma diagnoses by age and gender 2005–2008

	Additional diagnoses		Male		Female		Age group			
							15–34	35–49	50–64	65+
	n	(%)	n	(%)	n	(%)	%	%	%	%
Mental health	8468	(12.4)	3580	(9.7)	4888	(19.8)	23.0	37.4	28.5	11.2
Drug use	7808	(11.4)	4537	(9.0)	3271	(18.1)	51.3	35.0	12.0	1.7
Fall	6681	(9.7)	4997	(9.9)	1684	(9.3)	22.5	24.1	31.1	22.3
Road traffic accident	1051	(1.5)	907	(1.8)	144	(0.8)	61.4	21.6	12.5	4.5
Assault	1446	(2.1)	1267	(2.5)	179	(1.0)	61.8	28.6	8.1	1.5

The burden of alcohol-related morbidity on hospital services *(continued)*

Conclusion

These results indicate that alcohol-related morbidity is a considerable burden on Irish hospitals, with alcohol-related discharges accounting for 161,016 of all bed days in 2008 at a cost of €143,143,224. The data presented here do not include emergency department presentations; we can therefore conclude that the actual burden of alcohol on acute Irish hospitals is substantially higher.

(Deirdre Mongan)

1. HSE National Casemix Programme (2010) Letter dated 17 February in response to Parliamentary Question [5857/10] put to the Minister for Health and Children by Caoimhghín Ó Caoláin TD. Dáil Éireann, 4 February 2010. Accessed 17 August 2010 at www.hse.ie/eng/about/PersonalPQ
2. Morgan K, McGee H, Dicker P, Brugha R, Ward M, Shelley E *et al.* (2009) *SLÁN 2007: survey of lifestyle, attitudes and nutrition in Ireland. Alcohol use in Ireland: a profile of drinking patterns and alcohol-related harm from SLÁN 2007*. Dublin: Department of Health and Children.

Sponsorship of sports events by the alcohol industry

There is a link between alcohol marketing and consumption. According to a WHO report, 'in markets where alcohol is more widely advertised young people are more likely to continue to increase their drinking as they move into their mid-twenties, whereas drinking declines at an earlier age among those who are less exposed.'¹ Sports events are widely sponsored by alcohol brands. Sports sponsorship by the alcohol industry provides an opportunity to build the alcohol brand into the name of the event through mention in sports commentaries, signage on clothing and sports grounds, and products retailed to fans.

The Department of Health and Children established a working group in 2008 to deliver on the commitment in the programme for government to discuss the question of the sponsorship of sporting events by the alcohol industry with a view to phasing it out.² The group's terms of reference were:

- To facilitate engagement among stakeholders, including representatives from the main sporting organisations in Ireland and the alcohol industry regarding this issue
- To establish the extent of the existing sponsorship of sporting events by the alcohol industry and the terms and lengths of existing contracts
- To report to the Minister for Health and Children by 30 September 2009.

Conclusions of the working group

The working group accepted that sport has many benefits and contributes to Irish society, while also recognising that alcohol is responsible for many harms in Ireland. While all members were willing to play their part in reducing this harm, views diverged on how this might be achieved. A population health approach seeking to reduce overall alcohol

consumption was favoured by some, while others were in favour of focusing on specific at-risk groups and on the drinking patterns of people who use alcohol harmfully.

It was not possible to establish the full financial extent of the existing sponsorships of sporting events by the alcohol industry or the terms and length of these contracts. However, the financial contribution to sport in Ireland by the industry is very significant, with two of the largest national sporting bodies (FAI and IRFU) maintaining that their organisations could not exist without the support currently provided by the alcohol industry.

One view presented to the working group argued for the elimination of alcohol sponsorship of sport to protect the health of young people in particular. The opposing view was that there are huge economic, social and health benefits accruing from sport and that the support provided by the alcohol industry was integral to the survival of mainstream sport.

The working group was not charged with finding a means of reconciling these two opposing views. It is now a matter for the Minister for Health and Children to consider the findings of this report and to use them to inform any decisions that may be made in relation to sports sponsorship by the alcohol industry in Ireland.

(Deirdre Mongan)

1. WHO Regional Office for Europe (2009) *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen: World Health Organization. p. 70.
2. Department of Health and Children (2010) *Report of the working group on sports sponsorship by the alcohol industry*. Dublin: Department of Health and Children. Available at www.drugsandalcohol.ie/13322

'What's the point?' A conference on understanding suicide and supporting life



Dr John Connolly, Irish Association of Suicidology, and Dr Evelyn Gordon, DCU, pictured at the conference

The aim of this conference was to bring together various professionals in suicidology and people who have had a direct encounter with suicide, themselves or through friends or relatives, in order to review the impact of suicide on society, to reflect on current policy and research in this area, and to discuss what helps to prevent suicide. Held in Dublin City University's Helix theatre on 18 June 2010, the conference was organised by the DCU School of Nursing, Shine (a part-voluntary organisation supporting people with mental illness and their families) and St Vincent's Hospital, Fairview.

The panel and audience included representatives of the three hosting organisations and of other public, private, voluntary and part-voluntary bodies. There were speakers and guests from the National Office of Suicide Prevention (NoSP), the Royal College of Surgeons, the Irish Association of Suicidology, the National Service Users Executive (NSUE), Bodywhys (the Eating Disorder Association of Ireland), Mental Health Ireland, GROW, Headline (the national media-monitoring programme for mental health and suicide), the Health Research Board, and other organisations.

Mr Geoff Day, CEO of NoSP, presented alarming WHO statistics showing that one suicide occurs globally every minute, and one suicide attempt every three seconds.¹ In Ireland, the highest rate of suicide is among males aged between 20 and 24 years; the highest rate for females is among those aged between 50 and 54 years.² Among the multiple risk factors for suicide are mental illness; having made a previous suicide attempt; substance misuse; physical illness; personality traits; being unemployed; socio-economic deprivation; unplanned pregnancy; and abortion. Protective factors include efficient coping skills; seeing reasons for living; physical health; good family communication; supportive schools; good social support; religious affiliation;

employment; and access to quality health treatment. Suicidal states and recovery from them constitute a unique interaction of individual existential, emotional, cognitive, behavioural, physical, family, social, and economic factors.

While there is no 'one-size-fits-all' strategy for preventing suicide, the approach taken by professionals and policy-makers can influence how a person deals with suicidal feelings. Mann and colleagues³ found that factors associated with reduction of suicide rates were GP education on suicide; development of coping and problem-solving skills; education of the community; and regulation of the quantity of medication such as paracetamol sold without prescription. An Irish study⁴ developed the theory that, among young Irish males, transcending suicidality meant changing orientation from death towards life, which required an inner struggle towards accepting oneself as worthy of life. Professionals who acknowledged such struggle and worked together with clients to overcome their fears and concerns were perceived as the most helpful.

The conference highlighted that the circumstances of each individual case are complex and multifactorial. Being wealthy and healthy does not guarantee protection from suicidal feelings at any stage of one's life. Whereas a lot of data on suicide are published nationally and internationally, there is a lack of research on understanding individual contexts and recovery from suicidal states. A deeper understanding of these aspects can help us to develop better suicide prevention strategies. For more information about the conference please contact shanola@svhf.ie or kartalova@hrb.ie

(Yulia Kartalova-O'Doherty)

1. See www.who.int/mental_health/prevention/en
2. National Office of Suicide Prevention (2009) *Annual report 2008*. Dublin: HSE. Available at www.drugsandalcohol.ie/12494
3. Mann J, Apter A, Bertolote J, Beautrais A, Currier D, Haas A et al. (2005) Suicide prevention strategies: a systematic review. *Journal of the American Medical Association*, 294 (16): 2064–2074. Available at <http://jama.ama-assn.org/cgi/cpmtent/full/294/16/2064>
4. Gordon E (2010) *Re-vitalizing worthiness: a theory of transcending suicidality among young men*. PhD thesis, Dublin City University. Retrieved 15 July 2010 from <http://doras.dcu.ie/15083>

Reconnecting with life: recovering from mental health problems

A *Vision for Change*, the blueprint for Irish mental health policy,¹ recommends that the mental health services adopt a recovery perspective. It broadly defines the principle of recovery as the belief that people with mental illness can recover their self-esteem and regain control of their lives despite their illness. However, at present there is no clearly laid-out theory of recovery to guide daily clinical practice.²

In February 2010 the Health Research Board (HRB) published

the research report *Reconnecting with life: personal experiences of recovering from mental health problems in Ireland*.³ Dr Tony Bates, the founding director of Headstrong,⁴ referred to this publication as 'the most important report to have been published since *Vision*, because it brings clarity to an issue that has been poorly understood. Without a shared understanding and belief in recovery, our services will remain stagnant, regardless of how many new resources are provided'.⁵



Recovering from mental health problems (continued)

The aim of the HRB study was to develop a coherent theory of recovery from mental health problems from the point of view of those recovering. This was the first classic grounded theory (GT) study of recovery in Ireland carried out from a service-user perspective. Classic GT seeks to identify the main concern of the population under study.⁶ Understanding the main concern helps service providers to readjust their practices to better meet the needs of service users. The study was based on individual interviews with 32 self-nominated volunteers who had experienced mental health problems more than once over a period of two years or more, and who now considered that their mental health had improved.

An analysis of the interviews identified participants' main concern as striving to reconnect with life. The dynamic and non-linear process of reconnecting with life had three interactive dimensions: 1) reconnecting with self, i.e. accepting oneself as a worthy individual capable of positive change; 2) reconnecting self with others, i.e. experiencing empathic, accepting, and validating interaction with others; and 3) reconnecting with self, others and time, i.e. getting a glimpse of a positive future, coming to terms with the past, and planning and executing one's present. The process involved exploring, acknowledging and developing personal strengths and capabilities through trial and error.

As the study findings show, some isolated elements of recovery-oriented care already exist in Irish mental health services, at least in community mental health services. Participants complimented individual psychiatrists, nurses, psychotherapists and other professionals for their understanding, empathy, sense of humour, encouragement and listening skills which facilitated their reconnection with self, others and time. Educational and occupational activities provided by day centres were also reported by participants as facilitating their reconnection with life. Such qualities and activities need to be supported and enhanced, and used as positive examples of recovery-oriented care.

This study also provided qualitative evidence that depersonalised, paternalistic and pessimistic attitudes and behaviours, which can slow down reconnection with life, generally prevail over a person-centred, empathic and accepting approach within the Irish mental health services. Recovery-oriented mental health care requires a paradigm shift towards refocusing on the life goals of those recovering, and the vital importance of service users' input into the planning and delivery of care. Service users should be encouraged to talk at length, narrate their story, voice their concerns and aspirations, and participate in a dialogue with service providers.

It is hoped that the study will encourage creative innovation in mental health practice and research, and will not only improve the quality of care, but also contribute to the morale and job satisfaction of service providers. The underlying processes and tasks of mental health recovery identified in this study are highly relevant and applicable to any clinical or community context. Service users' preferred individual strategies for reconnecting with life can be effectively combined with therapies and supports available in the services and in the wider community to match specific tasks of reconnecting with self, others and time. In addition, this study informs the Irish public about the possibility of recovery, and the

important role of community in reconnection with one's life and thus can aid mental health promotion campaigns.

Viewing recovery as a process of gradual reconnection with life embraces and synthesises diverse concepts and theories of recovery and rehabilitation in a coherent theory of mental health recovery.⁷ The theory thus generated is congruent with the WHO definition of mental health as 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.⁸ The generated theory, with its concepts of self-acceptance, meaningful connection with others, and reconnection with time as it changes can be relevant to other health areas, such as recovery from addiction or physical illness.⁹ The relevance and applicability of the generated theory to other areas of health and well-being can be further addressed by reviews of previous findings, or further research carried out from the perspectives of users of various health services.

Familiarisation with this study is recommended for mental health professionals and educators, service users, carers, researchers, policymakers and the general public.

(Yulia Kartalova-O'Doherty)

1. Department of Health and Children (2006) *A vision for change: report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office.
2. Care Services Improvement Partnership, Royal College of Psychiatrists, and Social Care Institute for Excellence (2007) *A common purpose: recovery in future mental health services*. Joint position paper 08. London: Social Care Institute for Excellence. pp. 3–5. Available at www.scie.org.uk/publications/positionpapers/pp08.pdf
3. Kartalova-O'Doherty Y and Tedstone Doherty D (2010) *Reconnecting with life: personal experiences of recovering from mental health problems in Ireland*. HRB Research Series 8. Dublin: Health Research Board. Available at www.hrb.ie/publications/hrb-publication/publications//508
4. The National Centre for Youth Mental Health. www.headstrong.ie
5. See www.irishtimes.com/newspaper/health/2010/0302/1224265422637.html. Accessed 22 July 2010.
6. Glaser B (2001) *The grounded theory perspective: conceptualisation contrasted with description*. Mill Valley, CA: The Sociology Press.
7. See, e.g., Onken S, Craig C, Ridgway P, Ralph R and Cook J (2007) An analysis of the definitions and elements of recovery: a review of the literature. *Psychiatric Rehabilitation Journal*, 30(1): 9–22.
8. World Health Organization (2007) *Mental health: strengthening mental health promotion*. Fact sheet No 220. Retrieved 6 August 2010 from www.who.int/mediacentre/factsheets/fs220/en
9. Kartalova-O'Doherty Y (2010) *Reconnecting with life: reconnecting with self, others and time. A grounded theory study of recovering from mental health problems in an Irish context*. PhD thesis. Dublin City University. Available at <http://doras.dcu.ie/15081>

Further update on psychoactive substances sold in head shops and on line

Legislation

The Criminal Justice (Psychoactive Substances) Act 2010 (No. 22 of 2010)¹ came into operation on Monday 23 August 2010. The intention of the Act is to prevent the misuse of dangerous or otherwise harmful psychoactive substances by making it an offence to sell, import, export or advertise such psychoactive substances. The Act provides powers to the Garda Síochána (police) to investigate such offences and to issue prohibition notices. It allows the District Court to institute prohibition and closure orders in certain circumstances. The Act also amends the Customs and Excise (Miscellaneous Provisions) Act 1988.

Numbers of head shops

A Garda inventory of head shops in Ireland indicated that at their peak in early 2010 there were 113 head shops in the country, with at least one in every county. On 11 May 2010 (the date of the government ban on a range of head shop products) there were 102 shops, 11 having closed for a variety of reasons. On 12 May, the gardaí visited all head shops and warehouses and seized all banned products. By 13 May there were 34 head shops selling psychoactive substances, and in early August the number increased to 39 shops. Following the introduction of the Criminal Justice (Psychoactive Substances) Act 2010, the gardaí visited head shops in early September; only 19 were open and none were selling psychoactive substances (Garda Síochána, personal communication, 2010).

New substances detected 'post-ban'

Several additional psychoactive substances have been identified in head shop products by Dr Pierce Kavanagh and his laboratory team (at Trinity College and the Drug Treatment Centre Board) since the publication of Issues 33 and 34 of Drugnet Ireland. The team illustrated their results in a 'post-ban' identification chart,² reproduced on pages 16–17. A summary of the substances identified is given below.

Dimethocaine, also known as larocaine, is a local anesthetic with stimulant properties that are nearly as potent as those of cocaine. However, anecdotal user reports indicate no euphoria and only mild stimulating effects. This drug may induce a fast and irregular heart beat which could be problematic for those who continuously redose. The drug has induced respiratory arrest. Dimethocaine was identified in the head-shop products Amplified, Mint Mania and Mind Melt. The Ana Liffey Drug Project reported that a number of clients experienced negative effects of a product called Amplifier (most likely Amplified). The clients reported that the drug is available in two forms; a rock which is smoked by pipe and a tablet which is broken down to inject. According to the users of this drug, it has a stimulant effect and a bad come down. Some users reported paranoia or auditory or visual hallucinations. In August 2010 three users, who had a previous mental health diagnosis, were admitted to a psychiatric hospital following hallucinations and depression.

AM-694 is a drug which acts as a potent and selective agonist for the cannabinoid receptor CB1. No public data about AM-694 metabolism is known. AM-694 has emerged as a designer drug, and in Ireland, it was detected in the product Shamrock. Concerns have been raised over the possible toxicity of this compound, because of its likely metabolism to w-fluoroalkanoic acids.

Glucine is an alkaloid found in several different plant species. It has bronchodilator and anti-inflammatory effects and is used as a cough suppressant in some countries. Glucine may induce fatigue or hallucinations (which are usually colourful visual images). This substance was detected as the active ingredient in the head-shop product Entrophy.

Phenethylamine (PEA) is a natural monoamine alkaloid and a psychoactive drug with stimulant effects. This substance was detected in the head-shop products Diablo, Dr Feelgood, Entrophy, Nemesis, and Party On.

Metamfepramone also known as dimethylcathinone, dimethylpropion, or dimepropion, is a stimulant drug of the phenethylamine, amphetamine, and cathinone chemical classes. Dimethylcathinone was evaluated as an appetite suppressant and for the treatment of hypotension, but was never widely marketed. Metamfepramone is used for the treatment of the common cold. This substance was detected in a product sold in tablet form as BluE.

Synephrine is the main active compound found in the bitter orange which is an extract of a plant called *Citrus aurantium*. It is a stimulant that constricts the blood vessels, increases metabolic and heart rates. Synephrine has been identified in the head shop products Energy, Go-E, Empathy, Bio Happiness, Exotic and Molotov

Mitragynine, an opioid agonist, is a stimulant at low doses and a painkiller or sedative at higher doses. It can cause constipation, weight loss, dependence, psychosis and withdrawal symptoms. It is not controlled in Ireland. Mitragynine is an active ingredient in the products Kratom and Xscape.

Hordenine occurs in a variety of grassy plants and grains, and in some species of cactus. It stimulates the release of norepinephrine in humans, and also has antibacterial and antibiotic properties. There are unsubstantiated claims that hordenine helps people lose weight. It was detected in the products Go-E and Dr Feelgood.

5-hydroxytryptophan (5-HTP) is a naturally-occurring amino acid and a metabolic intermediate in the biosynthesis of the neurotransmitters serotonin and melatonin from tryptophan. 5-HTP sourced from the seeds of the plant *Griffonia simplicifolia* is sold over the counter in the US and Canada as a dietary supplement and as an antidepressant, appetite suppressant, and sleep aid. It is marketed in many European countries for the treatment of major depression. Several double-blind placebo-controlled clinical trials have demonstrated the effectiveness of 5-HTP in the treatment of depression, though the quality of the studies has been disputed. There are no regulated manufacturing standards in place for many herbal compounds and some marketed supplements have been found to be contaminated with toxic metals or other drugs. 5-HTP was detected in the head-shop product Dr Feelgood.

Head Shop 'Legal Highs' Active Constituents Identification Chart (July - August 2010, '714' - '823')

(The Criminal Justice (Psychoactive Substances) Act 2010 came into force on August 23rd)



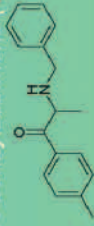
•3',4'-Methylenedioxy- α -pyrrolidinobutophenone (MDPBP)

(Identified using a characterized sample of MDPBP extracted from Vanilla Sky as a reference standard)

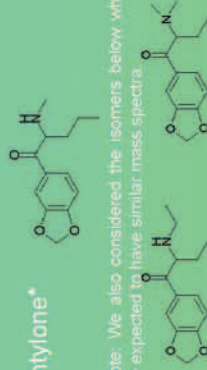
•Caffeine

•4-Methylethcathinone (4-MEC)†

•4-Methyl-N-benzylcathinone (**Benzodrone**)†



•Pentylone*



Note: We also considered the isomers below which would be expected to have similar mass spectra:



However, based on first principles, the preparation of derivatives and comparison with the mass spectra analogous molecules, the mass spectral data most closely fits pentylone. In this case the mass spectrum displays a significant m/z 44 ion which may arise by loss of propylene from m/z 88 iminium ion.



•Glucaine*
•Caffeine (trace)

Note: GC/MS analysis also revealed several unidentified peaks. Could be compounds related to glucaine?



•Glucaine*
•Caffeine
•Synephrine
•Dimethylamylamine (DMAA)

Note: GC/MS analysis also revealed an unidentified peak. Could be a compound related to glucaine?



•Dimethylamylamine (DMAA)
•Caffeine



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



•3',4'-Methylenedioxy- α -pyrrolidinobutophenone (MDPBP)*

Note: This product contained MDPBP and glucaine before the '511' ban.



•Naphyrone†



•AM-694*



•Naphyrone†
•Caffeine



•AM-694*

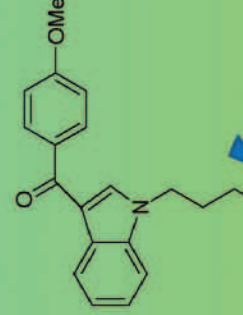


•Naphyrone†
•Caffeine



•Benzocaine
•Caffeine

Note: This product contained Intephedrate before the '511' ban.



•Cleamide
•3-(4-Methoxybenzoyl)-1-pentylindole
(**DD-001**) †

•3-(4-Methoxybenzoyl)-1-pentylindole
(**DD-001**) † ‡

•Cleamide
•3-(4-Methoxybenzoyl)-1-pentylindole
(**DD-001**) †



•AM-694*

•Caffeine
•Naphyrone†

Based on mass spectrometric data we also suspect the presence of **1-naphthylindole**
Note: Purchased on July 31, 2010.

CCN(CC)C(=O)c1ccc2ccccc12

•AM-694*

•Dimethocaine*

Note: Also contains desethyl dimethocaine Manufacturing by-product?

This product contained butylone and lignocaine before the '511' ban
At the time of purchase the sales assistant said that this was the same as 'Amplified'

CCCCN(C)C(=O)c1ccc2ccccc12

•AM-694*

NMR analysis indicates that this product contains 1-[(4-methyl-2-piperidinyl)methyl]-3-(1-naphthyl)indole
MS data is consistent with this. Investigations are continuing.
In Patent no. WO 01/29557 (University of Connecticut, Makryannis and Deng) this compound is referred to as both AM1296 and AM1220.

CC1CCN(CC1)CN(C)C(=O)c2ccc3ccccc32

•AM-694*

Based on NMR and MS data we suspect the presence of 3-(adamantan-1-yl)carbonyl-1-pentylindole
(**DD-001**) Investigations are continuing.

CCCCN(C)C(=O)c1ccc2c(c1)C3CC4CC5CC6C(C3)CC456

•AM-694*

•AM-694*

•AM-694*

•AM-694*

•Buphedrone †

Note: Previously this contained ethcathinone and ethcathinone /iso-ethcathinone.
Note: Purchased to check if these products still contained the same ingredients as reported previously

CCN(CC)C(=O)c1ccccc1

•Octopamine
•Caffeine
•Synephrine
•Dimethylamylamine
•(DMAA)
•Hordenine

•Fluorotropocaine*

Note: GCMS analysis also revealed an unidentified peak. Could be a compound related to fluorotropocaine?

CC1CCN(CC1)C(=O)c2ccc3ccccc32

•'Herbal mix'

•Resin

•AM-694*

* Tentatively identified from its mass spectrum as no standard was available
† Reference standard synthesized in our laboratory

These are the active constituents identified to date. Analysis is on-going. If you have any questions please contact us - id.lab.team@gmail.com

We wish to thank Dr. István Ujváry for his immense help with this work

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Further update on psychoactive substances sold in head shops and on line (continued)

L-dopa (levodopa) is a naturally occurring dietary supplement and psychoactive drug found in certain kinds of food and herbs. It is synthesized from the essential amino acid L-tyrosine in humans. L-dopa is the precursor to the neurotransmitters dopamine, norepinephrine (noradrenaline), and epinephrine (adrenaline). Aside from its natural and essential biological role, L-dopa is also used in the clinical treatment of Parkinson's disease (PD) and dopamine-responsive dystonia (involuntary spasms of the limbs). It was detected in the product Raz.

Desoxy pipradrol was developed in the 1950s, and has been researched for applications such as the treatment of narcolepsy (a condition which results in uncontrolled sleeping) and attention deficit hyperactivity disorder (ADHD), and facilitation of rapid recovery from anaesthesia; for various reasons its development for application in these areas was not continued. The hydroxylated derivative, pipradrol, was introduced as a clinical drug for the treatment of for depression, narcolepsy and cognitive enhancement in organic dementia. Desoxy pipradrol was detected in the head-shop product Whack.

Tests in recent weeks have identified yet more psychoactive substances that may be used as recreational drugs. There is very little information available about the uses or effects of these substances:

- **3',4'-Methylenedioxy-a-pyrrolidinobutiophenone (MDPBP)** is a stimulant compound developed in the 1960s which has been reported as a novel designer drug.
- **Oleamide** was found in the smoking blends Smoke and Skunk alongside the synthetic cannabinoid JWH-018, which was classified as the active ingredient. There is no evidence that oleamide is used specifically as a recreational drug.

- **Octopamine** and **syneprhine** are the adrenergic amines in bitter orange.
- **Buphedrone**, also known as a-methylamino-butyrophenone, is a stimulant of the phenethylamine, amphetamine, and cathinone chemical classes that was first synthesized in 1928. It has similar effects to methcathinone but is several times more potent by weight.

The products caffeine and lignocaine were found in numerous head shop products.

- Caffeine is a legal psychoactive stimulant and easy to acquire. Caffeine was found in the products Blowout, Bliss Bomb, Diablo, Dr Feelgood, Energy, Embrace, Extreme Star Dust, Go-E, Koru, Nemesis, NRG Now, Pure NRG, Pinkys, Raz, Sno*berry, Star Dust, and Party On.,
- Lignocaine (or lidocaine) is an anaesthetic drug; it was found in Extreme Star Dust, Pure NRG, Raz, Star Dust.

(Jean Long)

1. Criminal Justice (Psychoactive Substances) Act 2010 (No. 22 of 2010). Available at www.attorneygeneral.ie/eAct/2010/a2210.pdf
2. Kavanagh P, Spiers P, O'Brien J, McNamara S, Angelov D, Mullan D *et al.* (2010) Head shop 'legal highs' active constituents identification chart (July-August 2010). Dublin: Department of Pharmacology, TCD

Adulterants, bulking agents and contaminants in illicit drugs

At the point of purchase, illicit drugs usually contain substances in addition to the active ingredient (or named drug); these adulterants can have serious, sometimes fatal, health consequences. Substances may be added in order to:

- bulk or dilute the drug,
- complement or enhance the effects of the active ingredient,
- facilitate the administration of the drug.

Also, additional substances or contaminants may be created through a chemical reaction during processing, or added though accidental contamination during storage.

A systematic review of the published evidence of drug adulterants found in multiple samples of illicit drugs was published by the Centre for Public Health (UK) in April 2010.¹ The review included only articles in English. The evidence suggests that some adulterants and bulking agents are not dangerous. Various types of sugars are used as bulking agents in most illicit drugs. An adapted version of the authors' summary of the evidence of adulterants, other than sugars, found in heroin, cocaine, methamphetamine,

ecstasy and cannabis is presented in Table 1. These substances are generally added to the drugs during processing and can cause health problems.

The findings in the international literature are consistent with findings in Ireland. In recent years, the Forensic Science Laboratory in Ireland has reported the presence of caffeine, paracetamol and levamisole in heroin samples to the Early Warning sub-committee of the National Advisory Committee on Drugs (NACD). Phenactin, lignocaine and levamisole were reported in cocaine, and glass beads were reported in cannabis; the latter practice occurred for a short period during 2007 and is no longer an issue.

According to this review, a number of bacterial contaminants have been reported in illicit drugs. The negative effects were usually experienced by injecting drug users. The bacteria identified were: *Bacillus anthracis*, *Bacillus cereus*, *Clostridium botulinum*, *Clostridium novyi*, *Clostridium sordellii* and bacteria causing necrotising fasciitis. Bacterial contaminants identified in Ireland were *Clostridium botulinum* (in 2005) and *Clostridium novyi* (in 2002).

Adulterants in illicit drugs (continued)

Table 1 Adulterant by drug type

Heroin			
Adulterant	Licit use	Possible reason for presence	Public health risks and health consequences
Phenobarbital	Sedative	Facilitates smoking of heroin	Overdose in injectors, death
Quinine	Anti-malarial medication	As a diluent Has bitter taste similar to heroin Mimics respiratory rush felt by heroin injectors	Gastric disturbances, blood clotting, low blood pressure, blindness, renal failure, CNS over-stimulation, overdose (headache, hearing loss, tinnitus), death
Clenbuterol	Decongestant and bronchodilator	Unknown May be accidental	Dilated pupils, agitation, cardiovascular events, neuromuscular syndrome, overdose and poisoning at high dose
Scopolamine	Anticholinergic	Increases retention when volatilised	Drowsiness at low dose, euphoria at high dose, poisoning
Lead	Soft metal	May be a residue of manufacturing process	Headache, dizziness, nausea and vomiting, abdominal cramps, muscle weakness, anaemia, seizures, coma, CNS damage, renal damage, poisoning
Caffeine	Psychoactive stimulant	Legal and easy to acquire Vaporises heroin at lower temperature and makes smoking it more efficient	Anxiety, sleep disturbance, mood disturbance, addictive, risk factor for a range of health conditions
Procaine	Local anaesthetic	Facilitates smoking and reduces pain at the injection site	Nausea and vomiting, dizziness, tremors, anxiety, convulsions, CNS problems, poisoning at high doses
Paracetamol	Pain medication	Same function, painkiller, same taste, and similar melting point May be used to disguise poor quality heroin	Gastro-intestinal effects, liver damage, death, risk of toxicity at high doses
Strychnine	Pesticide	Not easy to detect	Abnormal posture caused by severe muscle rigidity, muscle spasm, death, poisoning at medium doses
Cocaine			
Adulterant	Licit use	Possible reason for presence	Health consequences
Lidocaine	Local anaesthetic	Similar but stronger anesthetic than cocaine Gives the impression of high purity	Nausea, vomiting, dizziness, tremors, convulsions, adverse cardiac events, CNS problems, increases toxicity of cocaine
Hydroxyzine	Sedative Anxiolytic Antihistamine	Unknown	Headaches, dizziness, tinnitus, drowsiness, gastrointestinal effects, loss of consciousness, CNS problems, overdose
Phenactin	Pain medication Banned in many countries		Analgesic neuropathy, haemolytic anaemia, methheamoglobinanaemia, bladder cancer, renal cancer, renal failure
Levamisole	Medication used to dispel worms from the intestine	Unknown, may give a more intense high	Fever, agranulocytosis, toxic
Caffeine	Psychoactive stimulant	Legal and easy to acquire	Anxiety, sleep disturbance, mood disturbance, addictive, risk factor for a range of health conditions
Procaine	Local anaesthetic	Facilitates smoking and reduces pain at the injection site	Nausea, vomiting, dizziness, tremors, anxiety, convulsions, CNS problems, poisoning at high doses

Adulterants in illicit drugs (continued)

Adulterant	Licit use	Possible reason for presence	Health consequences
Strychnine	Pesticide	Not easy to detect	Abnormal posture caused by severe muscle rigidity, muscle spasm, poisoning at medium doses, death
Methamphetamine			
Adulterant	Licit use	Possible reason for presence	Health consequences
Methylsulfonyl- methamine (MSM)	Dietary supplement	Creates the impression of high-quality methamphetamine	None known
Caffeine	Psychoactive stimulant	Legal and easy to acquire	Anxiety, sleep disturbance, mood disturbance, addictive, risk factor for a range of health conditions
Lead	Soft metal	May be a residue of manufacturing process	Headaches, dizziness, nausea and vomiting, abdominal cramps, muscle weakness, anaemia, seizures, coma, CNS damage, renal damage, poisoning
Ecstasy			
Adulterant	Licit use	Possible reason for presence	Health consequences
Dextromethorphan	Cough suppressant	Euphoria similar to ecstasy when taken at high doses	Tachycardia, lethargy, ataxia, nystagmus, heatstroke
Amphetamine and/or Methamphetamine	Stimulant drug	Similar properties to ecstasy, Often sold as or in combination with ecstasy	Anxiety, sleep disturbance, mood disturbance, addictive
Paramethoxymethamphetamine and/or Paramethoxyamphetamine	Psychoactive drug	Added to enhance stimulant properties	Fatal at high dosage
Caffeine	Psychoactive stimulant	Legal and easy to acquire	Anxiety, sleep disturbance, mood disturbance, addictive, risk factor for a range of health conditions
Cannabis			
Adulterant	Licit use	Possible reason for presence	Health consequences
Lead	Soft metal	Increases weight	Headache, dizziness, nausea and vomiting, abdominal cramps, muscle weakness, anaemia, seizures, coma, CNS damage, poisoning, renal damage, death
Aluminium	Soft metal	Unknown, but may result from impure water supply during processing	Exacerbates smoking-related diseases
Glass	May be to increase weight		Inhalation of hot glass fumes may lead to: sore mouth, mouth ulcers, tight chest, persistent cough

Source: Adapted from Cole *et al.* (2010): Table 1.

(Jean Long)

1. Cole C, Jones L, McVeigh J, Kicman A, Syed Q and Bellis M (2010) *Cut: a guide to adulterants, bulking agents and other contaminants found in illicit drugs*. Liverpool: Liverpool John Moores University. Available at www.cph.org.uk/showPublication.aspx?pubid=632

HSE awareness campaign on legal and illegal highs

Pat Carey TD, Minister for Community, Equality and Gaeltacht Affairs, launched the new HSE drug awareness campaign 'Legal or illegal highs can cause serious health problems – they're anything but safe' in July 2010.¹ The minister welcomed the campaign as an important part of the strategy against head shop drugs, alongside the ongoing legislative reform.

Introducing the campaign, Ms Alice O'Flynn, HSE assistant national director for social inclusion, said that the risk to mental and physical health as a result of taking these substances was very real. The campaign aims to raise awareness of the ill effects in a series of messages highlighting the health risks, such as heart problems, kidney failure, impotence, seizures and paranoia.

Aimed primarily at people aged between 15 and 40 years, the campaign messages will be reproduced on posters and t-shirts, and in a Z-folded wallet card. They will also feature on radio ads, in cinemas, in 'pop-ups' on Facebook, in washrooms in bars and clubs, and at festivals over the summer. The campaign was developed in consultation with all the key stakeholders, including the target audience.

There is also an information booklet for parents and guardians. The booklet explains what legal highs are and the current legal issues, and offers some basic advice on how to talk to your child about these drugs and what to do if they are using them. It includes information on harm reduction and on what to do if someone is having a bad reaction to a drug.

A range of presenters also spoke at the launch. Dr Una Geary, consultant in emergency medicine, spoke about her experience of treating young people who had taken head shop drugs. She spoke about the serious damage and harm that she had seen, ranging from cardiac problems to psychosis. Dr Eamon Keenan, consultant psychiatrist in addiction, spoke about addiction and psychological problems such as delusions and depression, and of the effect of the proliferation of head shop products on the addiction services.



Other speakers included Tanya and Justin from the Voices of Youth organisation and Sinead O'Mahony Carey, HSE. The www.drugs.ie website provides an online presence for the campaign. Andy Osborne explained how the website has been updated to include new information on legal and illegal highs and resources for young people and parents/guardians. The website also has a directory of counselling, education, treatment, rehabilitation and other services responding to problem drug and alcohol use throughout the country. Podcasts, videos of interviews with experts and other multimedia resources are also available on the site. The drugs helpline number is 1800 459 459.

(Suzi Lyons)

1. Carey P (2010, 7 July) *Minister Pat Carey launches National Drugs Awareness Campaign*. Press release issued by Department of Community, Equality and Gaeltacht Affairs. Available at www.pobail.ie/en/PressReleases/htmltext,10421,en.html

Lapse and relapse following inpatient treatment of opiate dependence

A paper published in 2010¹ examined the factors associated with lapse and relapse² in a prospective follow-up study of opiate users who had been admitted to an Irish residential detoxification facility between June 1995 and December 1996. Follow-up interviews were conducted by out-reach workers between June 1998 and March 1999.

Of the 109 participants, 99 (91%) reported a relapse. Within the first week of discharge, 72 (66%) had lapsed and 64 (59%) had relapsed. Only 42 (32%) of those recruited had completed the full six-week programme.

The study identified several factors independently associated with early relapse: being aged 20 to 24, not having a partner who used opiates, history of injecting drug use, heroin use of between 1.5 and 3 'quarters' per day, and failure to complete treatment or enter aftercare.

Lapse and relapse following inpatient treatment of opiate dependence (continued)

This study, based on data collected in the late 1990s, found that lapse and relapse occurred very soon after opiate detoxification: 80% of participants had lapsed within the first month. The study findings are similar to those of international studies based on more recent data. The authors recommend that clients should be provided with improved psychological supports both before and after entering residential opiate detoxification. These include encouraging clients to remain for the full treatment period, improving relapse prevention supports, especially during the first week after discharge, and providing prompt access to aftercare.

(Suzi Lyons)

1. Smyth BP, Barry J, Keenan E and Ducray K (2010) Lapse and relapse following inpatient treatment of opiate dependence. *Irish Medical Journal*, 103(6): 176–179. Available at www.drugsandalcohol.ie/13405
2. A lapse was defined as any misuse of an opiate after discharge, and a relapse as a return to a pattern of daily opiate use.

Reintegration of prisoners in Ireland

In May 2010 the Irish Penal Reform Trust (IPRT) published the report *'It's like stepping on a landmine...': reintegration of prisoners in Ireland*.¹ The IPRT is an independent non-governmental organisation which campaigns for the rights of people in prison and the reform of penal policy.

The study, conducted between October 2009 and February 2010, consisted of a literature review, a number of semi-structured interviews with service providers (in the statutory and non-statutory sectors), a questionnaire completed by service providers throughout Ireland, and two focus groups with ex-prisoners in Dublin. The report lists the aims of the study:

- to review national and international practice and policy (including human rights standards) relating to reintegration;
- to identify barriers to reintegration of ex-prisoners in Ireland;
- to map, as far as possible, available services and identify possible gaps in service provision; and
- to make recommendations for development of future policy and practice.

The study found that, although 'significant progress has been made in recent years in integrating post-release services... by the Irish Prison Service [IPS] and its partners, there remains a less than uniform approach to the provision of necessary services in individual prisons and access to support is dependent on the facility in which the prisoner finds his- or herself' (p.3). Service provision also varies between different areas of the country. The study also found that the unstructured use of Temporary Release (TR), often used to alleviate pressure on overcrowded prisons and to make spaces available to new prisoners, impacts negatively on preparation for release. The study found that prisoners are sometimes given no more than a few hours notice before being released, and some are released when outside services are unavailable, on Friday evenings or at the weekend for example.

The report notes some positive developments in recent years, such as the development of a system of Integrated Sentence Management (ISM) in some prisons, and wider provision of drug counselling services, including those provided in Dublin by Merchants' Quay Ireland. The IPRT makes a number of recommendations arising from the findings of the study, including the following:

- The IPS should provide appropriate access and facilities for practitioners working with prisoners on drug and alcohol addictions, including the provision of facilities ensuring confidentiality and a therapeutic environment for service users.
- All prisons should provide drug-free landings.
- The IPS, in partnership with relevant service providers, should ensure arrangements are made for prisoners to continue drug and alcohol addiction treatment upon release when required.
- The government should make the introduction of spent convictions legislation a priority in 2010, to assist prisoners in entering employment post release.

The authors state that during the research it became clear that they would not be able to address many of the issues which arose, including the specific needs of children and young people leaving custody, or of foreign national prisoners, and the needs of families who support prisoners during custody and upon release. The IPRT plans to follow up on these issues in the near future.

(Johnny Connolly)

1. Martynowicz A and Quigley M (2010) *'It's like stepping on a landmine'; reintegration of prisoners in Ireland*. Dublin: Irish Penal Reform Trust. Available at www.drugsandalcohol.ie/13496

Drug Treatment Court to continue operating

In May 2010, the Minister for Justice and Law Reform, Dermot Ahern TD, published a review by his department of the Drug Treatment Court (DTC) which has been operating in Dublin since 2001.¹

According to the department's press release:² 'Participants who engage with the programme have reduced rates of recidivism and improved health, education and social skills, which impact positively on the participants and the community. However, the review also confirmed that the DTC, as currently operating, is not dealing with sufficient numbers of participants and programme completion rates are very low.'

The press release quotes Minister Ahern: 'Drug treatment courts can make an important contribution as a restorative justice measure but international studies also indicate they need to evolve and develop on an ongoing basis. This review stems from my concern about the very low throughput of participants in the DTC programme, despite the dedicated team attached to the Court and considerable goodwill on the part of all the agencies involved. I am pleased therefore that the report has identified a number of recommendations which should lead to a marked improvement in the programme's throughput and effectiveness.'

The review sought to ascertain why so few people were going through the DTC, how throughput could be increased and whether further expansion was desirable given poor results thus far. It identified the following costs and outcomes:

- Average annual justice sector cost for the years 2001–2009 was €300,000.
- A total of 374 people were referred in the nine-year period, of whom 174 were deemed unsuitable (90% of whom were outside the DTC catchment area).
- Twenty-nine people have graduated from the programme (14% of 200).
- Involvement in the court led to significant reduction in offending.
- Estimated weekly cost of DTC per offender in 2008 was €320.
- Weekly cost of a prison space in 2008 was €1,783.

The press release continues: 'The review identifies particular issues to be addressed in terms of the management and operation of the DTC which, when implemented will, it concludes, enable the DTC to fulfil its potential in terms of the numbers participating in the programme and

increasing the numbers who successfully complete it. The review recommends that, having implemented the recommendations, the DTC should continue its operations for a further two years with an interim assessment to consider if the improvements are being achieved.'

The review identified the following reasons for the low number of referrals to the DTC:

- Eligibility criteria exclude offenders aged under 18, those from outside the defined catchment area, and those whose offences involve violence.
- Offenders can only be referred to the DTC when they have pleaded guilty and/or have been convicted of certain offences where a prison sentence is likely.
- Judges/solicitors are unaware of the DTC as an option.
- There is a lack of management support and resources.

The press release concludes: 'The DTC operates on a multi-agency basis and all the agencies involved have confirmed their continued commitment to support the work of the Court. The Courts Service has agreed that the administration of the project will now be led by the Chief Clerk of the Dublin Circuit and District Courts, supported by a designated Deputy Chief Clerk who will be appointed shortly. The review also recommends the establishment of an Advisory Committee to oversee the project. This will be chaired by the Courts Service and made up of senior staff members of the Garda Síochána, the Health Service Executive, the Probation Service and the City of Dublin Vocational Educational Committee, and will consider the entry requirements to the programme, expectations of participants and measures of success and how the numbers of participants in the programme can be increased quickly. The Committee will also look at the questions of research into the work and effectiveness of the DTC process and examine how third-level institutions might assist the Court in this work.'

(Johnny Connolly)

1. Department of Justice, Equality and Law Reform (2010) *Review of the drug treatment court*. Dublin: Stationery Office. Available at www.justice.ie
2. Ahern D (2010) *Ahern publishes review of Dublin's Drug Treatment Court*. Press release issued by Department of Justice and Law Reform, 24 May 2010. Available at www.justice.ie

Drug Tests in Irish prisons

Information on drug testing in prisons in 2009 was obtained from the Irish Prison Service. These data indicate that more than 28,000 voluntary tests were carried out to monitor drug use and responses to treatment in 2009. These tests included those carried out on some committals (new entries) as well as those carried out on existing inmates. It may be assumed therefore that some of the positive test results relate to drugs or alcohol consumed outside the prison.

Excluding methadone, between one-tenth and two-fifths of those screened tested positive for at least one drug. The common metabolites detected indicated use of cannabis, benzodiazepines and opiates (Table 1). It is not clear whether the numbers of positive cases exclude prisoners who were prescribed benzodiazepines; if they do not, these figures overstate the extent of unregulated

use of benzodiazepine in prisons. Cocaine, amphetamines and alcohol were detected in a small number of tests. The profile of positive opiate and benzodiazepine tests indicated moderate use of such drugs among prisoners tested in Mountjoy, Wheatfield and Portlaoise prisons. The proportion of positive tests was very low in St Patrick's Institution and in the Training Unit. It would be useful if the test results of prisoners who were tested at committal interview could be fully removed from this analysis as this would provide a more accurate assessment of drug use in Irish prisons.

(Jean Long)

Table 1 Number of tests, by prison, and number (%) of positive tests, by prison and by drug type, 2009

Prison	No. of tests	Cannabis	Benzo-diazepines	Methadone	Opiates	Cocaine	Amphetamines	Alcohol
		Number (%)						
Mountjoy Male	6102	2661 (44)	2717 (45)	5148 (84)	3519 (58)	46 (0.8)	1 (0.02)	28 (0.5)
Mountjoy Medical Unit	4366	679 (16)	664 (15)	2018 (46)	667 (15)	7 (0.2)	3 (0.07)	7 (0.2)
Dóchas Centre	2491	450 (18)	1214 (49)	2045 (82)	557 (22)	53 (2)	4 (0.2)	21 (0.8)
Training Unit	2607	24 (0.9)	15 (0.6)	1 (0.04)	38 (1.5)	0 (0)	1 (0.04)	4 (0.2)
Wheatfield	4131	1303 (32)	1229 (30)	3664 (89)	1499 (36)	12 (0.3)	2 (0.04)	16 (0.4)
Cloverhill*	2328	290 (12)	414 (18)	1604 (69)	389 (17)	43 (2)	3 (0.1)	36 (2)
St Patrick's Institution	1312	105 (8)	66 (5)	158 (12)	16 (1)	1 (0.1)	0 (0)	6 (0.5)
Castlerea	126	33 (26)	33 (26)	23 (18)	36 (29)	1 (0.8)	1 (0.8)	2 (1.6)
Loughan House	486	157 (32)	88 (18)	4 (0.8)	44 (9)	2 (0.4)	5 (1)	5 (1)
Shelton Abbey	770	150 (19)	55 (7)	3 (0.4)	15 (1.9)	7 (0.9)	1 (0.1)	10 (1.3)
Limerick	695	120 (17)	236 (34)	593 (85)	176 (25)	2 (0.3)	3 (0.4)	4 (0.6)
Cork	165	26 (16)	18 (11)	0 (0)	3 (2)	0 (0)	1 (1)	1 (0.6)
Midlands	2529	400 (16)	551 (22)	2287 (90)	908 (36)	15 (0.6)	3 (0.1)	27 (1)
Portlaoise	107	31 (29)	39 (36)	59 (55)	32 (30)	2 (1.9)	0 (0)	0 (0)
Arbour Hill	27	3 (11)	2 (7)	1 (4)	1 (4)	1 (4)	1 (4)	0 (0)

*Results for Cloverhill exclude all committal cases; those for all other facilities exclude only some committal cases.

Source: Irish Prison Service, unpublished data, 2010

Drug-related deaths among recently released prisoners

International research has found an increased risk of mortality among prisoners within the days and weeks following their release from prison.¹ Many of these deaths are drug-related and the increased mortality risk is thought to be caused by the altered tolerance to drugs which an individual may develop while in prison.² A recently published paper based on data from the National Drug-Related Deaths Index (NDRDI) for the years 1998–2005 examined the relationship between date of release from prison and drug-related death.³ This was the first study of its kind in Ireland.

Profile of cases examined

Between 1998 and 2005, 2,442 drug-related deaths were recorded on the NDRDI. One hundred and thirty of the individuals who died had a documented history of imprisonment. Of the 130 individuals, 105 were not in prison at the time of death. The analysis presented in this article is based on these 105 individuals, of whom:

- the majority (93, 88.6%) were male;
- most (69, 65.7%) were aged between 20 and 29 years (median age 29 years);
- the majority (88, 83.8%) were unemployed;
- 21 (20.0%) were living in unstable accommodation, and 10 (9.5%) were homeless;
- 64 (61.0%) had a history of injecting, and 36 (34.3%) were injecting at the time of death;
- 11 (10.5%) had a blood-borne viral infection recorded in their history, of whom five were co-infected with two or more viruses.

Time between release from prison and death

Of the 105 individuals, 89 had a known date of release. Of these, nine (10.1%) died on day one or day two, and 16 (18.0%) died between day three and day seven. Almost half (42, 47.2%) of the 89 deaths occurred within the first month of release (Figure 1).

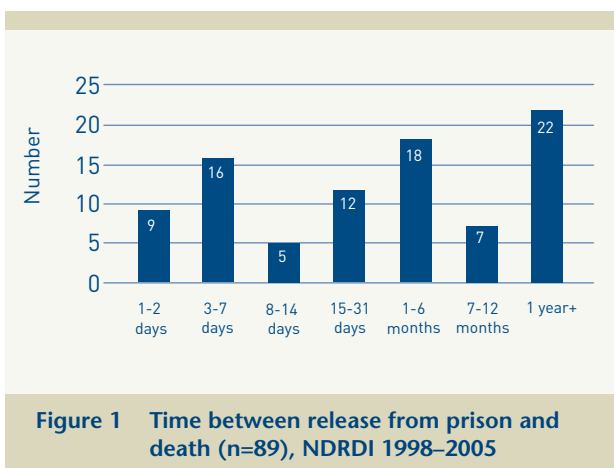


Figure 1 Time between release from prison and death (n=89), NDRDI 1998–2005

Deaths by poisoning within the first month of release

Of the 42 deaths within the first month of release, 38 were due to poisoning (Table 1), and many of those who died were injecting drugs at the time of their death. Of the 14 deaths involving a single drug, 11 involved an opiate, mainly heroin and/or methadone. Of the 24 deaths involving polysubstances, 23 involved an opiate (in addition to one or more other substances).

Table 1 Substances involved in deaths by poisoning within the first month of release (n=38)

Substance	n (%)*
Heroin	19 (50.0)
Methadone	18 (47.4)
Benzodiazepines	11 (28.9)
Antidepressants	6 (15.8)
Stimulants†	7 (18.4)
Other‡	11 (28.9)

* The sum of percentages in this column exceeds 100% as most deaths involved more than one substance.

† Includes cocaine and methamphetamine.

‡ Includes non-benzodiazepine sedatives, unspecified opiates, analgesics containing an opiate compound, anti-psychotics, non-opiate analgesics, alcohol, solvents, cardiac and all other types of medication, including over-the-counter products.

The findings of this study are consistent with those of international studies in this area. The number of cases reported in this study is likely to be underestimated, as history of imprisonment is not routinely recorded in the NDRDI data sources. The study highlights the need for education and awareness among prisoners and their families and friends about the risk of overdose in the days and weeks following release. Many of these deaths are preventable and the findings of the study support the need for an overdose prevention strategy.

(Simone Walsh and Suzi Lyons)

1. See, for example, Binswanger I *et al.* (2007) Release from prison – a high risk of death for former inmates. *New England Journal of Medicine*, 356(2): 157–165; Kariminia A *et al.* (2007) Suicide risk among recently released prisoners in New South Wales, Australia. *Medical Journal of Australia*, 187(7):387–390.
2. See, for example, Jones R, Gruer L, Gilchrist G *et al.* (2002) Recent contact with health and social services by drug misusers in Glasgow who died of a fatal overdose in 1999. *Addiction*, 97: 1517–1522; Seymour A, Oliver J and Black M (2000) Drug-related deaths among recently released prisoners in the Strathclyde region of Scotland. *Journal of Forensic Science*, 45(3): 649–654.
3. Lyons S, Walsh S, Lynn E, Long J (2010) Drug-related deaths among recently release prisoners in Ireland 1998 to 2005. *International Journal of Prisoner Health*, 6(1): 26–32. Available at www.drugsandalcohol.ie/13332.

Finglas Addiction Support Team launches two reports



Pictured at the launch of the FAST reports: Family support group, manager of FAST, and Finglas LDTF and aftercare workers

The Finglas Addiction Support Team (FAST) was established in 2004 and is funded by the Finglas/Cabra Local Drugs Task Force (LDTF). It is a holistic service providing support to individuals and families affected by drug- and/or alcohol-related problems in the greater Finglas area. It offers a number of services, including counselling, support for cocaine users, aftercare support, family support and complementary services.

Pat Carey, TD for Finglas and Minister for Community, Equality and Gaeltacht Affairs, recently launched two reports for FAST, *Services report 2009*¹ and *Strategic plan 2010–2013*.²

Services report 2009 highlights the range and volume of work undertaken by FAST. In 2009, 412 individuals accessed the service.

Of those who accessed cocaine support:

- 50% experienced a reduction in mental health problems such as depression and suicidal thoughts, and paranoia,
- 45% stopped using drugs/became drug free.

Of those who accessed aftercare:

- 90% maintained drug free status,
- 70% moved back into mainstream society.

Of those who accessed family support:

- 80% improved the stability of their family unit,
- 95% increased their knowledge of addiction.

Strategic plan 2010–2013 details the rationale and road map for the service going forward. Key objectives for the coming years include:

- Consolidate existing services and structures,
- Promote a community of acceptance in Finglas,
- Promote genuine person-centred progression routes,
- Balance the service/programme elements of FAST with community development and volunteerism,
- Expand the current premises,
- Prove the business case for FAST and secure additional funding to mitigate budgetary cuts to existing services.

Minister Carey commended Ms Barbara Condon, FAST manager, and all the staff on the quality of their work and the positive outcomes they had achieved, noting in particular the cocaine-specific services and the drug and alcohol services provided. Mr Carey went on to say ‘in terms of alcohol, I am sure all of you here tonight are aware that my Department together with the Department of Health & Children are jointly developing proposals for a National Substance Misuse Strategy that will combine the approaches to alcohol and drugs. This is something that I have advocated for some time and I look forward to proposals going to Government on the matter by the end of the year.’

FAST has recently received funding of 1.5 million Euro through the Department of Community, Equality and Gaeltacht Affairs and Finglas/Cabra Local Drugs Task Force to redevelop their current premises; the work will commence at the end of the summer.

(Mairea Nelson)

1. Finglas Addiction Support Team (2010) *Services report 2009*. Dublin: Finglas Addiction Support Team Ltd. Available at www.drugsandalcohol.ie/13319
2. Russell C (2010) *Strategic plan 2010–2013*. Dublin: Finglas Addiction Support Team Ltd. Available at www.drugsandalcohol.ie/13320

National Registry of Deliberate Self Harm annual report 2009

The eight annual report from the National Registry of Deliberate Self Harm was published in July 2010.¹ The report contains information relating to every presentation of deliberate self-harm to hospital emergency departments in 2009, giving complete national coverage of hospital-treated deliberate self-harm.

In 2009, there were 11,966 presentations of deliberate self-harm, involving 9,493 individuals, to emergency departments. The rate of presentations increased from 200/100,000 of the population in 2008 to 209/100,000 in 2009, a 5% increase. Repeat presentations accounted for more than one in five (21%) of all presentations. The biggest rise in the number of presentations was observed in men, with an increase of 10% on the 2008 figure. This is the second successive major increase in such cases, following an 11% increase in 2008.

For the first time, the report details and maps the incidence of male and female deliberate self-harm by HSE local health office (LHO) area of residence. This, the authors hope, will raise awareness of the problem of deliberate self-harm among LHO primary and community care service providers. Limerick LHO area had the highest male rate and the second highest female rate. Cork North Lee and Louth LHO areas had high rates of deliberate self-harm for men only. Four of the eight Dublin LHO areas (Dublin North Central, Dublin West, Dublin South West and Dublin North West) were associated with high rates of deliberate self-harm for both men and women. In contrast, the incidence of male and female self-harm was low in Dublin South East and Dun Laoghaire.

Concordant with previous reports, deliberate self-harm was largely confined to the younger age groups. Almost half (45%) of all presentations were among people aged under 30 years. Among females, those aged 15–19 years were most likely to present with deliberate self-harm. The increase in male presentations was observed in several age groups. The rate among men aged 20–24 years increased by 21%. There was an increase in the number of 10–14-year-olds presenting.

Drug overdose was the most common form of deliberate self-harm, occurring in 71% of all such episodes reported in 2009. Overdose rates were higher among females (78%) than among males (64%). On average, at least 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 74% of cases. Forty-two per cent of all drug overdoses involved a minor tranquilliser, 29% involved paracetamol-containing medicines and 21% involved anti-depressants/mood stabilisers. The number of deliberate self-harm presentations involving street drugs increased by 26% in 2009 (from 461 to 579).

There was evidence of alcohol consumption in 41% of all episodes of deliberate self-harm and this was more common among men (45%) than women (37%). Alcohol may be one of the factors underlying the pattern of presentation by time of day and day of week. Presentations peaked in the hours around midnight and almost one-third occurred on Sundays and Mondays.

Attempted hanging was involved in 608 of all deliberate self-harm presentations (7% of men and 3% of women). This is the highest number of attempted hangings recorded by the Registry, and was 18% higher in 2009 than in 2008. Self-cutting was used in one in five cases (22%) and significantly more often by men (25%) than by women (19%).

The emergency department was the only treatment setting for 44% of all deliberate self-harm patients, that is, they did not proceed to further treatment.

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

- Provide increased support for evidence-based prevention and mental health promotion programmes.
- Develop and implement initiatives to increase awareness of mental health issues among the general public and service providers supporting the unemployed or people experiencing financial difficulties.
- Develop a system to enable deliberate self-harm data to be linked with suicide mortality data to enhance insight into predictors of suicide risk.
- Restrict access to minor tranquillisers as they are the most common type of medication involved in intentional acts of drug overdose.
- Increase awareness among addiction service professionals and service users of the risk of suicidal behaviour related to drug abuse.
- Enhance health service capacity at specific times and increase awareness of the negative effects of alcohol misuse and abuse, such as increased depressive feelings and reduced self-control.
- Consideration should be given by LHOs to the development of response plans and intervention programmes related to suicidal behaviour.
- Minimum guidelines for the assessment of deliberate self-harm patients should be implemented by the HSE in line with the guidelines of the National Institute for Clinical Excellence in the UK.
- Provide uniform psychosocial and psychiatric assessment to all self-harm patients, paying particular attention to patients using highly lethal methods.
- Prioritise national implementation of evidence-based treatments shown to reduce risk of repetition, such as cognitive behavioural, dialectical behavioural and problem-solving interventions.

(Mairea Nelson)

1. National Registry of Deliberate Self Harm Ireland (2010) *Annual report 2009*. Cork: National Suicide Research Foundation. Available at www.drugsandalcohol.ie/13249

From Drugnet Europe

Drugs and prison: improving our understanding

Cited from article by Linda Montanari and Dagmar Hedrich in Drugnet Europe No. 71, July–September 2010

A considerable proportion of the prison population in Europe is made up of drug law offenders and of drug users who have committed drug-related crime to support their addiction. Drug using prisoners often suffer from health problems (e.g. infectious diseases, mental disorders) and, on account of reduced tolerance are at high risk of a fatal drug overdose after release. Yet, in many countries, drug interventions in the prison setting remain limited.

In this context, the EU drugs action plan (2009–12) sets the goal of developing a methodological framework for monitoring drug use, drug-related health problems and drug service delivery in prisons (1). This work, to be carried out by the European Commission, with the support of the EMCDDA, will be based on steps already taken in this field by the EMCDDA and international organisations (UNODC, WHO). Ultimately, the EU Member States will be asked to endorse and implement a set of indicators to monitor these three factors in the prison setting. ... In 2012, the EMCDDA will publish in its 'Selected issues' series a review of drugs and the prison setting.

New EMCDDA manual for prevention professionals

Reproduced from Drugnet Europe No. 71, July–September 2010

The EMCDDA's Prevention and Evaluation Resources Kit (PERK) is a package of evidence-based prevention principles, planning rules and evaluation tips for prevention professionals. Until recently available only as an online product, this valuable resource has now been released as a printed EMCDDA manual.

Available at www.emcdda.europa.eu/publications/perk

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

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

Health Research Board
Knockmaun House
42–47 Lower Mount Street
Dublin 2
Tel: 01 2345 148; Email: drugnet@hrb.ie

Pharmacy guidelines on safe supply of codeine-based products

The Pharmacy Act 2007 and the Regulation of Retail Pharmacy Businesses Regulations 2008 require that all codeine-based products are dispensed under the supervision of a pharmacist, and that individuals in receipt of the product should receive appropriate counselling. In May 2010, the Pharmaceutical Society of Ireland published guidelines on the safe dispensing of non-prescription products containing codeine.¹ Codeine is an opiate-based analgesic which is controlled under the Misuse of Drugs Acts 1977 and 1984 and is most often sold as a combination drug in non-prescription medication. It is well established that codeine-based medications have the potential to be abused and, if used for long periods, psychological and physical dependence can occur. Withdrawal of codeine in individuals who have taken excess doses over long periods of time may result in restlessness and irritability.

Codeine is used in many popular over-the-counter painkillers (e.g. Solpadeine), often in combination with other non-prescription painkillers such as paracetamol or ibuprofen (e.g. Nurofen Plus). Certain cough medicines and flu remedies also contain codeine.² An individual who takes excess amounts of a combination drug is at risk of the toxic effects of both drugs.

The guide aims to ensure the safe supply of medicines and to support pharmacists in their legal obligation to dispense non-prescription products containing codeine. The main points in the guide are:

- Products containing codeine cannot be displayed in the 'self-selection' area of the pharmacy.
- Codeine-based products should only be dispensed under the supervision of the pharmacist, who should be in a position to consult with the patient so as to determine the appropriateness of the request. Each repeated request should have a separate consultation.

- Education should be provided to the individual in receipt of codeine-based products, including dosage regime, overdose risk, drug interactions, side effects and safe storage.
- Pharmacists should be alert to the possibility that some patients may request codeine-based medicines for symptoms that are in fact secondary to excess codeine consumption.
- Products containing codeine are a second-line treatment and should only be considered when the likes of paracetamol, aspirin and ibuprofen have not been successful in pain management.
- It is the responsibility of the pharmacist to manage the supply and ensure suitable controls are in place for the management of dispensing codeine-based products.
- If a pharmacist suspects that an individual is abusing or dependant on codeine, she/he is obliged to make a reasonable attempt to facilitate the individual in accessing treatment services.
- Advertising medication containing codeine is prohibited; this includes window displays, in-pharmacy promotions, promotional displays and leaflets and stickers.

(Simone Walsh)

1. Pharmaceutical Society of Ireland (2010) *Non-prescription medicinal products containing codeine: guidance for pharmacists on safe supply to patients*. Dublin: Pharmaceutical Society of Ireland. Available at www.drugsandalcohol.ie/13191
2. Irish Medicines Board (2010) *Human medicine product list: codeine*. Accessed 30 July 2010 at www.imb.ie

In brief

On 6 April 2010 **Social Justice Ireland** published its **Socio-Economic Review** for 2010 entitled 'An agenda for a new Ireland'. The authors argue that Ireland's policy-making for more than a decade was guided by false assumptions concerning economic growth, taxation, services and infrastructure, and that many policy failures arose from these false assumptions. They contend that Ireland needs a new vision to guide policy development and decision-making, and set out four core values that should underpin a guiding vision for Ireland – human dignity, sustainability, equality/human rights, and 'the common good'. www.socialjustice.ie

On 7 May 2010 the **Office of the Minister for Children and Youth Affairs** published a report **Study of young carers in the Irish population**. The researchers defined a young carer as 'a child or young person under 18 years whose life is affected in a significant way by the need to provide care for a family or household member who has an illness, disability, addiction or other care requirement'. The research team failed to recruit and interview children and young people of parents with drug or alcohol addictions, and concluded that, as a result, it was 'likely that the final sample does not include the most vulnerable categories of young carers'. www.omcya.ie

In its editorial on 22 May 2010 **The Lancet** (Vol. 375, Issue 9728) applauded US President Barack Obama's five-year National Drug Control Strategy (NDCS), which was released on 11 May 2010: 'Obama's new plan is a welcome departure from the ideologically driven measures of previous administrations and from other countries such as the UK, which have failed on several occasions to use evidence as the basis of drugs policy.' The NDCS aims to reduce the rate of youth drug use and the number of chronic drug users by 15% not only through law enforcement initiatives but also by strengthening efforts to prevent drug use in communities, improving early intervention opportunities in health care, integrating treatment for substance use disorders into health care, expanding support for recovery, and improving information systems. In 2010 the NDCS is focusing on three specific areas: preventing drug use, driving under the influence of drugs, and prescription drug abuse. *The Lancet* comments: 'these are well-chosen priorities since those who reach 21 years without developing an addiction are less likely to do so afterwards, driving under the influence of illegal drugs is now more common than drunk driving in the USA, and the abuse of prescription drugs is the country's most rapidly growing drug problem'. www.thelancet.com and www.ondcp.gov/policy/ndcs.html

For 26 June 2010, **International Day Against Drug Abuse and Illicit Trafficking**, the United Nations Office on Drugs and Crime (UNODC) chose the theme 'Think health, not drugs'. The intention is to raise awareness about the major challenge that illicit drugs represent to society as a whole, and especially to the young. The goal of the campaign is to mobilise support and to inspire people to act against drug abuse. The campaign encourages young people to put their health first and not to take drugs. www.unodc.org

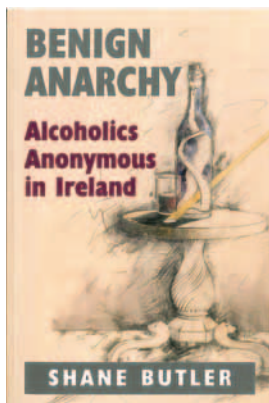
On 6 July 2010 **medicinal cannabis** was the subject of a response to a written question in Dáil Éireann. Minister for Health and Children, Mary Harney TD, stated: 'The current legal position in Ireland in relation to cannabis and cannabis based medicinal products such as Sativex is that they are Schedule 1 controlled substances under the

Misuse of Drugs Act 1977. All Schedule 1 substances are substances which are considered as having no medicinal use and the manufacture, production, preparation, sale, supply, distribution and possession of cannabis and cannabis derivatives is unlawful except for the purposes of research. My Department is aware that claims have been made in respect of Sativex and its possible benefits for patients suffering from certain conditions such as Multiple Sclerosis and cancer. As the law currently stands it would not be possible for Sativex to be licensed here for medicinal use or for a General Practitioner to prescribe it. As cannabis is the drug which is most abused in Ireland, I am reluctant to loosen the controls on its use. However, I am seeking expert clinical advice in this matter and I am open to making a change to the Misuse of Drugs legislation to allow for the use of medicinal cannabis based drugs such as Sativex, if the expert advice indicates that a change is warranted.' www.oireachtas.ie

Between 18 and 23 July 2010 the **XVIII International Aids Conference (AIDS 2010)** was held in Vienna. The conference issued an official declaration, the **Vienna Declaration**, which seeks to improve community health and safety by calling for the incorporation of scientific evidence into illicit drug policies. Drafted by a team of international experts, the Declaration states: 'The criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences. A full policy reorientation is needed ... Reorienting drug policies towards evidence-based approaches that respect, protect and fulfil human rights has the potential to reduce harms deriving from current policies and would allow for the redirection of the vast financial resources towards where they are needed most: implementing and evaluating evidence-based prevention, regulatory, treatment and harm reduction interventions.' Scientists, health practitioners, organisations and the public around the world are being invited to endorse this document in order to bring these issues to the attention of governments and international agencies, and to illustrate that drug policy reform is a matter of urgent international significance. www.viennadeclaration.com

On 26 July 2010 the **UK Drug Policy Commission (UKDPC)** published **The impact of drugs on different minority groups: a review of the UK literature**. This review found that drug services were of 'little relevance' to many in Britain's diverse communities, including LGBT (lesbian, gay, bisexual and transgender) groups, disabled people and BME (black and minority ethnic) communities. The authors argue that a better understanding of drug use within diverse minority communities is needed to reduce drug problems. Appropriate data-gathering and intelligence-sharing mechanisms could also be used to flag health risks associated with the use of new drugs within these groups before their use becomes widespread. www.ukdpc.org.uk

(Compiled by Brigid Pike)



Recent publications

On our shelves

Books recently acquired by the National Documentation Centre on Drug Use

Benign anarchy: Alcoholics Anonymous in Ireland by Shane Butler

Publisher: Irish Academic Press
Date of publication: 2010
ISBN: 9780 7165 3064 0 (paper)

Journal articles

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

What are the risk factors for soft tissue abscess development among injecting drug users?

Maloney S, Keenan E and Geoghegan N
Nursing Times.net 2010; 106(23)
www.drugsandalcohol.ie/13439

Background: Much research has been conducted on the risk taking behaviour of injecting drug users. Cutaneous or subcutaneous skin and soft tissue abscesses are common complications of intravenous drug use.

Aim: To identify the risk factors to which injecting drug users expose themselves to improve initial assessment.

Method: A convenience sampling method was used, and structured interviews were carried out with 70 injecting drug users attending a methadone treatment setting in Dublin.

Results and discussion: Forty-eight (69%) participants have had an abscess at some stage. Poor levels of skin cleansing were identified as a main cause, and 80% admitted to sharing injecting equipment.

Conclusion: Healthcare professionals need to develop better strategies for delivering safety messages to clients about safer injecting behaviour.

Longitudinal outcomes for treated opiate use and the use of ancillary medical and social services

Comiskey C and Stapleton R
Substance Use & Misuse 2010; 45(4): 628–641
www.drugsandalcohol.ie/13079

Using an extended Maudsley Addiction Profile, 404 opiate users entering treatment across Ireland were interviewed at intake, at one year and at three years between 2003 and 2006. At three years clients were abstinent, in treatment, or relapsed. Analysis of lifetime use of treatment services revealed that greater proportions of those who were drug free at three years had had counselling in the past. Multiple regression revealed that the number of previous treatment episodes had a significant positive effect on outcomes. Findings are important during times of financial constraint,

when treatment providers are under pressure to cut back to core services.

Cannabis and hyperemesis

Harris E, McDonagh M and Kennedy N
Irish Journal of Psychological Medicine 2010; 27(1): 47–48
www.drugsandalcohol.ie/12950

The adverse effects of marijuana are well documented, as well as its positive therapeutic uses. Cannabis has traditionally been associated with an antiemetic action following acute ingestion and synthetic cannabinoids have an established use as anti-emetics for chemotherapy induced nausea. However, there has been limited recognition of chronic cannabis use as a cause of cyclical vomiting syndrome. Cannabinoid hyperemesis was first identified by Allen et al in 2004. Compulsive bathing was also described as part of the clinical picture. This same syndrome has been confirmed a number of times in the medical literature in the interim. The condition has, to our knowledge, never been reported, in a psychiatric patient.

Absinthe and suicidality

Rizvi N, Whitty M and Daly R
Irish Journal of Psychological Medicine 2010; 27(1): 44–45
www.drugsandalcohol.ie/12951

Absinthe is an alcoholic drink which is becoming more widely consumed after being banned for many decades. An association between absinthe use and psychiatric symptoms, ranging from impairment of concentration to marked hallucinations and seizures, has been suggested, but evidence remains unclear. Thujone, identified as a possible psychoactive ingredient, has recently been implicated in absinthe's putative neuropsychiatric effects. This report presents a case where acute suicidality emerged during absinthe consumption; possible neurobiological aetiological mechanisms and the history of absinthe use and associated adverse effects are reviewed.

Suppression effects of partner type on the alcohol-risky sex relationship in young Irish adults

Cousins G, McGee H and Layte R
Journal of Studies on Alcohol and Drugs 2010; 71(3): 357–365
www.drugsandalcohol.ie/13412

Objective: The present study examined the link between alcohol consumption and condom use, testing whether partner type suppresses the effects of alcohol consumption on condom use. This study also sought to determine whether the effects of alcohol on condom use during casual sex remain after adjusting for condom-use intentions and planning or preparatory behaviors, such as having a condom available.

Method: A retrospective, cross-sectional study design was used. A subset of participants aged 19–30 years from the national Irish Study of Sexual Health and Relationships were recontacted (n = 388). Telephone interviews regarding participants' most recent sexual event in their normal social

Recent publications *(continued)*

environment (i.e., not on holidays) were conducted (n = 362). Partnership type was defined as 'just met', 'casual' or 'steady'. Men comprised 51% of the sample. The mean age was 23.9 years.

Results: Both alcohol consumption and condom use were more common in casual sexual events than steady sexual events. In addition, partnership type was found to suppress the effects of alcohol consumption on condom use, such that the relationship between alcohol consumption and condom use became significant and negative only after controlling for partner type. Furthermore, the negative effects of alcohol consumption on condom use during casual sex remained after adjusting for condom-use intentions and planning.

Conclusion: These findings illustrate the complexity of the relationship between alcohol consumption and condom use, highlighting the importance of contextual factors such as partner type. Furthermore, the effects of alcohol on condom use during casual sex cannot be explained by the fact that such events tend to be more spontaneous and less planned.

Deliberate self-harm (DSH) out of hours presentation

McNicholas F, O'Sullivan M, Lennon R, Doherty M and Adamson N

Irish Journal of Psychological Medicine 2010; 27(1): 11–14
www.drugsandalcohol.ie/12952

Objective: To establish time of presentation to paediatric accident and emergency (A&E) services of children with deliberate self-harm (DSH).

Method: All children presenting to an acute paediatric hospital with DSH or suicidal ideation between 1993–2003 were identified and time of presentation collected from their case notes.

Results: Of the 172 children where the actual time of presentation was recorded, 137 (80%) presented to the hospital outside of the 'normal working hours' of 9am–5pm, Monday–Friday. These children represent an at-risk group, and were more likely to have consumed alcohol, to have made a suicide attempt, and to have a family history of psychiatric illness than children presenting within normal working hours.

Conclusion: DSH in young people is a significant public health problem in Ireland and is a major risk factor for completed suicide. Access to an out-of-hours, on-call Child and Adolescent Psychiatry (CAP) services is essential if these children are to have a mental health assessment, as recommended by the Royal College of Psychiatry and National Institute of Clinical Excellence. These services need to be urgently developed.

Upcoming events

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

September

9 September – 23 October 2010

Dublin 8 Art by Dublin 8 Artists

Venue: National College of Art and Design, Thomas Street, Dublin 8

Organised by / Contact: RADE (Recovery through arts, drama and education) www.rade.ie

Information: On 9 September RADE will launch 'Portraits', a collection of the group's creative writing stories, facilitated by poet Paula Meehan, along with their first ever Retrospective Art Exhibition showcasing artwork from the past five years. This will be RADE's first time showcasing their work in the NCAD and we are delighted with the freedom and space that has been allowed to us. We are also thrilled that for the first time ever we are able to display the artistic talents of the different groups that have been in RADE since the organisations first exhibition in 2005. The showcase runs until 23 October.

23 September 2010

Shifting Focus: from Criminal Justice to Social Justice

Venue: Gresham Hotel, Dublin 1

Organised by / Contact: Irish Penal Reform Trust, Barnardos and the Irish Association of Young People in Care (IAYPIC)
Email: info@iprt.ie www.iprt.ie

Information: At a time of a deepening economic and social crisis, we want to propose a simple yet proven idea – that a shift in resources from criminal justice to social justice makes social and economic sense. Informed by a common commitment to human rights and social justice, IPRT has come together with Barnardos and IAYPIC to analyse how this idea can be put in practice.

To this end, we will host a one-day conference to consider how Ireland might begin to refocus our approach to crime and social

policy in line with these principles. The conference will hear from leading Irish and international speakers, who will address the social and economic dimensions of crime, and explore the theory and practice of how interventions can be designed to achieve effective results.

27 September 2010

Together – Making A Difference

Venue: Liberty Hall Theatre, Eden Quay, Dublin 1

Organised by / Contact: North Inner City Drugs Task Force
Email: admin@nicdtf.ie; tel: 01 8366 592 www.nicdtf.ie

Information: The theme of this one-day conference is: Responses to drugs problems for individuals, family and communities – contexts, achievements, challenges. The event will include:

- Exhibits and information about NICDTF projects and actions;
- Recorded and live short displays of local involvement;
- A panel discussion among community activists on the North Inner City in the last 15 years;
- Comments on local actions and national drugs strategies from Minister Pat Carey TD, NICDTF Chair Joe Barry and community/NGO activists.

October

9–10 October 2010

Family Support Network Annual Work Conference

Venue: Fairways Hotel, Dundalk

Organised by / Contact: Family Support Network
Email: info@fsn.ie; tel: (01) 836 5168 www.fsn.ie

Information: The FSN Annual Work Conference brings together members of family support groups and individual family members living with drug use. Over 350 family members attend on an annual basis. The conference is an opportunity

for family members to discuss and inform themselves on the different issues affecting their lives as a result of drug use. This year's conference will include discussion of national policy developments and training workshops. A key element of the conference is that it provides respite for family members and this is supported by family members volunteering their time to provide holistic therapies. If you would like to volunteer to provide holistic therapies during the conference please call Megan on (01) 836 5168.

11–17 October 2010

Cork Drug Awareness Week 2010

Venue: Various community / city-wide venues in Cork
Organised by: Cork Local Drugs Task Force Projects
Email: Gemma.OLeary@hse.ie mimagee@partnershipcork.ie
www.corkcitypartnership.ie for detailed schedule of the week. Cork Local Drugs Task Force website will be re-launched during the week.

Information: The aim of Cork Drug Awareness Week is to raise awareness and signpost information so that communities, families and individuals know where to go for information and support on drug and alcohol issues. Various Cork Local Drugs Task Force projects are organising information events / coffee mornings / holistic therapies etc. in community settings across the city throughout the week. The programme includes events for youth, families, parents, and minority communities. Mark Johnson (author of 'Wasted') is a featured speaker. Topical DVDs will be screened and a memorial event for those who have lost family members or friends to drugs or alcohol will also take place. Topics covered by speakers include heroin, prescription drugs and family support, among others.

15 October 2010

A Community Drug Problem: defining the problem – defending the responses

Venue: St Andrews Resource Centre, Pearse Street, Dublin 2
Organised by / contact: CityWide Drugs Crisis Campaign
Email: info@citywide.ie; tel: 01 836 5090/ 01 836 5039
www.citywide.ie

Information: This conference is an opportunity for those working in local community projects and groups to come together with local and regional drugs task force community representatives to discuss some of the key issues facing communities responding to the continuing drugs crisis. Minister Pat Carey will open the conference. Our key note speaker is Brian Harvey, who has just completed research on the impact of the last budget on the community and voluntary sector. He will address this conference specifically on the impact of government cuts on communities and community drugs services.

The conference is divided into three main sections:

- Engaging 'communities of interest' locally, regionally and nationally in service provision and policy development
- Challenges for communities with the Alcohol Strategy roll-out and findings in one area of changing patterns of drug use
- Community safety – overview of local, national and international responses.

November

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: See p. 1 of this issue.

17 November 2010

Addiction: the case for recovery in a changing world

Venue: Congress Centre, London W1B 3LS
Organised by / Contact: Medineo for Medical Events
Tel: +357 25 878844
www.medineo.org

Information: This conference will look at the evidence base to support recovery and to inform the field on what it takes to build recovery capital in our towns and cities. Leaders in the field will discuss the evidence base for drug and alcohol recovery models and what the implications are for therapeutic interventions. Using examples of best practice we will explore how drug treatment systems can gear up for the increased demand for recovery options from the public; the political support for recovery options and how to make this possible within the economic climate. We will also look at how new political drivers and the economic context plays in to this agenda and will build the economic argument for ensuring that drug and alcohol treatment systems include viable recovery options.

May 2011

23–24 May 2011

Fifth annual ISSDP conference

Venue: Utrecht, The Netherlands
Organised by / Contact: International Society for the Study of Drug Policy (ISSDP) / Alex Stevens
Email: enquiries@issdp.org www.issdp.org

Information: Further information about the conference and a call for abstracts will be available on the society's website in due course.

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