drugnet IRELAND

Issue 38
Summer 2011

Alcohol and Drug Research Newsletter

National drugs strategy goes to Department of Health

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CityWide conference on drug-related intimidation

Pictured at the CityWide conference: Mel MacGiobúin of the North Inner City Drugs Task Force and Independent TD Maureen O'Sullivan

CityWide Drugs Crisis Campaign hosted a conference in May of this year addressing the issue of drug-related crime and intimidation. Over 80 people attended the half-day event in Ballybough Community Centre in Dublin's north inner city. The conference followed an event in October 2010 at which CityWide hosted a meeting titled: 'A community drug problem: defining the problem – defending the responses', where the issue of intimidation emerged as a central issue for many communities throughout Dublin.[1]

In 2009 the Family Support Network (FSN)[2] published the findings of research into the issue of intimidation of the families of drug users by those involved in drug dealing.[3] Through its work, the FSN became aware of a large number of families experiencing intimidation as a result of a family member's drug-related debts. The intimidation of drug users and their families has also been highlighted as a key issue in the National Drugs Strategy 2009–2016 (NDS).[4] Action 5 of the NDS aims 'To develop a framework to provide an appropriate response to the issue of drug related intimidation in the community.'

The CityWide conference began with four short presentations. Detective Superintendent Michael O'Sullivan of the Garda National Drugs Unit reported on a pilot project in the Dublin Metropolitan Region. Established in March for a six-month trial period, the pilot works closely with the Family Support Network, and is designed to provide families and the wider community with a point of contact with the Garda Síochána. The project is to be reviewed at the end of August and, following feedback from stakeholders, is to be rolled out nationally.

Graham Ryall, a community activist in the Canal Communities in Dublin's south inner city, set the current issues against the historical backdrop of the 1980s and 1990s when anti-drugs groups such as the Concerned Parents Against Drugs (CPAD) emerged throughout the city to tackle drug dealing. In recent years, a partnership approach in Dolphin House involving the gardaí and local residents managed to put an end temporarily to open drug dealing. However, the economic downturn and the 'shelving of plans' to regenerate Dolphin House has, according to Ryall, 'had a major negative impact on the community'.

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CityWide conference *(continued)*

The third speaker, Audra Cotter of the Clonmel Community Based Drugs Initiative in Tipperary, reported on an inter-agency initiative which has been positively evaluated and which is currently being rolled out across the south east region. Prior to this initiative, families who needed advice or direction from the gardaí were reluctant to attend the local Garda station for a number of reasons, including the lack of consistency in the Garda personnel they would encounter. Now, families can meet specific gardaí from the Community Policing Unit in venues in which they feel safe and comfortable.

Johnny Connolly of the HRB highlighted the limited knowledge base in this area and the general failure of research and other information sources historically to properly reflect the local impact of drug-related crime and intimidation on the individuals, families and communities most affected. He cited a recent Limerick study to illustrate the way in which gangs can employ a variety of strategies, from serious violence to verbal abuse and vandalism by young children, to instill fear and impose territorial control on communities.[5] In terms of building sustainable responses, the potential of community-based mediation and the further enhancement of Joint Policing Committees were highlighted.

The final part of the conference was dedicated to workshops where participants addressed the following three questions:

- What is the level of intimidation in your community?
- How has your community responded to the issue of intimidation so far?
- What actions need to be taken?

The level and types of intimidation reported ranged from graffiti and low-level harassment directed at vulnerable people to the killing of family pets, beatings, stabbings, hostage taking, the petrol bombing of people's homes, threats of and actual sexual violence, shootings and murder. Threats of violence come from money lenders as well as from drug dealers. Gang members were known to wait outside post offices and dole offices to collect money from dependent drug users. Individuals also reported being forced to smuggle drugs into prison as part payment of a drug debt. Although many people turned to credit unions to pay drug debts, it was reported that many credit unions are now refusing to provide loans in such circumstances.

Single mothers living alone were particularly vulnerable; having to store or smuggle drugs as payment for a child's drug debt contributed to high stress levels, leading to illness and depression. In such circumstances, the growing dependence of such people on prescription drugs exposes an ironic connection between illicit and licit drug markets. A rise in suicides by those in debt was also reported, although the debt does not die with the person. Another ominous development was the disruption of local drug projects, either through graffiti or with gang members loitering outside projects to intimidate drug workers and clients. Outreach and healthcare workers reported being unable to enter certain areas because of control exerted by individuals or gangs.

With regard to community responses, all areas represented at the conference reported a reluctance to report incidents to the gardaí due to fear of reprisals. One immediate consequence of this is that the true levels of intimidation are not officially recorded anywhere. Where people did make formal complaints, it was felt that a promise of full Garda protection was not forthcoming. Community policing fora, where they existed, did help to build trust between the Garda Síochána and the local community. Also, an increase in Garda presence on the ground was reported as having a positive effect, although it could not be sustained over the long term. Similarly, CCTV had limited or no impact, as footage captured on cameras was reportedly not regularly monitored. Where it was monitored, the issue appeared to be simply displaced elsewhere.

A recurring theme related to drug-related intimidation within the Traveller community. The close-knit and isolated nature of the community meant that issues were seldom if ever reported to the gardaí. Where Travellers did report to the gardaí, other minor issues such as road tax were sometimes raised with the complainant, leaving them reluctant to engage further with the gardaí.

Services also face difficulties working with young people who are themselves involved in intimidating others, as some will arrive in to services in bullet-proof vests and carrying guns. On the other hand, a great deal of positive youth work was reported at the conference, including efforts to encourage problematic youth into facilities and exploring perceptions of crime among young people. Another initiative involved young people working with senior citizens, teaching them how to use computers, for example. A local area partnership initiative involved attempts to promote a positive sense of community in response to anti-social behavior. Despite these positive examples, in general, most delegates at the conference reported a sense of frustration at the absence of effective responses to the serious issues being confronted.

With regard to possible future approaches, a range of ideas was discussed, including:

- More secure ways of reporting problems and more protection for those reporting.
- A 'Dial to Stop Intimidation' service, to be promoted as a community-based campaign, taking the emphasis away from Garda involvement so as not to

CityWide conference *(continued)*

deter people from making calls. Community workers could also assist service users to make reports using this mechanism.

- An evidence base of incidences of intimidation, initially to be compiled informally at local level.
- More resources into early interventions and youth development work.
- Joint Policing Committees be made more effective and accountable.
- The court system to fast track intimidation charges and to ensure that evidence could be given safely.
- Community-based mediation, and community representatives to mediate safety issues with drug dealers.
- A national conference/national day on intimidation to highlight the issue and create unity among communities.

It was agreed that the Citywide Drugs Crisis Campaign would facilitate the establishment of an Intimidation Working Group comprising specialists from various agencies and representatives from the community and voluntary sector. The full conference report is available on CityWide's website at www.citywide.ie.

(Johnny Connolly)

1. Connolly J (2010) CityWide conference discusses drug-related intimidation. *Drugnet Ireland*, (36): 24.
2. The FSN was established in 2000 to support the development of family support groups throughout Ireland. There are currently over 70 family support groups affiliated to the FSN.
3. O'Leary M (2009) *Intimidation of families*. Dublin: Family Support Network. Available at www.drugsandalcohol.ie/12898. See also Connolly J (2010) Drug-related intimidation of drug users and their families. *Drugnet Ireland*, (33): 18.
4. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
5. Hourigan N (ed.) *Understanding Limerick: social exclusion and change*. Cork: Cork University Press.

National drugs strategy goes to Department of Health

Transfer of functions from the Department of Community, Equality and Gaeltacht Affairs

With effect from 1 May 2011, the functions of the disbanded Department of Community, Equality and Gaeltacht Affairs transferred to other reconfigured Departments. The table below sets out the functions relevant to the drugs issue and the Departments to which they have transferred.

Function	Department responsible	Website
Community and rural development (including PEACE and INTERREG, dormant accounts and the Western Development Commission)	Department of the Environment, Community and Local Government	www.environ.ie
Co-ordination of the National Drugs Strategy	Department of Health	www.dohc.ie
Equality, human rights, integration and disability	Department of Justice and Equality (these functions transferred with effect from 1 April 2011)	www.justice.ie
Charities regulation	Department of Justice and Equality	www.justice.ie
Social inclusion	Department of Social Protection	www.welfare.ie
Family policy	Department of Children and Youth Affairs	www.omc.gov.ie

Taken from a notice posted on the home page of the Department of Community, Equality and Gaeltacht Affairs (www.pobail.ie) on 11 May 2011

New units in the Department of Health

The functions relating to the co-ordination of the National Drugs Strategy have been assigned to two new units created in the Department of Health.

Drugs Programme Unit
The main function of this unit is to manage the Drugs Initiatives Programmes, which are primarily drug-related projects and initiatives in drugs task force areas.

Drugs Policy Unit
The main function of this unit is to oversee the implementation of the National Drugs Strategy 2009–2016 through the five pillars of supply reduction, prevention, treatment, rehabilitation and research.

These new units can be contacted by email at dpu@health.gov.ie

National drugs strategy goes to Department of Health *(continued)*

The National Advisory Committee on Drugs (NACD) now also comes within the remit of the Department of Health. Its main function is to advise the minister and the government in relation to the prevalence, prevention, treatment and consequences of drugs misuse. It also conducts and commissions research in relation to drug misuse.

Co-ordination of drugs policy

Roisín Shortall TD, Minister of State at the Department of Health

On 31 May 2011 Roisín Shortall TD, the Minister of State at the Department of Health with responsibility for Primary Care, with lead responsibility for the National Drugs Strategy 2009–2016, responded to questions put to the Minister for Health in Dáil Éireann with regard to how drug policy will be co-ordinated at ministerial and departmental level.[1] She and the Minister for Health, James Reilly TD, will both have roles – the Minister at Cabinet level, the Minister of State at Cabinet Committee level. While confirming that the Oversight Forum on Drugs (OFD) and the Drugs Advisory Group (DAG), established under the National Drugs Strategy, will both continue, she went on to talk solely about an 'oversight committee', the quarterly meetings of which she will chair, which indicates that she is referring to the OFD.

> The NDS is a cross cutting area of public policy and service delivery and it is based on a co-ordinated approach across many Departments and agencies in conjunction with the community and voluntary sectors. The institutional arrangements to support cross agency working, advise on operational and policy matters, assess progress across the strategy and address any operational difficulties include the drugs advisory group and the oversight forum on drugs. I intend that the work of these bodies will continue, …
>
> With regard to implementation of the strategy, there is an oversight committee, which I will chair, and that will continue to meet on a quarterly basis and identify any logjams, difficulties or delays in implementing the strategy. We are, therefore, serious about ensuring it is implemented in full. In addition, the Minister will be responsible for this issue at Cabinet level and it will continue to have a voice at the Cabinet table. The Cabinet sub-committee on social exclusion will deal with this issue as well and many of the officials involved in the oversight will feed into the sub-committee. It will receive attention there and the sub-committee will meet later this week. I will attend that meeting and I will be a voice in respect of the NDS. …
>
> The purpose of the oversight committee is to address issues such as crystal meth and other developments relating to illegal drugs. All the relevant bodies are represented at a senior level and one of the committee's functions is to update all the members on current trends in respect of drug misuse. I give an assurance that all of the relevant agencies are represented at a senior level. I will convene the first meeting of the oversight committee in the coming weeks.

(Brigid Pike and Mairea Nelson)

1. Shortall R (2011, 31 May) *Parliamentary Debates Dáil Éireann (Official report: unrevised). Priority questions.* Vol. 733, No. 4, p. 10. National Drugs Strategy. Question 42. http://debates.oireachtas.ie/dail/2011/05/31/00010.asp

Programme for Government 2011–2016: measures that may impact indirectly on the drugs issue

In the last issue of *Drugnet Ireland*, the directly drug-related measures contained in the new Programme for Government were outlined.[1] Other measures included under the broad heading of Fairness in the new Programme, which may be expected to impact indirectly on the drugs issue, are noted below.[2]

Health and mental health

The proposed Universal Health Insurance (UHI) will guarantee equal access to care for all, in both the primary care and the hospital systems. There will be no discrimination on the grounds of income or insurance status: in line with the European principle of social solidarity, access will be according to need and payment will be according to ability to pay.

The government intends to establish an Integrated Care Agency to oversee the flow of resources between the different arms of the health system, in order to incentivise the provision of care in the best setting.

With regard to mental health, the government endorses the recommendations contained in *A vision for change*. Ring-fenced funding will be provided to recruit additional psychologists and counsellors to community mental health teams, working closely with primary care teams to ensure early intervention, reduce the stigma associated with mental illness and detect and treat people who are at risk of suicide.

Education

The government states that 'education is at the heart of a more cohesive, more equal and more successful society'. As resources allow, it will invest in a targeted early childhood education programme for disadvantaged children, building on existing targeted pre-school supports for families most in need of assistance such as the Ballymun Youth Action project.

Programme for government *(continued)*

Having considered the recommendations contained in the review of DEIS, the government will use DEIS as the platform for new initiatives to deliver better outcomes for students in disadvantaged areas. It will also examine how to make existing expenditure on educational disadvantage more effective, and innovative ways in which teenagers at risk of leaving the school system may stay connected, for example through use of ICT-based distance learning and projects such as iScoil.

Housing

Believing that prevention is better than cure, the government pledges to aggressively target the root causes of homelessness. By having a dedicated body to co-ordinate policy across government, it will target initiatives across departmental domains that will help to prevent problems like homelessness. The government is also committed to ending long-term homelessness and the need to sleep rough. It intends to review and update the existing Homeless Strategy, including a specific focus on youth homelessness. It endorses the 'housing first' approach, first championed in Ireland by the Homeless Agency in Dublin. Finally, the government is committed to urban regeneration to revitalise communities in areas such as Limerick in order to give families a better quality of life.

Justice and law reform

Anti-social behaviour, viewed as 'so destructive of community life', will be tackled through strengthening existing interventions such as community policing partnerships and forums, community policing, and alternative programmes for juvenile offenders such as the Juvenile Liaison Officer Scheme, the Garda Juvenile Diversion Programme, and the use of restorative justice measures. A 12-month probationary period will be imposed on all new tenants public or social housing, and where tenants engage in anti-social behaviour during this probationary period, the tenancy will be terminated. The government also plans to examine outcomes-based contracts with community organisations to help reduce reoffending by young people, based on the social impact bond model in the UK.

The prison inspectorate is to be strengthened. The office of the Inspector of Prisons will be put on a statutory footing. The Inspector of Prisons will make an annual report to the Minister for Justice and the Oireachtas Justice Committee, and will be empowered to appear before that Committee on such other occasions as may be appropriate. Prison visiting committees will furnish their reports to the Inspector of Prisons who will be under an obligation to publish them.

Equality and social protection

Reiterating the principle of social solidarity, already mentioned in relation to health, the government pledges to tackle Ireland's economic crisis in a fair and balanced way. It lists a raft of measures to tackle poverty and protect the most vulnerable in society including those on social welfare benefits, the low paid, and the self-employed. With regard to child poverty, the government will 'adopt a new area based approach to child poverty, which draws on best international practice and existing services to tackle every aspect of child poverty. Initially, this model will be rolled out to up to ten of Ireland's most disadvantaged communities, in cooperation with philanthropic partners.

(Compiled by Brigid Pike)

1. Connolly J, Pike B, Keane M and Lyons S (2011) Drugs policy in the new programme for government. *Drugnet Ireland*, (37): 1–2.
2. Fine Gael and the Labour Party (2011) *Government for national recovery 2011–2016*. www.taoiseach.gov.ie

What's Working for Children conference

A recent conference focusing on intervention and prevention for children, youth and their families, highlighted current research and evaluation of evidence-based programmes conducted over the last 10 years. What's Working for Children, organised by Archways in conjunction with the Office of the Minister for Children and Youth Affairs and Atlantic Philanthropies, took place in Dublin in May. Barnardos and other organisations working directly and indirectly with disadvantaged children also supported the conference. Experts in evidence-based practice from the US, the UK and Ireland presented the positive outcomes for children and families from well-implemented programmes and demonstrated the cost effectiveness of these programmes to government.

Over 300 delegates from the community, voluntary and statutory sectors, including representatives of drugs task forces and other agencies working with children, youth and families, attended the conference.

Minister for Children and Youth Affairs Frances Fitzgerald delivered the opening address. She spoke about the government's commitment to children and youth in Ireland, illustrated by the decision to appoint a full cabinet minister and to amalgamate functions relating to children into a single department. She also endorsed the value of evidence-based programmes which she said was a priority of government.

Dr Steve Aos, Director of the Washington State Institute for Public Policy, spoke about the economic value to be gained from implementing evidence-based early intervention programmes. The benefits include reductions in child welfare interventions and in crime levels. Cheryl Hopkins of Birmingham City Council outlined the portfolio of evidence-based programmes that form part of their 'Brighter Futures' strategy to improve the lives of children and young people in Birmingham. The council has allocated an investment of £41.7m over 15 years to evidence-based programmes and she anticipates a considerable return from this investment in terms of better outcomes for children and youth, and reduced costs in other areas such as child welfare and

What's working for children *(continued)*

criminal justice. Dr Karen Blase of the University of North Carolina shared her expertise in relation to fidelity in implementing evidence-based programmes – ensuring that programmes are implemented as they are intended so that they achieve the expected results.

In addition to informative keynote presentations and engaging panel question and answer sessions, there were 12 practice-based seminars which showcased evidence-based programmes throughout Ireland, including the Triple P programme in Longford/Westmeath, Start Strong in Ballymun and Incredible Years in Limerick. Several drugs task forces support projects based on the Strengthening Families Programme. There was a presentation on one of these projects, the Mate-Tricks Programme, in the Tallaght West Childhood Initiative seminar.

Further information, including video recordings, speaker's presentations and a summary conference report, is available from www.whatsworkingforchildren.org

We would like to thank Eamonn Gillen and Aoife Stack of Dún Laoghaire Rathdown Local Drugs Task Force, with input from Helen Cahill, for preparing this report of the conference.

What do children want to know?

Every four years some 40 countries survey their school-aged children in order to find out about their health and well-being, health behaviours and their social context and to inform future health promotion policies. Known as the Health Behaviour in School-aged Children (HBSC) study, this survey uses a methodology and protocol chosen in collaboration with the WHO Regional Office for Europe. Ireland has participated in this project since the 1990s and the results of the fourth iteration of the study in Ireland, undertaken in 2010, are due to be published in the near future.[1]

In undertaking this research and disseminating the findings over the years, HBSC Ireland has liaised with various stakeholder groups, with one exception – school children themselves. Following the completion of the third iteration of the survey in 2006, it was decided to rectify this omission. The Health Promotion Research Centre at National University of Ireland Galway undertook an exploratory study of Irish school students' views on the questions contained in the HBSC survey.[2]

Students aged 10–18 years in mixed gender primary and post-primary schools, both advantaged and disadvantaged, in urban and rural areas, took part in participatory workshops with HBSC researchers. They were invited to identify which of the 51 HBSC topics they found most interesting and to document what they would like to know about the top 12 topics that they had selected.

The top five 'most interesting' topics included, in descending order of priority as determined by the school students, use of alcohol, puberty, drugs, getting drunk and smoking,. The broad types of questions that the workshop participants identified in relation to each of these five topics are as follows.

1. Alcohol – types and makes, why drink and the cost, age and how many, effects, drinking amounts?
2. Puberty – what is it, what happens and why, body changes and effects, age and gender, does it hurt, pregnancy and sex?
3. Drugs – what are they and types, how are drugs made, sources, cost, effects, why use them, addiction and quitting?
4. Being really drunk – how it works, how many, how much, effects, age and source, why get drunk?
5. Smoking – types and makes, cost and how many, age and gender, effects, addiction, quitting?

The authors concluded, 'Within this study, children have clearly articulated the HBSC topics that were of most interest to them and what they would like to know about these topics, resulting in a reference document for those working in health practice and policy. ... The questions that the students have about health and well-being need to be answered, through both school and out of school settings' (p. 23).

(Brigid Pike)

1. Reports on the results of the 2002 and 2006 HBSC surveys in Ireland may be found in *Drugnet Ireland*, Issues 8 and 24.
2. Doyle P, Kelly C, Cummins G, Sixsmith J, O'Higgins S, Molcho M and Nic Gabhainn S (2010) *Health behaviour in school-aged children: what do children want to know?* Dublin: Office of the Minister for Children and Youth Affairs and the Department of Health and Children.

Drug prevention in the family

Family policy development, including supports for family-based drug prevention, could benefit from a child-centred ethos that takes account of the developmental needs and rights of individual children. Children's views on what constitutes safe and effective discipline could be incorporated into existing parenting programmes that seek to provide support for parents. These are just some of the conclusions of a recently published study of Irish children's perspectives on parenting styles and discipline.[1]

The overall aim of this study was to explore the views of children and young people, including their perceptions of the effects of different parenting styles and disciplinary strategies on their lives. A qualitative approach was used, involving focus group interviews with children and young people aged between 6 and 17 years. The study was carried out jointly by the School of Psychology and the Children's Research Centre, Trinity College, Dublin, and the Centre for Social and Educational Research in the Dublin Institute

Drug prevention in the family *(continued)*

of Technology, and was commissioned by the Office of the Minister for Children and Youth Affairs.

Parenting styles

Children's descriptions of what parents do in a family revealed a variety of parental roles, from providing sustenance, protection and support, to monitoring and regulating, guiding and teaching, to facilitating children's independence and autonomy. The authors reported that parental control was seen as necessary and good, and particularly important to prevent children from engaging in risk behaviour and to keep them safe, for example to ensure they were not 'going out drinking or doing drugs', as one boy in 1st year said.

Parent and child roles were perceived to change over time, with dependence on parents decreasing as children grew older. Given adolescents' need for autonomy and independence, the authors observed that parenting at this stage brought novel challenges for regulation and control of behaviour at a time when the likelihood of risk-taking behaviour may be heightened.

Parental control

The research revealed that Irish parents are important figures of authority and control for their children. Key aspects of this role were perceived to be monitoring and checking children's activities and whereabouts, enforcing limits and boundaries, and disciplining children. Parental monitoring was reportedly facilitated largely through talking, asking questions and via mobile phones. Parents were also perceived as 'all-knowing' and attentive to familiar and unfamiliar patterns of behaviour.

Older children emphasised the need for parents to negotiate rules and regulations with their adolescents, rather than imposing restrictions upon them as might be done with younger children, and the need to establish trust, which was seen as a prerequisite to effective monitoring and developing children's sense of responsibility. A boy in Transition Year expressed it thus: 'Kids have to be trusted, you know. You read sometimes about home drug-testing and things like that and you think, well it's obviously going to be something wrong with the family dynamic here if the parents are going behind their kid's back to do something like that. Trust your kids … you know, give them responsibility.' (p. 44)

Discipline

Discipline strategies identified by the children were classified by the researchers into three categories:

- *power-assertive responses*, including the removal of privileges, time-out, grounding, being allocated extra chores or physical punishment;
- *inductive responses*, involving communication about behaviour and its consequences, and reinforcement of positive behaviour; and
- *love withdrawal*, where parents express their disappointment in their children with the intention of inducing feelings of guilt and regret for misbehaviour.

Children's perspectives on the rationale for physical punishment were context-dependent, considering in particular the age of the child, frequency and intensity of the administration of the physical punishment and the severity of the misdeed that elicited such a response. Physical punishment was deemed both more effective and more acceptable when used with younger children, and then should involve only a light slap or tap; the children were unanimous in their opposition to frequent or severe physical punishment.

The researchers noted that a key argument in favour of physical punishment centred on its effectiveness in curbing or preventing health-risk behaviours. Some children in the older age groups endorsed parental use of physical punishment in contexts where children's safety and health was at risk, such as smoking and drug-related activities.

(Brigid Pike)

1. Nixon E and Halpenny A M (2010) *Children's perspectives on parenting styles and discipline: a developmental approach.* Dublin: Stationery Office.

Drugnet digest

This section contains short summaries of recent reports and other developments of interest.

State of the nation's children report: Ireland 2010

On 21 December 2010 the Minister for Children and Youth Affairs, Barry Andrews TD, launched the State of the nation's children report: Ireland 2010. The third in a biennial series, which draws on recent administrative, survey and census data on children's lives, the report contains a series of indicators highlighting children's health, educational and social, emotional and behavioural outcomes; their relationships with family and friends; and services and supports for children.

With regard to the use of psychoactive substances by children and young people, the report shows that lifetime use of cannabis by 9–17-year-olds increased between 2002 and 2006 by 3.6%, while the prevalence of daily smoking among young people declined by 1.5% over the same period. With regard to alcohol, in 2006, 20.4% of children aged 10–17 reported that they had been drunk at least once in the last 30 days.

Two indicators illustrate the nature and extent of problems associated with the use of psychoactive substances.

- Referrals to the Garda Juvenile Diversion Programme: Between 2008 and 2009 the number of children referred to the Garda Juvenile Diversion Programme decreased substantially, from 21,412 to 18,519. In 2009 alcohol-related offences were the single highest cause of referrals to the programme, representing 17.8% of all referrals; possession of drugs accounted for 4.3% of referrals.
- Admissions to psychiatric hospitals: While the total number of children admitted to psychiatric hospitals increased from 352 in 2004 to 406 in 2008, the number

Drugnet digest *(continued)*

of children being admitted with a diagnosis of drug dependence fell from 32 in 2004 to 17 in 2008 (4.2 % of total admitted in 2008 and a rate of 1.6 per 100,000), and those diagnosed with an alcohol disorder dropped from 17 to 8 (2% of those admitted in 2008 and a rate of 0.7 per 100,000).

You can download the report from www.dcya.gov.ie

Official launch of Polish Centre for Addiction Counselling

In June 2011 the Polish Centre for Addiction Counselling (CKU) was officially launched. To mark the occasion CKU held a seminar, Inclusive and Innovative Approach to Addiction Counselling in Multicultural Ireland, in conjunction with the South Inner City Drugs Task Force (SICDTF) and Coolmine Therapeutic Community. The aim of the seminar was to address the issue of accessibility of addiction services to ethnic minorities in Ireland. Mr Dermot Lacey, chairperson of the task force opened the seminar at Dublin's Mansion House.

CKU was founded in May 2009 in response to demand from Polish nationals who could not access mainstream addiction services because they did not speak English. CKU provides free help and support, through the Polish language, to addicts and their families and is supported by the SICDTF. The CKU.therapeutic programme is based on the Minnesota model. Since its foundation CKU has provided support to approximately 300 clients. The service operates on voluntary basis and is located in Coolmine House, 19 Lord Edward Street, Dublin 2.

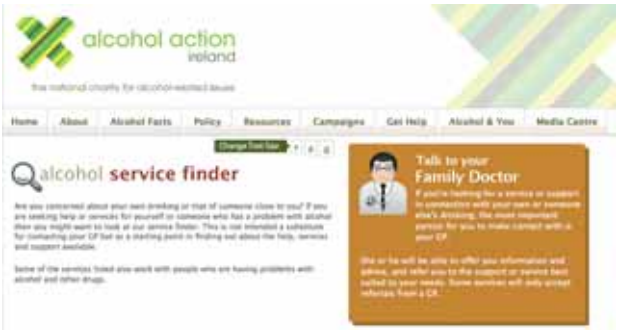
Further information is available at http://ckudublin.org/

Alcohol Action Ireland online guide to services

Alcohol Action Ireland, the national charity for alcohol-related issues, has launched an online guide to alcohol services around the country.The service is called the 'Alcohol Service Finder'. Visitors to the AAI website can search for services by location or by the age profile of the person for whom help is being sought, using Google mapping technology.

There are six categories in the guide: adults with alcohol problems; under-18s with alcohol problems; children affected by parental alcohol problems; parents of children under 18 with alcohol problems; families of adults with alcohol problems; and teens/young adults with alcohol problems.

AAI Director Fiona Ryan said: 'We considered how we could best support people in this situation, we consulted and found what people wanted was access to targeted, relevant information as quickly as possible. So we contacted alcohol services across the country and asked if they would be included in the guide and then designed it to give people what they told us they wanted.'



You can search the Alcohol Service Finder at: www.alcoholireland.ie/get-help, at www.drinkhelp.ie and at www.alcoholhelp.ie or by searching for 'Alcohol Service Finder' on Facebook.

For further information, or comment, contact:
AAI Communications Officer Cathy Gray at
(01) 878 0610 or (087) 995 0186

(Contributors Brigid Pike, Anne Marie Carew and Brian Galvin)

Inequality and illicit drug use

The more unequal a society, the higher the level of drug use. This finding is just one in a study by UK epidemiologists Richard Wilkinson and Kate Pickett into the social determinants of health, into 'why health gets worse at every step down the social ladder'.[1] Ireland was one of 22 'rich' countries included in the study. The authors concluded that where there is inequality in a country, there is a corresponding loss of general health and well-being, as indicated by measures of community life and social relations, mental health, illicit drug use, physical health and life expectancy, obesity, educational performance, teenage births, violence, imprisonment and punishment, and social mobility.

The nub of Wilkinson and Pickett's argument is that the prevalence of poor health and social problems is related not to the average standard of living in a country but to the degree of inequality (as measured by the disparity between the incomes of the richest and the poorest inhabitants). The problem is not associated with the overall level of wealth in a country but with the size of the difference between those with the highest incomes and those with the lowest. With regard to illicit drug use, the authors found 'a strong tendency for drug use to be more common in more unequal countries', with Ireland lying just above the midpoint in terms of the relationship between drug use prevalence and income inequality.[2]

Widely read and debated, Wilkinson and Pickett's work has been challenged on many grounds – the choice of countries studied, the selection of problems to be assessed, and failure to control for intervening variables such as national culture or welfare system. It has also been asserted that their findings were the result of 'statistical flukes', in other words, dependent on the presence of outliers.[3] While it is not within the remit of Drugnet Ireland to assess the merits or otherwise of their approach and their arguments, Wilkinson and Pickett's work provides a framework within which to interrogate the new government's programme Government for national recovery 2011–2016 (PGNR),[4] and in particular to explore whether and how they have made the link

Inequality and illicit drug use *(continued)*

between illicit drug use and inequality. Although Ireland's policy makers have never made the link explicitly, they have made indirect links by associating illicit drug use with socio-economic disadvantage, marginalisation and exclusion.[5]

As long ago as 1996, the Ministerial Task Force on Measures to Reduce the Demand for Drugs, chaired by Pat Rabbitte TD, then Minister of State, recognised the link between drug misuse and socio-economic disadvantage. The task force recommended the establishment of drugs task forces in areas experiencing high levels of drug misuse, which also coincided with areas experiencing social and economic deprivation. Since 2001 Ireland's national drugs strategies have set the drugs issue within the wider policy context of social inclusion, to which a number of other national strategies in Ireland, such as health, anti-poverty and education, are also linked.[6]

In the PGNR, the government brings two new terms to the fore in relation to social policy – fairness and equality. In their introductory Statement of Common Purpose, the coalition partners state: 'We are both committed to forging a new Ireland that is built on fairness and equal Citizenship. ... By the end of our term in Government Ireland will be recognised as a modern, fair, socially inclusive and equal society supported by a productive and prosperous economy.' Along with chapters on the Economy, Reform and Progress, the PGNR contains a chapter on Fairness.

Although the authors of the PGNR do not define fairness, the measures in the chapter on Fairness are placed within the context of principles which, it may be assumed, the government believes will lead to a fair society – social solidarity, social inclusion, and reduction of stigma. With regard to equality, the chapter on Fairness does provide some explanation: under the heading Equality and Social Protection, the authors describe equality as being at the heart of what it means to be a citizen in Ireland's democracy: 'The government believes that everyone has the right to be free from discrimination and that we all benefit from living in a more equal society.' The government commits to ensuring equal access to health and to education, and lists measures to ensure equality and social inclusion for women and men, Travellers, members of the lesbian, gay bisexual and transgendered community, workers, members of minority ethnic groups and immigrants, and people with disabilities.

Although the drugs issue is addressed in the chapter on Fairness, at no point is policy to tackle the illicit drugs problem mentioned in conjunction with either equality or the concepts and principles understood to underpin fairness. The drugs issue is included the section entitled Justice and Law Reform, and four broad objectives are listed:

- to introduce a combined drugs and alcohol strategy (a 'national addiction strategy'),
- to provide 'renewed impetus to the fight against drugs',
- to ensure that the drugs strategy 'once again becomes relevant and effective', and
- to enhance, where possible, 'the demand reduction strategies'.

Although not as clear or unambiguous as recent statements on drug policy by the governments in Britain and Denmark,[7] the new Irish government's stated objectives suggest, as much by omission as inclusion, that a shift in emphasis may be occurring. This is borne out by the 12 'key priorities for short-term implementation' listed alongside the four objectives, which focus on supply reduction, prevention and rehabilitation; just one action refers to harm reduction, increasing the number of needle exchange programmes as well as the number of rehabilitation places throughout the country.

The new government's reallocation of responsibilities for Ireland's drugs policy, detailed elsewhere in this issue of Drugnet Ireland, does not help to clarify its thinking on the nature of the links between the drugs problem and other social policy issues. Prior to the February election, responsibility for drugs policy had come to be located in the same government department as community and local development, equality and social inclusion policy, suggesting a common goal or shared aspiration among all these policy domains. The new government's transfer of functions sees these four policy areas separated once again and assigned to four different government departments.

How the Department of Health will approach its new function of co-ordinating the national drugs strategy remains to be seen. In their study of the links between health, social problems and inequality, Wilkinson and Pickett argued that policy makers should integrate health and social problems as elements of a single policy problem – inequality – rather than approach them as separate issues:

Attempts to deal with health and social problems through the provision of specialized services have proved expensive and, at best, only partially effective. ... Rather than reducing inequality itself, the initiatives aimed at tackling health and social problems are nearly always attempts to break the links between socio-economic disadvantage and the problems it creates. The unstated hope is that people – particularly the poor – can carry on in the same circumstances, but will somehow no longer succumb to mental illness, teenage pregnancy, educational failure, obesity or drugs. (pp. 238–9)

(Brigid Pike)

1. Wilkinson R and Pickett K (2010) *The spirit level: why equality is better for everyone.* Published with revisions and a new postscript. London: Penguin Books.
2. The authors obtained data on drug use in the 22 countries, as reported in the *World drug report* compiled annually by the United Nations Office on Drugs and Crime, and plotted this against the level of income inequality in the countries, as reported in the *Human development report* compiled annually by the United Nations Development Programme.
3. A full account of the criticisms and the authors' responses may be found at www.equalitytrust.org.uk/resources/other/response-to-questions
4. Fine Gael and the Labour Party (2011) *Government for national recovery 2011–2016*. www.taoiseach.gov.ie
5. An exception is the strategic plans of the newly-established regional drugs task force, completed in 2005, some of which explicitly discussed the relationship between illicit drug use and social exclusion and inequality. See Pike B (2006) RDTF strategies push out the boundaries. *Drugnet Ireland*, (20): 11–12.
6. See, for example, the *National Drugs Strategy 2001–2008* (Department of Tourism, Sport and Recreation, 2011) para. 6.1.9, and the National Drugs Strategy 2009–2016 (Department of Community, Rural and Gaeltacht Affairs 2009) para. 6.21.

Inequality and illicit drug use *(continued)*

7. McKeganey N (2011) From harm reduction to drug user abstinence: a journey in drug treatment policy, *Journal of Substance Use*, 16(3): 179–194, traces a recent policy shift in Britain from the goal of harm reduction to one of drug user abstinence, while Houborg E and Bjerge B (2011) Drug policy, control and welfare, Drugs: *education, prevention and policy* 18 (1): 16–23, describe how the welfarist political rationality that underpinned Denmark's drug 'policy space' in the 1970s and 1980s has been superseded over the last two decades by a 'New Right' political rationality combining a tough-on-crime policy with the marketisation of drug service provision.

Human rights and extreme poverty in Ireland

Between 10 and 15 January 2011, at the invitation of the then Irish government, the UN's independent expert on human rights and extreme poverty, Magdalena Sepúlveda Carmona, undertook a mission to Ireland. She focused on the impact of the economic and financial crises in Ireland and the effects of recovery measures on the level of enjoyment of human rights, in particular economic, social and cultural rights, by the most vulnerable individuals and groups in Ireland, including problem drug users. On 17 May 2011 Ms Sepúlveda submitted her report to the UN. In it, she makes concrete recommendations on how to implement a human rights-based recovery in Ireland.[1]

While acknowledging that the government's anti-poverty and social inclusion strategies may need to be adapted in light of the worsening economic situation, she encourages the government to ensure as a minimum that the 23 high-level goals in Towards 2016 continue to be the primary targets for Ireland's social policies. She also endorses the target set by the National Action Plan for Social Inclusion 2007–2016 to reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating consistent poverty by 2016.

Ireland's human rights obligations apply even during times of economic hardship, and recovery measures must not disproportionately impact the poorest segments of society, according Ms Sepúlveda. She calls on the government to undertake a human rights review of all budgetary and recovery policies to ensure they comply with fundamental human rights principles.

According to the independent expert, having signed and ratified the International Covenant on Economic, Social and Cultural Rights, Ireland must devote the maximum available resources to ensure progressive realisation of all economic, social and cultural rights by its population. Given that Ireland remains an affluent country with a relatively high GNP per person, Ms Sepúlveda expresses concern about the level of taxation in Ireland, which she notes is lower than in most other European countries: '... seeking to achieve adjustments primarily through expenditure cuts rather than tax increases might have a major impact on the most vulnerable segments of society. Reductions in public expenditure affect the poorest and most vulnerable with the most severity, whereas some increase in taxation rates could place the burden on those who are better equipped to cope. '

Ensuring non-discrimination and equality are regarded as fundamental pillars of the human rights framework. Despite the existence of a strong body of equality legislation in Ireland, Ms Sepúlveda urges the government to be particularly mindful that policies do not exacerbate the challenges faced by groups vulnerable to discrimination, such as single mothers, children, Travellers, people with disabilities, migrants, asylum-seekers and the homeless. She also encourages the government to take positive measures to help these vulnerable segments to 'regain their equal footing with the rest of Irish society'. She goes on to observe:

> A number of recent measures are concerning in this respect, especially reductions in child benefits and benefits for job seekers, carers, single parent families, persons with disabilities and blind persons. The impact of these measures will be exacerbated by funding reductions for a number of social services which are essential for the same vulnerable people, including disability, community and voluntary services, Travellers supports, drug outreach initiatives, rural development schemes, the Revitalising Areas by Planning, Investment and Development (RAPID) programme and Youthreach. (para. 34)

(Brigid Pike)

1. *Report of the independent expert on the question of human rights and extreme poverty, Magdalena Sepúlveda Carmona. Addendum: Mission to Ireland.* United Nations General Assembly, Human Rights Council, Seventeenth Session, 17 May 2011. A/HRC/17/34/Add.2

TILDA reports alcohol use and dependence

The Irish Longitudinal Study on Ageing (TILDA) is a detailed study of the health, lifestyles and financial situation of 8,000 to 10,000 people as they grow older and as their circumstances change over a 10-year period. The study is being carried out by Trinity College Dublin in collaboration with an inter-disciplinary panel of scientific researchers who have expertise in various fields of ageing. TILDA is funded by the Department of Health, Irish Life and Atlantic Philantropies. The information gathered in TILDA will improve our understanding of the factors that aid successful ageing in Ireland.

The first results from this study have now been published.[1] The section on alcohol in chapter 5 of the report includes the following (cross-references removed):

TILDA respondents were asked about the frequency of their alcohol consumption as well as the quantity of alcohol consumed within the preceding six months. Respondents were also asked if [at any stage in their life] a doctor had told them that they suffered from alcohol or substance abuse. In addition, respondents completed the CAGE (cut-annoyed-guilty-eye) questionnaire, which consists of four questions evaluating alcohol patterns and behaviour and is a valid screening assessment for is a valid screening assessment for alcoholism.

Overall 1.8% of older Irish adults report a diagnosed history of alcohol or substance abuse. The rate is highest in men aged 65-74 years (3.9%). No association with education is observed. Individuals in the lowest wealth quartile are more likely to report a diagnosis of alcohol and substance abuse compared to those in the highest wealth quartile. When alcohol problems are assessed using the CAGE questionnaire, a different pattern emerges. The overall prevalence of 'problem drinking' (defined as a CAGE score of 3 or more) is higher at 4.8% and no association with wealth or education is observed.

Table 1 Problematic alcohol use and diagnosed substance abuse, by age and sex

	Alcohol problem using CAGE		Diagnosed alcohol or other drug misuse	
	%	(95% CI)	%	(95% CI)
Male				
50–64	8.6	(7.3–10.2)	3.2	(2.4–4.2)
65–74	6.0	(4.5–8.0)	3.9	(2.9–5.4)
>=75	2.4	(1.2–4.5)	0.7	(0.3–1.8)
Total	7.0	(6.1–8.2)	3.0	(2.4–3.7)
Female				
50–64	4.0	(3.2–5.1)	1.0	(0.7–1.6)
65–74	1.5	(0.8–2.8)	0.5	(0.2–1.3)
>=75	0.6	(0.2–2.1)	0.1	(0.0–0.6)
Total	2.7	(2.2–3.4)	0.7	(0.5–1.0)
All				
50–64	6.3	(5.5–7.2)	2.1	(1.6–2.7)
65–74	3.7	(2.8–4.8)	2.2	(1.6–3.0)
>=75	1.3	(0.7–2.3)	0.3	(0.1–0.8)
Total	4.8	(4.2–5.4)	1.8	(1.5–2.2)

Source: After Barret *et al.* (2011), Table 5.A23, p. 120.

(Abstracted by Jean Long)

1. Barrett A, Savva G, Timonen V and Kenny RA (eds) (2011) *Fifty plus in Ireland 2011: first results from the Irish longitudinal study on ageing (TILDA)*. Dublin: Trinity College Dublin. www.drugsandalcohol.ie/15040

UN reviews responses to world drugs problem

2011 marks the 50th anniversary of the 1961 Single Convention on Narcotic Drugs. An important a milestone in international drug control, this convention codified all existing multilateral treaties on drug control and extended the existing control systems to include the cultivation of plants grown as the raw material of narcotic drugs.

While the UN's Commission on Narcotic Drugs (CND), the central policy-making body of the United Nations in drug-related matters, acknowledged this anniversary, it was business as usual at the CND's 54th annual meeting in Vienna. Four resolutions passed at the meeting relevant to drug policy issues currently being addressed in Ireland are noted here.[1]

54/2: Promoting international co-operation to prevent drug-affected driving

Member states are urged to develop national responses to address the issue of drug-affected driving by assessing and monitoring the magnitude of the phenomenon at national level and by exchanging information and best practices on effective responses. They are also encouraged to develop effective roadside testing options to assess drug-affected driving and to raise public awareness. With regard to this last issue, member states are invited to ensure measures are consistent with measures tackling other road safety risks, such as driving under the influence of alcohol.

Responses to world drugs problem *(continued)*

54/5: Promoting rehabilitation- and reintegration-oriented strategies in response to drug use disorders and their consequences that are directed at promoting health and social well-being among individuals, families and communities

Member states are encouraged to ensure that drug demand reduction policies and practices include access to evidence-based and humane treatment, care and related support services aimed at rehabilitating and reintegrating people suffering from drug dependence and drug-related diseases, and that these services focus on health and social well-being among individuals, families and communities. They are also encouraged to provide a diverse range of treatment facilities, including medically assisted and psychosocial treatment and rehabilitation, that match the needs of dependent drug users in all relevant social and clinical conditions, and exhorted to improve the availability and coverage of these services as part of their country's overall health-care system. Finally, they are urged to identify and firmly counter discrimination against drug users, and to develop effective interventions that lead to social reintegration, including programmes that facilitate the employment of people in treatment and recovery that are tailored to their specific needs in the rehabilitation process.

54/8: Strengthening international co-operation and regulatory and institutional frameworks for the control of precursor chemicals used in the illicit manufacture of synthetic drugs

Acknowledging that the diversion of pharmaceutical preparations containing ephedrine and pseudoephedrine is a concern because these may not be subject to similar levels of control as bulk (raw) ephedrine and pseudoephedrine, the meeting identified a wide range of actions to address the issue. These included strengthening legislative and regulatory frameworks, monitoring and controlling all points of entry to and exit from countries, including communications via the Internet, improving information-sharing with the International Narcotics Control Board (INCB) and collaborating with the national chemical industry.

54/11: Improving the participatory role of civil society in addressing the world drug problem

Member states are encouraged to ensure that civil society plays a participatory role, where appropriate, through consultation, in the development and implementation of drug control programmes and policies, in particular with regard to aspects of demand reduction. Member states are also encouraged to cultivate an environment that promotes innovation and to take into account promising approaches taken by civil society to assist governments in their efforts to address the world drug problem, provided that such approaches are in conformity with the international drug control conventions, are based on scientific evidence, and are in accordance with relevant human rights obligations.

Other items on the CND meeting agenda included (1) round-table discussions on regional and international co-operation to combat the world drug problem and its links with organised crime, revitalising the principle of common and shared responsibility for the world drug problem, and addressing key public health issues such as addictive behaviours by youth and drugged driving; (2) a review of the implementation of the international drug-control treaties, including consideration of the annual report of the INCB; and (3) a review of the implementation of the UN's political declaration and 10-year action plan, agreed in 2009, to counter the world drug problem.[2]

(Brigid Pike)

1. The full text of these resolutions, together with other 10 resolutions passed at the meeting, are contained in the advance unedited official report issued by the Commission on Narcotic Drugs, *Report on the fifty-fourth session (2 December 2010 and 21-25 March 2011)* Economic and Social Council Official Records, 2011, Supplement No. 8 (E/2011/28–E/CN.7/2011/15) http://www.unodc.org/unodc/al/commissions/CND/session/54.html As Ireland is not currently a member of the CND, the Irish delegation attended with observer status.
2. Accounts of the CND meeting have been posted on the internet by international NGOs, including a summary of the main events and analysis of the key discussions and debates, compiled by the International Drug Policy Consortium http://www.idpc.net/publications/2011-cnd-proceedings-document , and a detailed account accessible on the International Drug Policy Consortium–International Harm Reduction Association CNDblog at http://www.cndblog.org/ For further information on Ireland and UN drug policy, see *Drugnet Ireland*, Issues 8, 18, 22, 27, 30 and 34.

Experiences and health effects of head shop substances in Ireland

A number of short articles or letters published in journals in the past six months have reported adverse health events associated with the use of psychoactive substances sold in head shops and on line. Summaries of these articles are presented below in the form of edited extracts from the journals.

Mephedrone and 'head/hemp' shop drugs: a clinical and biochemical 'heads up'

This editorial[1] emphasises that it is important that primary care physicians, the emergency services and psychiatric specialists realise that they need to consider these drugs when cases present with drug-induced psychoses and/or suicide ideation (thoughts of and plans for suicide). Some of these drugs can be detected using laboratory standards, the standards and equipment required for identifying these drugs are only available in specialist toxicological laboratories and the Drug Treatment Centre Board.

Head shop substances *(continued)*

Users' experiences of cathinones sold in head shops and online

This paper[2] describes the use and effects of head shop powders among opiate-dependent polydrug users and recreational drug users in Dublin. These powders contained cathinones and were sold as bath salts or plant food via the internet or in head shops. As this is a relatively new phenomenon, a qualitative approach using three data sources, in-depth interviews, a focus group (of 10 opiate users) and a head shop website containing 49 product reviews, was employed. A thematic approach was used to analyse the data.

According to the study population, these powders mimic the effects of cocaine, ecstasy and amphetamines. These substances were snorted, ingested or injected by people and were not used as bath salts or plant food. The users' experience indicates that these powders have the potential for dependence, and exhibit side effects such as insomnia, anxiety and other more serious mental health effects. The users report that the effects of the substances vary over time, indicating that the chemical contents of the powders may change.

Though users' descriptions of effects varied, there were indications of health and dependency effects which were more severe and more common among problematic opiate users when compared to the recreational drug users, who also experienced increased social vulnerability. In general, the recreational drug users considered their side effects to be mild and worth the drug-induced experience.

Two psychiatric presentations linked with 'head shop' products

This paper[3] reports two cases of acute onset of and rapid recovery from psychotic symptoms, the first after eating a head shop product and the second after injecting it; the product probably contained methylone. Common psychotic symptoms include hallucinations, delusions, and disturbed thoughts.

A 30-year-old woman with no past psychiatric history attended a Dublin emergency department with a 24-hour history of restlessness, irritability, paranoid delusions and maculo-papular rash on the lower third of her right thigh and on upper third of both thighs. Physical examination revealed raised and fluctuating blood pressure and pulse rates with peaks of 160/100mmHg and 120bpm respectively. Her brain scan and lumbar puncture (spinal fluid) were normal. Her urine test was negative for 'common' illicit substances.

A 29-year-old man with no fixed abode and a long history of injecting drug use attended the same emergency department with signs of a recent onset and florid psychotic episode (evidenced by hallucinations and delusions). On examination, he was quite agitated and described hearing voices and seeing visual hallucinations. He had delusions (beliefs not backed by reality)and also reported passing thoughts about suicide. He also described some sub-clinical symptoms of depression. There were no abnormalities identified during the physical examination, and the only abnormal laboratory findings were his urine tested positive for opiates and benzodiazepines. He was already attending the addiction services for methadone maintenance therapy. He had no past history of psychotic or mood disorder.

Both cases were admitted to hospital for five days and were treated with an atypical antipsychotic and a benzodiazepine. Their symptoms settled within 48 hours of admission.

Whack induced psychosis: a case series

'Whack' is a new psychoactive substance available until recently in head shops. It contains two active constituents, 4-fluorotropacocaine and desoxypipradrol.

On 9 May 2010, the Health Service Executive (HSE) issued an emergency warning about Whack, as in the preceding 10 days, 40 people attended emergency departments or general practitioners suffering side-effects from the drug. The majority of these cases were young males in their twenties from different regions in Ireland. A range of physical symptoms were reported, including fast pulse, high blood pressure and difficulty in breathing. The majority of cases also experienced anxiety and at least seven were reported to have experienced psychotic symptoms. None of these cases have been reported in the medical literature to date.

This paper[4] presents two case studies of men who developed acute psychotic states after using Whack. There was a striking similarity between the two cases symptoms, with initial euphoria and disinhibition followed by severe anxiety, insomnia, depressed mood, restlessness, agitation, pacing and psychosis. These symptoms persisted for 7–10 days after using Whack. Both men required inpatient treatment but displayed a good treatment response to atypical antipsychotic agents. This is the first published case series relating to this psychoactive substance in Ireland.

Benzylpiperazine-induced acute delirium in a patient with schizophrenia

Benzylpiperazine is a psychotropic compound that has been widely available until recently from 'head shops'. This report[5] describes the case of a 48-year-old man with schizophrenia who developed an acute delirium or confusion secondary to benzylpiperazine use. This is the first documented case of delirium due to benzylpiperazine use in Ireland. Investigation of his delirium unearthed a temporal meningioma, which appears to be an unrelated or supplementary finding.

New Doves: a new legal high?

This letter to the editor[6] reports two cases of people who sought medical assistance after taking butylone (sold as London Underground Doves). The first case was that of a 25-year-old woman who experienced dilated pupils, facial flushing and tachycardia (fast pulse). The second was that of a 37-year-old man who experienced vomiting, abdominal pain, palpitations and chest pain. Both cases recovered following symptomatic treatment.

Headshop heartache: acute mephedrone 'meow' myocarditis

This paper[7] presents a case study of 19-year-old man who came to hospital with crushing chest pain 20 hours after eating a gram of plant food containing mephedrone. His history and urinalysis indicated that he had not taken other drugs. His electrocardiograph (ECG) showed an abnormal heart rhythm (ST elevation) and his MRI confirmed the abnormal heart rhythm and showed swelling of the heart muscle. The patient recovered after five days in hospital. The authors report that it is not clear how mephedrone induces inflammation of the heart but it is though that such damage to the heart could cause death; it is speculated that mephedrone has caused a number of deaths in the UK and confirmed that it has caused one death in Sweden.

Head shop substances *(continued)*

(Compiled by Jean Long)

1. O'Domhnail S and Ni Chleirigh C (2011) Editorial: Mephedrone and 'head/hemp' shop drugs: a clinical and biochemical 'heads up'. *Irish Journal of Psychological Medicine*, 28(1): S2–S3.
2. O'Reilly F, McAuliffe R and Long J (2011) Users' experiences of cathinones sold in head shops and online. *Irish Journal of Psychological Medicine*, 28(1): S4–S7.
3. Uhoegbu C, Kolshus E, Nwachukwu I, Guerandel A and Maher C (2011) Two psychiatric presentations linked with 'head shop' products. *Irish Journal of Psychological Medicine*, 28(1): S8–S10.
4. El-Higaya E, Ahmed M and Hallahan B (2011) Whack induced psychosis: a case series. *Irish Journal of Psychological Medicine*, 28(1): S11–S13.
5. Tully J, Hallahan B and McDonald C (2011) Benzylpiperazine-induced acute delirium in a patient with schizophrenia and an incidental temporal meningioma. *Irish Journal of Psychological Medicine*, 28(1): S14–S16.
6. Herbert J and Tracey JA (2010) New Doves: a new legal high? *Irish Medical Journal*, 103(3): 92–93.
7. Nicholson PJ, Quinn MJ and Dodd JD (2010) Headshop heartache: acute mephedrone 'meow' myocarditis. *Heart*, 96(24): 2051–2052.

Drug Treatment Court reports progress

Attending a recent Drug Treatment Court presentation were (l to r): Hilda McDermott, DTC co-ordinator; Garda Liam Reynolds, DTC; Fiona Carolan, DTC education co-ordinator; David Patten, DTC graduate; Linda O'Driscoll, DTC liaison nurse; and Declan Donnelly, DTC probation officer

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]

Highlighting the low number of participants entering and successfully completing the DTC Programme, the review made several recommendations designed to improve the court's operational effectiveness and overall success rate.[2] It was decided that, having implemented the recommendations, the DTC should continue its operations for a further two years.

Although the review found that only 14% of programme participants had graduated from the programme since its establishment, participation in the programme was seen to have had a positive effect on behaviour. Although many participants took several years to progress through the initial phases of the programme, the focused attention and support they received during this period had 'a positive effect on their offending behaviour, as well as on their health and personal relationships', even if they ultimately failed to complete the programme (p. 19). Writing on page 5 of the March issue of *Courts Service News*,[3] Tom Ward, chief clerk of the Dublin Metropolitan District Court, reports on how the programme has been adapted to address this issue:

The principal achievement over the past year has been the agreement of a new strength's based approach to determining the progress of participants… . Under the new system, participants continue to be tested as part of their treatment with progress measured over the period of participation. A greater weighting is ascribed to positive behaviours, such as not coming to unfavourable notice of the Gardaí. Participants receive credits for attending the in-house support group which is based on the '12 steps' approach to managing addictions. Interim achievements are recognised and those who achieve a silver standard, but do not manage to attain gold, may be the subject of a report from the Drug Treatment Court Judge to their Sentencing Judge, proposing a suspended rather than a custodial sentence.

Drug Treatment Court *(continued)*

Progress is also reported on the establishment of a new Support and Advisory Committee to assist the Court. This comprises senior managers from the Health Service Executive, An Garda Síochána, the Probation Service, City of Dublin VEC, the Health Research Board and the Courts Service.

According to Mr Ward, 'The Court hopes to be able to accept participants with addresses outside the Dublin North Inner City in the near future. In the meantime, it continues to encourage referrals from those with addresses in Dublin 1, 3 or 7.'

The review of the DTC recommended that the programme be extended to offenders aged 16–18 years who are before the Children Court. The current programme for government is also committed to carrying out 'a full review of the Drug Treatment Court programme to evaluate its success and potential in dealing with young offenders identified as having serious problems with drugs'.[4] An interim assessment of the DTC is due to take place in the autumn (Tom Ward, personal communication, June 2011). This will examine the progress made to date in implementing the recommendations of the review.

For more information about the DTC, phone 01-8886294 or e-mail drugtreatmentcourt@courts.ie.

(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. See Connolly J (2010) Drug Treatment Court to continue operating. *Drugnet Ireland*, (35): 23.
3. Ward T (2011) New look Drug Treatment Court offers hope for the future. *Courts Service News* (13): 5. Dublin: Courts Service.
4. Fine Gael and the Labour Party (2011) *Government for national recovery 2011–2016*. www.taoiseach.gov.ie (p. 20).

Supreme Court overturns mandatory drug sentence

A recent decision by the Supreme Court to overturn a 10-year prison sentence for drug possession has raised doubts about the operation of legislation under which sentences are determined based on the estimated market value of seized drugs.[1]

What follows is an abridged extract from the judgement setting aside the conviction as delivered by Mr Justice Fennelly in the Supreme Court on 15 February 2011.

In the original trial it was alleged that the appellant in this case had in his possession for the purpose of sale or supply amphetamines with a market value of €13,000 or more contrary to section 15A (as inserted by section 4 of the Criminal Justice Act, 1999) and section 27 (as amended by section 5 of the Criminal Justice Act, 1999) of the Misuse of Drugs Act 1977. This offence attracts a minimum presumptive sentence of 10 years' imprisonment.

Counsel for the appellant submitted at trial that the proof of value of the drugs proffered by the prosecution was insufficient and that he had no case to answer. The trial judge refused his application for a direction. The appellant appealed against his conviction to the Court of Criminal Appeal on the single ground that:

> … there was no evidence on which a properly directed jury could come to the conclusion and be satisfied beyond a reasonable doubt that the market value of the drugs concerned was €13,000 or more.

The Court of Criminal Appeal concluded that there had been no error of law in the original trial. However, the CCA referred the following matter to the Supreme Court to be determined[2] as a question of law of exceptional importance:

> In a prosecution pursuant to section 15A of the Misuse of Drugs Act 1977, for the purpose of ascertaining the amount of a controlled substance present in a powder in a sealed container or in a number of such containers proven by expert evidence to contain that particular controlled substance, may the amount of that controlled substance present in the powder be established by the oral evidence of an expert as to the range within which amounts of that controlled substance in other powders generally fell and, if the answer is in the affirmative, must the prosecution disclose to the defence a statement or a report by that expert setting out the facts upon which her or his opinion as to that range is based?

The primary issue considered by the Supreme Court was the sufficiency of proof required to determine the value of drugs. The appellant had been arrested in possession of approximately ten kilograms of amphetamines packed in 10 separate bags. At trial, a member of the Garda National Drugs Unit estimated the value of the drugs at €145,755, using a price of €15,000 per kilo. The Garda assumed that each of the packs of amphetamine contained at least 10% of amphetamine. It was accepted that proof of the actual contents and percentage of amphetamine present was a matter to be determined by the Forensic Science Laboratory (FSL).

A scientist of the FSL explained that she had analysed five of the packs and could say with 100% certainty that the five packs contained amphetamine, but not how much. She added that, taking into account the general appearance of the packs and the powder her professional opinion was that it was highly unlikely that any of the packs would be negative. However, she stated further:

> I can't say for definite what the purity of the samples are but I can give a range in which amphetamine purities generally fall between that is maybe 10 and 40% but the samples were not quantified because quantification is not a routine course of qualitative analysis so I cannot put an exact figure on the purity…

Supreme Court overturns mandatory drug sentence *(continued)*

In further cross-examination, the scientist agreed that the presence of as little as 1% would trigger the test she had carried out, but repeated that the range is generally between 10% and 40%.

[Mr Justice Fennelly then explained the nature of the proof required to secure a conviction under the relevant legislation.]

> Proof of value is an essential ingredient of the offence under section 15A. It is what distinguishes it from the offence of possession for sale or supply of an unquantified and unvalued amount of drugs. Most importantly, it is what has caused the Oireachtas, subject to exceptional mitigating circumstances, to mark the offence as one of extreme seriousness such as to require the court, in sentencing a convicted person, to impose a penalty of a minimum of ten years' imprisonment. The ingredient of value must be proved to the satisfaction of the jury beyond reasonable doubt.

At the original trial, the forensic scientist established the presence of amphetamine in each of the five packs she had analysed, but had not determined the extent of the amphetamine content and was therefore unable to say 'for definite' what the level of presence of amphetamine was. She said that the range in which amphetamine purities 'generally fall' was between 10% and 40%.

Everything turns on the meaning to be attributed to the word 'generally'. It is a word of flexible use. It may imply, perhaps, that a majority of cases fall within that range, but, in a weaker sense, may mean no more than 'commonly'. If the facts were that analysis of seized drugs for amphetamine always or nearly always falls within the 10/40% range, one might have expected the witness to say so. Instead, she used the word 'generally' three times. In its normal usage the word leaves open the very real possibility that there are cases outside that range. It cannot be assumed that Dr Casey meant any more than that there was probably 10% to 40% amphetamine present. Probability is not enough.

The evidence did not exclude the very real possibility that the percentage of amphetamine present could have been as low as 1%. Such a percentage was sufficient to produce the result which she obtained from her test. However, if that were the case the value of those drugs would be less than the amount required to sustain a conviction for the offence in issue.

The proof of value is an objective matter. In this case it was not sufficient for the prosecution to prove the mere presence of amphetamine and to rely on an unexplained range of values which generally applies without evidence which addressed the extent to which there are cases outside the range. This left a gap in the prosecution evidence. I believe that the case should have been withdrawn from the jury. I would allow the appeal and set aside the conviction of the appellant in respect of count number 1 on the indictment.

I would not direct a retrial. There is no reason to believe that Dr Casey would be in a position to give any different evidence on another occasion.

(Compiled by Johnny Connolly)

1. *Director of Public Prosecutions v Connolly* [2011] IESC 6. Supreme Court. Judgement by Fennelly J. www.courts.ie/judgments.nsf
2. As provided for pursuant to section 29 of the Courts of Justice Act 1929, as substituted by section 22 of the Criminal Justice Act 2006.

The social norms approach to tackling substance use

What are the underlying assumptions of the social norms approach?

Numerous surveys have shown that young people tend to overestimate the prevalence (behaviour) and acceptance (attitudes) of substance use among their peers. It is assumed that young people are strongly influenced by what they perceive to be the group norms among their peers (norms = behaviours and attitudes) hence there is a strong likelihood that they will think and behave in similar ways. For example, if they perceive that binge-drinking of alcohol is the norm among their peers, a) they will form the belief/attitude that it is expected of them and b) they will engage in such behaviour. In such cases, they may ignore the information campaigns that tell them the dangers of consuming large amounts of alcohol or the long-term adverse effects of smoking tobacco and/or cannabis.

Why is this approach gaining favour?

McAlaney and colleagues[1] state in a recent paper on the international development of the social norms approach to drug education and prevention: 'The growth of the social norms approach is perhaps partially explained by growing disenchantment with conventional prevention approaches.'

Such approaches include providing information awareness (drug education) on the adverse consequences of substance use, affective education where interventions seek to improve self-esteem and, to some extent, the life-skills approach, particularly when targeting 'at-risk' youth. All these conventional approaches are coming in for criticism and are increasingly viewed as being ineffective in preventing, delaying or reducing substance use among young people.

What are the key components of the social norms approach and how is it delivered?

Reliable data are required on what young people perceive to be the norm in a) peer attitudes towards substance use, and b) peer behaviour in relation to substance use. Reliable data are also required on a) actual attitudes towards substance use and b) actual behaviour in relation to substance use. Data can be collected at baseline with the target group and used to design interventions and for follow-up comparisons. Data from published studies, for example, the ESPAD,

The social norms approach *(continued)*

HBSC and NACD surveys[2] can also be used to challenge misperceptions about the prevalence and attitudes towards substance use among young people.

How is the social norms approach delivered?

'Social norms interventions have typically come in one of two forms: social marketing or individual normative feedback. Social marketing approaches rely on universal, mass communication methods for educating students regarding actual [substance use] behaviours... . Individual normative feedback is personalised and may provide a more relevant and powerful intervention.'[3]

What is the evidence that the social norms approach can be effective?

According to McAlaney and colleagues,

> The goal of [global social norms] campaigns is to disseminate the accurate substance use norms to the target population, such as "Most (73%) students at [college name] have no more than four alcoholic drinks on a night out." This approach was first implemented in 1989 at Northern Illinois University, which reported a drop in rates of heavy drinking from 43% to 25% over a 9-year period, accompanied by a reduction in the misperception of heavy drinking among peers from 70% to 33%.

Moreira and colleagues undertook a Cochrane systematic review to determine whether social norms feedback reduces alcohol misuse among university or college students. The review included 22 controlled trials involving 7,275 participants randomly assigned to a social norms intervention group or to a control group (no social norms intervention – assessment only, questionnaire used to measure alcohol consumption or alternative educational or psychosocial intervention). The following outcomes were observed:

- Alcohol-related problems; significant reduction with web/computer feedback in three studies (278 participants);
- Peak Blood Alcohol Content (BAC); significant reduction with web/computer feedback in two studies (198 participants);
- Drinking frequency; significant reduction with web/computer feedback in two studies (243 participants) and individual face-to-face feedback with two studies (217 participants);
- Drinking quantity; significant reduction with web/computer feedback in five studies (556 participants) and group face-to-face feedback with three studies (173) participants;
- Binge drinking; significant reduction with web/computer feedback in one study (80 participants), individual face-to-face feedback in three studies (278 participants) and group face-to-face feedback in four studies (264 participants);
- Drinking norms; significant reduction with web/computer feedback in three studies (312 participants).

In summarising the key findings of the Cochrane review, the authors make the following points:

> This systematic review based on 22 trials enrolling 7,275 participants shows that a social norms intervention delivered by web or computer or via individual face-to-face sessions (for some outcomes) is more effective than a control intervention, typically consisting of a leaflet with drinking related advice, for reduction of alcohol misuse in college or university students. Significant effects were more apparent for short term outcomes (up to three months). However, there was some evidence of effect continuing through to medium-term follow-up from four to sixteen months, particularly for web/computer feedback.

Authors' conclusion on the implications for practice

Overall, this systematic review suggests that individual and personalised normative interventions over the immediate and medium term appear to reduce alcohol use, misuse and related problems amongst university or college students. The use of social norms interventions should also be considered for use and study in other settings since they have the potential to be a very cost-effective intervention for reducing alcohol use and related harms. The use of new technologies, such as computer or web/computer delivered interventions, could be a successful and cost-effective method for providing normative feedback.

Limitations of the Cochrane review

Small sample sizes in many of the studies

Can the social norms approach be transferred to alternative settings and target groups?

The evidence to date suggests that the social norms approach has been mainly delivered to university and college students in the USA. However, this is changing and, as pointed out by McAlaney and colleagues, the approach has been used to change an array of behaviours e.g. sunscreen use, rumour spreading in high-school and towel re-use in hotels. In addition, Moreira and colleagues state that social norms should be considered for other settings.

(Martin Keane)

1. McAlaney J, Bewick B and Hughes C (2011) The international development of the 'social norms' approach to drug education and prevention. *Drugs: education, prevention and policy,* 18(2): 81–89.
2. ESPAD (European School Survey Project on Alcohol and other Drugs); HBSC (Health Behaviour in School-aged Children); NACD (National Advisory Committee on Drugs).
3. Moreira MT, Smith LA and Foxcroft D (2009) Social norms interventions to reduce alcohol misuse in University or College students. *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD006748. DOI: 10.1002/14651858.CD006748.pub2. http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD006748/pdf_fs.html.

Maternal and neonatal health among opiate users

Two recent papers present the results of studies on the health of women who had been prescribed methadone for the treatment of opiate dependence and their infants born in the Coombe Women and Infants University Hospital in Dublin. The first paper reported that the services of a liaison midwife were required to encourage pregnant women with opiate dependence to attend drug and maternity services regularly, and to liaise between professionals in both services. The second paper reported that the outcomes for mothers prescribed methadone and their new infants were not as good as those for other mothers and infants attending the maternity service. The key issues addressed in the papers are presented below.

Drug use in pregnancy: challenges for health care workers

This comparative study examined maternal and neonatal outcomes for pregnant women from the case load of a drug liaison midwife over the period 2002–2007,[1] compared with outcomes in a similar study carried out in 1999–2000.[2]

Of 524 women who attended the drug liaison midwife in the six-year period, 436 delivered a live baby after 32 weeks' gestation who did not have congenital anomalies. All women were engaged with drug treatment and obstetric services.

The 2002–2007 cohort was older (average age 25.9 years, range 17–32 years) and had marginally more pregnancies than the 1999–2000 cohort (average age 23.8 years, range 16–41 years). The 2002–2007 cohort attended their first antenatal visit earlier (at 15 weeks gestation) than the 1999 to 2000 cohort (at 18 weeks). Three-fifths of both cohorts attended five or more antenatal visits (satisfactory antenatal attendance). There were no maternal deaths among either cohort.

The average age at first heroin use was higher by one year (at 18 years) in the later cohort when compared to the earlier cohort. Opiate stability was marginally lower (50%) in the later cohort than in the earlier cohort (53%). Tobacco (91%), benzodiazepines (66%), alcohol (percentage not reported) and cocaine (71%) were commonly used alongside heroin by the later cohort. The rates of tobacco and benzodiazepine use were marginally lower, and the rate of cocaine use was higher, in the later cohort.

A very high proportion (93%) of the 2002–2007 cohort was taking prescribed methadone, compared to the 1999–2000 cohort (75%). The average dose of methadone at delivery was higher for the later cohort (60mg) than for the earlier cohort (39 mg). The average gestation at delivery was 38 weeks for both cohorts. The average birth weight was higher by 66g in the later cohort. The percentage of babies requiring admission to the special care baby unit had increased from 42% in the earlier cohort to 56% in the later cohort. The proportion of babies requiring treatment for neonatal abstinence syndrome was considerably higher in the later cohort (45%) than in the earlier cohort (29%). The babies' average length of stay in the special care baby unit increased by over 2 days in the later cohort when compared to the earlier cohort.

The data indicate that opiate-dependent pregnant women and their infants are a very vulnerable group and require special care at both drug treatment and maternity hospitals.

Methadone and perinatal outcomes: a retrospective cohort study

This study examined the relationship between methadone maintenance treatment and maternal characteristics, perinatal outcomes as well as neonatal abstinence syndrome.[3] This was a retrospective cohort study of 61,030 singleton births at a large maternity hospital in the period 2000–2007 based on antenatal, delivery and postnatal records and the Central Treatment List (of clients prescribed methadone).

Of the 61,030 singleton births, 618 (1%) were to women who were prescribed methadone at delivery. Methadone-exposed women were more likely to be younger, unemployed, Irish, unmarried, have had previous pregnancies, have an unplanned pregnancy, to book antenatal care later than 20 weeks into pregnancy, to be current smokers and to drink alcohol before pregnancy. In addition, and as expected, a higher proportion of methadone-exposed women were likely to test positive for hepatitis B, hepatitis C and HIV when compared to non-exposed women (Table 1).

Table 1 Blood-borne viral status among the study populations by exposure to methadone

	Exposed to methadone*		Non-exposed*	
Hepatitis B positive serological status	20	(3.5%)	326	(1.0%)
Hepatitis C positive serological status	275	(48.2%)	193	(0.6%)
HIV positive	35	(5.8%)	171	(0.3%)

* The total number tested in each group is not presented in the paper.

Methadone exposure was associated with an increased risk of very preterm birth (before 32 weeks' gestation), being small for gestational age (below the 10th percentile), admission to the neonatal unit, and diagnosis of a major congenital anomaly. There were four cases of Pierre Robin sequence among 618 methadone–exposed babies, compared to eight cases in 60,412 non-exposed infants. Although not statistically significant, the proportion of deaths within the first six weeks of birth was three times higher among the methadone-exposed group (2.4%) than the non-exposed group (0.8%).

There was a dose–response relationship between methadone and neonatal abstinence syndrome. As the dose of methadone increased so did the incidence of neonatal abstinence syndrome (Table2). Preterm birth and small gestational age also predicted the presence of neonatal abstinence syndrome.

Maternal and neonatal health among opiate users *(continued)*

Table 2 Methadone dose and its relationship with neonatal abstinence syndrome (n=615)

Neonatal abstinence syndrome					
Methadone dose in mg	Present		Absent		Adjusted odds ratios (95% CI)*
<21	19	(23.8)	61	(76.2)	1
21–50	73	(33.3)	146	(66.7)	0.9–3.5
51–80	117	(47.4)	130	(52.6)	1.6–6.53
81–100	26	(48.1)	28	(51.8)	1.3–7.5
>100	11	(73.3)	4	(26.7)	2.5–48.0

*Adjusted for preterm birth, gestational age, gender, maternal smoking during pregnancy and alcohol use before pregnancy

After controlling for known adverse socio-demographic factors, methadone exposure was found to be associated with an increased risk of adverse perinatal outcomes. Methadone dose at delivery was one of the important determinants of neonatal abstinence syndrome.

(Jean Long)

1. Carmody D, Geoghegan N, Sheppard R, Keenan E and O'Connell M (2011) Drug use in pregnancy: challenges for health care workers. *MIDIRS Midwifery Digest*, 20(4): 447–450.
2. Scully M, Geoghegan N, Corcoran P, Tiernan M and Keenan E (2004) Specialized drug liaison midwife services for pregnant opioid dependent women in Dublin, Ireland. *Journal of Substance Abuse Treatment*, 26(1): 27–33.
3. Cleary BJ, Donnelly JM, Strawbridge JD, Gallagher PJ, Fahey T, White MJ, Murphy DJ. (2011) Methadone and perinatal outcomes: a retrospective cohort study. *American Journal of Obstetrics and Gynecology*, 204(2): 139.e1–9.

Review of treatment for over-the-counter opiate misuse

There is a limited amount of detailed information in Ireland and internationally on the misuse of over-the-counter (OTC) opiates. Researchers at St Patrick's University Hospital have examined the clinical profiles, treatment and prevalence of patients admitted in a 12-month period with a diagnosis of OTC opiate abuse.[1]

All inpatient records between 1 April 2007 and 30 April 2008 were retrospectively reviewed, and 20 patients were identified as having a diagnosis of either harmful use of OTC opiate or dependency. These patients represented 0.6% of all patients admitted during that period, and 4% of all patients diagnosed with mental or behavioural disorder due to psychoactive substances. Of the 20 patients, 70% had a diagnosis of opiate dependency and 30% of harmful opiate use. In addition, all but one (95%) had a diagnosis of co-morbid psychiatric illness. Codeine was the opiate misused in all 20 cases, and all cases reported using a combination-type OTC opiate, that is, codeine with paracetamol (e.g. Solapdeine) or codeine with ibuprofen (e.g. Nurofen Plus). Fifteen patients received treatment for opiate withdrawal.

Some of the other main findings of the study were:

- The mean age of the 20 patients studied was 49 years;
- 13 were female;
- 13 had a history of harmful use of or dependency on alcohol;
- 8 had a history of harmful use of or dependency on benzodiazepines;
- 16 reported daily use;
- 4 reported chronic pain;
- 7 relapsed within six months;
- 15 obtained the drug over the counter;
- 5 obtained the drug over the internet.

Although the numbers in the study were small, the high rates of polysubstance misuse and co-morbid psychiatric illness among the cases reviewed are consistent with the findings of similar research internationally. The authors note with concern that the average reported amount of codeine taken daily was high (261mg), and suggest that this is likely to have been an underestimation. They point out that, to ingest such a large amount of codeine in the form of an OTC product, an individual would have to take correspondingly large daily doses of the combination compounds, usually paracetamol or ibuprofen, which greatly increased the risk of side-effects or overdose from both products. The authors suggest preventative measures, such as reducing the number of tablets per pack and placing an additional health warning on packaging. They state that any move to make OTC opiates prescription-only needs to be carefully considered, taking account of the increase in pressure on GPs and the reduction in patient autonomy that such a move might cause.

In May 2010 the Pharmaceutical Society of Ireland published guidelines[2] on the safe dispensing of OTC opiate products; these products can now be dispensed only under the supervision of a pharmacist.

(Suzi Lyons)

1. Thekiso T and Farren C (2010) 'Over the counter' (OTC) opiate abuse treatment. *Irish Journal of Psychological Medicine*, 27(4): 189–191.
2. 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.

Mental illness and alcohol and other drug use

Substance dependence and other mental illnesses co-exist in a proportion of patients attending health services and recent research has attempted to estimate and describe the phenomenon. Two such studies are described in this article.

Co-morbid drug use or psychiatric diagnosis among alcohol-dependent patients

Lyne and colleagues reviewed the records of patients presenting with co-morbid psychiatric diagnoses and drug use at a 12-bed alcohol treatment unit in a psychiatric teaching hospital in Dublin between 1995 and 2006.[1] Patients were included if they were aged 44 years or under, remained in hospital for more than 28 days, and had a diagnosis of alcohol dependence.

The review of 465 records revealed that 38.9% patients had used drugs other than alcohol during their life and 34.2% had a documented history of a co-morbid psychiatric diagnosis. Cannabis (26.4%), cocaine (17.1%), and ecstasy (12.5%) were the most common substances reported. Just under 10% reported use of benzodiazepines or other sedatives and just under 6% had used heroin. The disease-specific rates were: 25.3% had a depressive disorder; 3.9% an anxiety disorder; 2.8% a bipolar affective disorder and 2.2% a psychotic disorder. A small proportion (3.7%) of patients had two or more psychiatric diagnoses alongside their alcohol dependence. Forty-eight (10.3%) patients had a documented history of deliberate self-harm, of whom 29 had a psychiatric diagnosis as well as alcohol dependence.

The median age of the study population was 37 years and the age range was 17–44 years. Just over three-fifths (61.1%) of patients were men; 203 (44.3%) of the patients were never married; and 38 (8.3%) were separated or divorced. The proportions of women with a history of depressive disorder, eating disorder and deliberate self-harm were significantly higher than those for men. The proportion of men with psychotic disorder was marginally higher than that of women. Deliberate self-harm was associated with lifetime drug (excluding alcohol) use. Ecstasy users were more likely to have a diagnosis of depression.

Cannabis use and non-clinical dimensions of psychosis in university students presenting to a student health clinic

Skinner and colleagues explored the relationship between cannabis use and self-reported dimensions of psychosis in a population of university students presenting for any reason to primary care.[2]

Fifteen thousand students were enrolled in undergraduate or postgraduate courses at the National University of Ireland, Galway, in 2008. One thousand and forty-nine (7%) students attended the Student Health Unit between April and October of that year and these completed self-report questionnaires on:

- demographic profile;
- history of mental illness;
- alcohol and other drug misuse;
- non-clinical dimensions of psychosis [Community Assessment of Psychic Experiences (CAPE)];
- anxiety and depression [Hospital Anxiety and Depression Scale (HADS)].

The respondents may not be representative of the third-level student population. The average age of the respondents was 21.2 years (range 17–54); 82% were women; 94% were Irish; and 96% were single. Sixteen per cent sought professional help for emotional or psychiatric problems; 23% reported a family history of mental illness; and almost 5% reported a family history of psychotic illness.

Respondents reported drinking an average of 9.4 units (range 0–120) of alcohol per week and an average of 5.9 units (range 0–35) per sitting. Forty per cent (423) had smoked cannabis at least once in their life, of whom 327 reported use between 1 and 30 times and 86 reported use 30 or more times. The average age at first use of cannabis was almost 17 years (range 10–40). The rates of lifetime use of other drugs were: ecstasy 6.9%, cocaine 5.8%, magic mushrooms 5.1%, LSD 2.1% and heroin 0.1%.

Twenty one per cent had HADS scores of between 8 and 10 (borderline abnormal level) on the anxiety subscale and 15% had scores of 11 or above (abnormal level). Just under 3% reported borderline abnormal level on the depressive subscale and 1% reported abnormal level. The average weighted CAPE frequency score for negative symptoms was 1.57 (range 1–4), and for positive symptoms 1.29 (range 1–3).

The higher HADS anxiety scores were associated with a personal history of mental illness, a family history of psychiatric disorder and being female. The higher HADS depression scores were associated with a personal history of mental illness.

The CAPE positive psychotic symptom scores were associated with: personal history of mental illness, family history of psychiatric disorder, younger respondents and men. The CAPE negative psychotic symptom scores were associated with: personal history of mental illness and family history of psychiatric disorder. The CAPE depressive symptom scores were associated with: a personal history of mental illness, a family history of psychiatric disorder and being female.

After controlling for the effects of personal history of mental illness, family history of psychiatric disorder, age and gender, the CAPE positive and negative psychotic symptom scores were associated with high frequency cannabis use. In addition, the CAPE negative psychotic symptom scores and depressive symptom scores were associated with low frequency cannabis use.

After further controlling for frequency of cannabis use, it was found that the earlier the age at which a person commenced cannabis use the more positive psychotic symptoms they experienced.

These findings support the hypotheses that cannabis use increases the risk of developing psychotic symptoms and that this risk is further increased in individuals who use cannabis more heavily and commence use at a younger age.

(Jean Long)

1. Lyne J, O Donoghue B, Clancy M and O'Gara C (2011) Comorbid psychiatric diagnoses among individuals presenting to an addiction treatment program for alcohol dependence. *Substance Use & Misuse*, 46(4): 351–358.

Mental illness and substance use *(continued)*

2. Skinner R, and Conlon L, Gibbons D and McDonald C (2011) Cannabis use and non-clinical dimensions of psychosis in university students presenting to primary care. *Acta Psychiatrica Scandinavica*, 123(1): 21–27.

Infectious diseases update

A number of recently published studies examining different aspects of infectious diseases and drug use are summarised below.

Substance use among HIV patients

The authors compared the characteristics and behaviours of people with HIV living in Ireland with those in Australia.[1] The data were collected between June and December 2005 and the participants were asked about tobacco, alcohol and other drug use. The average age of the respondents in Ireland was 36.2 years, and in Australia 45.3 years. Sixty-seven per cent of the study group in Ireland were men, while 98% of those in Australia were men. Forty-seven per cent of the participants in Ireland were Irish and 42% were African. Two thirds of the participants in Australia were Australian and 16% were New Zealanders. Forty-two per cent of participants in Ireland reported using recreational drugs at some point in their life; seven respondents reported ever injecting, and four reported a history of drug dependence. Fifty-four per cent reported smoking tobacco at some point in their life. Seventy-two per cent drank alcohol at some point in their life, of whom 9% reported a history of alcohol dependence.

Table 1 Substance misuse among HIV patients

	Ireland		Australia	
	n	%	n	%
Recreational drugs				
Current use	12	13	61	41
Past use	28	29	46	64
Admits addiction	7	18	18	18
Admits injecting drug use	4	10	18	18
Tobacco				
Current use	34	37	55	37
Past use	16	17	38	26
Never used	42	46	54	37
Alcohol				
Current use	49	52	107	77
Past use	29	30	27	19
Never used	18	19	6	4
Admits addiction	7	9	11	8

MRSA and MSSA among attendees at a Dublin methadone clinic

Ninety-six of 183 clients attending methadone treatment at the Drug Treatment Centre Board in Dublin were randomly selected to complete a 12-item questionnaire, and to provide nasal swabs to be tested for meticillin resitant Staphylococcus aureus (MRSA) and meticillin sensitive Staphylococcus aureus (MSSA) and blood samples for viral analysis.[2]

Of the 96 nasal swab specimens submitted for culture and identification, 3.1% grew MRSA and 25% grew MSSA. The serological analysis revealed that 73% of the clients were hepatitis C positive and 12% were HIV positive.

Seventy three per cent of the sample were men. Twenty-seven per cent of the clients had been in prison in the year prior to the survey and 86% had been in prison at least once in their life. One quarter had been homeless at some stage in the preceding 12 months and 27% lived alone.

Seventeen per cent had snorted cocaine in the year prior to the survey and 24% had injected it. Forty- eight per cent had injected heroin in the 12 months prior to the survey, and 53% had injected either heroin or cocaine. All injectors had attended needle-exchange services at least once in the 12 months prior to data collection; only 7% had shared needles, while 18% had shared other injecting equipment. Twenty-eight per cent reported at least one soft-tissue abscess in the past year, 71% had had one or more courses of antibiotics, and 40% had had at least one hospital admission.

As the prevalence of MRSA was low and the sample size very small, it was not possible to identify factors associated with MRSA carriage among those in methadone treatment. The prevalence of MRSA in the opiate-dependent population in Dublin is lower than that in Brighton (49%) and Vancouver (19%) but higher than that in Italy (1.1%).

Hepatitis C management: the challenge of dropout

This study examined all referrals made to an urban tertiary care liver centre for hepatitis C virus (HCV) management, tracked subsequent progress and identified the dropout rate at the different stages.[3] The authors completed a cross-sectional retrospective review to examine HCV referrals received between 2000 and 2007. The demographic, clinical and treatment data were extracted from medical charts and the hospital information system.

A total of 588 individuals and 742 cases were referred for management of their hepatitis C. Sixty-seven per cent of referrals were men and the average age was 33.3 years. Three quarters (74%) of cases were injecting drug users. Eighty-three per cent of cases were Irish. Fifty-seven per cent of cases were referred by their general practitioner. Other sources of referral were hospital, drug treatment centres, prisons and asylum centres. Of the 742 referrals received, 141 (19%) failed to attend their initial appointment, 180 (24%) dropped out from early outpatient management, 29 (4%) failed to attend for liver biopsy and 81 (11%) did not attend subsequent outpatient follow-up. In total, 451 (61%) dropouts occurred. In those treated, a sustained viral response rate (successful treatment rate) of 74% was observed. The number and proportion of patients who experienced viral clearance varied with genotype, specifically, genotype 1 18/30 (60%); genotype

Infectious diseases update *(continued)*

2 4/5 (80%); genotype 3 40/49 (82%). Those with a history of injection drug use were more likely to drop out immediately after the referral, dropout from early outpatient management and dropout over entire span of disease management than their non-injecting counterparts. Men were more likely ($P<0.05$) to drop out of disease management than women. Eight individuals died during the study period.

The authors report that an 'exceptionally high rate of dropout exists' among those attending services to monitor and manage hepatitis C in injecting drug users, particularly in the early stages of service delivery. The study findings have led to the development of innovative approaches helping to optimize hepatitis C management in this population, such as texting reminders and using a change model to improve engagement and compliance with behaviour and treatment.

Hepatitis C virus in primary care: survey of nurses' attitudes to caring

This study measured the knowledge of and attitudes towards hepatitis C among 560 nurses working in general practice, public health and addiction, and identified the source of their knowledge.[4] The researchers completed a cross-sectional survey in 2006 with the nurses in the three categories of primary care through a postal questionnaire in one region of Ireland. The questionnaire contained five sections: demographic, work profile, knowledge, attitude and education. The questions were validated and pilot tested. The total number of primary care nurses working in the region was 981 and 560 (57%) completed a questionnaire. The response rates varied by type of nursing specialism: general practice was 57% (126), public health 55% (385) and addiction services 83% (49). The attitudes of the nurses towards hepatitis C are not presented in this paper.

Almost all (98%) of the nurses were female, and their average age was 43 years. Nurses in the addiction services were younger than those in general practice or in public health services. The nurses' qualifications ranged from certificate (25%) to post graduate degree (4%) level. Fifty-five per cent were qualified to diploma or higher diploma level and 15% were qualified to at least degree level. Nurses in the addiction and in the public health services had higher qualifications than those in general practice. Nurses working in the public health service had longer service than those in addiction or general practice. Addiction nurses were more likely to work full time.

Eighteen per cent had a personal friend or relative who had hepatitis C. Thirty-nine per cent of respondents reported having professional contact with people with hepatitis C. As expected, nurses in addiction services had more professional dealings with people with hepatitis C (96%) compared to nurses in public health (30%) or in general practice (44%). According to the authors, 90% of addiction service nurses provided information on the dangers of alcohol, the benefits of hepatitis A and B vaccination, dietary intake and transmission of the virus, while only 30% of nurses in public health provided advice on the dangers of alcohol, and 11% of the same cohort on the benefits of hepatitis vaccination. The advice provided by practice nurses is not reported.

Only 22% of nurses had received formal training on hepatitis C. Not surprisingly, a higher proportion (86%) of nurses working in the addiction services received training on hepatitis C, compared to the proportions working in public health (13%) or general practice (16%). Ninety-six per cent of nurses working in the addiction services reported that they were well informed about hepatitis C, while only 20% of practices nurses and 21% of public health nurses reported the same. The respondents were asked to identify 21 statements about hepatitis C as true or false. Though the nurses working in addiction services had good knowledge about hepatitis C, there were four areas where 25% or more provided an incorrect answer, and these were:

- Hepatitis C can be spread through close personal contact such as kissing; this is false but 25% of the nurses said it was true
- Hepatitis C is commonly spread through sexual transmission; this is false
- Most people who get hepatitis C will die prematurely because of the infection; this is false
- More than 50% of pregnant women with HCV will infect their children; this is false

The level of knowledge among the public health and practice nurses was less than desirable, with at least 12 areas where 25% of the nurses provided an incorrect answer. Four of the areas were those cited above and the other eight areas were:

- People with hepatitis C should be restricted from working in the food industry; this is false but 25% of nurses working in public health and general practice said it was true
- Hepatitis C is a mutation of the hepatitis B virus; this is false
- There is no pharmaceutical treatment for hepatitis C; this is false
- HIV is easier to catch than hepatitis C; this is false
- Once you have hepatitis C you cannot get it again because you are immune; this is false
- There is only one genotype of hepatitis C virus; this is false
- Hepatitis C is associated with an increased risk of liver cancer; this is true but 25% of nurses working in public health and general practice said it was false
- People can have the hepatitis C virus without being currently infected with the virus; this is true

The authors calculated mean knowledge-level scores for each group of nurses; the mean score for addiction nurses was 22.5, for nurses working in public health 16 and for practice nurses 16.9. The overall mean score was 16.7. Nurses were most likely to have better knowledge about hepatitis C if they were younger, educated to degree level or above, attended a formal training course, personally knew someone with hepatitis C, had professional contact with patients with hepatitis C, or considered that they themselves were well-informed about hepatitis C.

Nurses working in public health services and general practice require formal training in hepatitis C care and management. Nurses in the addiction services need to update their knowledge in four areas.

(Compiled by Jean Long)

Infectious diseases update *(continued)*

1. O'Connor MB, O'Connor C, Saunders SA, Sheehan C, Murphy E, Horgan M *et al.* (2010) Substance use among HIV patients. *Irish Journal of Medical Science*, 179(3): 467–468.
2. Somers CJ, Bridgeman J and Keenan E (2010) Nasal carriage prevalence of meticillin resitant (MRSA) and meticillin sensitive (MSSA) Staphylococcus aureus for subjects attending a Dublin methadone clinic. *Journal of Infection*, 60(6): 494–496.
3. Lowry DJ, Ryan JD Ullah N, Barry T and Crowe J (2011) Hepatitis C management: the challenge of dropout associated with male sex and injection drug use. *European Journal of Gastroenterology & Hepatology*, 23(1): 32–40.
4. Frazer K, Glacken M, Coughlan B, Staines A and Daly L (2011) Hepatitis C virus in primary care: survey of nurses' attitudes to caring. *Journal of Advanced Nursing*, 67(3): 598–608.

From *Drugnet Europe*

Over 40 new drugs reported in 2010

Cited from article by Roumen Sedefov and Ana Gallegos in *Drugnet Europe*, No. 74, April–June 2011

According to the EMCDDA–Europol 2010 report on new drugs entering the European market,[1] 41 new psychoactive substances were officially notified for the first time to the two agencies in 2010. This represents the largest number of substances ever reported in a single year, considerably up on 2009 (24 substances) and 2008 (13 substances). The full list of substances notified shows a 'rather diverse' group, including: synthetic cannabinoids, synthetic cathinones, synthetic derivatives of well-established drugs as well as one plant-based substance (arecoline).

The report gives an account of the risk assessment of the synthetic cathinone derivative, mephedrone, which led to the decision for Europe-wide controls on the drug in December 2010. A further 15 synthetic cathinone derivatives were detected during the year. Also documented is the first-time appearance of derivatives of two established drugs: ketamine and PCP (phencyclidine).

Commenting on this year's findings, EMCDDA Director Wolfgang Götz said: 'Given the speed at which new developments occur in this area, it is important to anticipate future challenges. While our early-warning system has recently upped its operational capacity to react rapidly to new substances and products identified, it currently lacks the ability to anticipate emerging threats. This could be addressed by actively purchasing, synthesising and studying new compounds and by improving capacity for investigative forensic analysis and research at European level.'

1. EMCDDA–Europol (2011) *EMCDDA–Europol 2010 annual report on the implementation of Council Decision 2005/387/JHA.* Lisbon: EMCDDA, www.emcdda.europa.eu/publications/implementation-reports/2010

Opioid substitution treatment: the role of general practitioners

Cited from article by Allesandro Pirona in *Drugnet Europe*, No. 74, April–June 2011

General practitioners are becoming an increasingly important provider of drug treatment services in Europe and are helping to reduce inequalities in the accessibility and availability of opioid substitution treatment (OST). GPs now provide OST to heroin dependent users in 14 EU countries, usually under shared care arrangements with specialised treatment centres. It is estimated that around a third of the estimated 670 000 clients in OST in Europe receive their treatment through GPs.

While specialist drug treatment services remain the EMCDDA's main data suppliers in this area, GPs and other service providers can be a key additional information source, helping to improve reporting on overall treatment provision in Europe. Such information is pivotal in assessing the availability and accessibility to effective treatment as well as gauging the unmet needs of drug users.

Under its 2011 work programme objective 'to develop and explore potential new data sources on drug treatment and harm reduction', the EMCDDA is investigating strategies for collecting treatment data from GPs. It is also facilitating the exchange of experience between GPs and scientists in the EU regarding the benefits of GP involvement in this type of treatment (e.g. client health management, continuity of care) and the challenges in current medical practice (e.g. managing polydrug use, diversion of medications).[1]

1. European exchange on the practice and current issues in opioid substitution treatment in general practitioners' settings. www.emcdda.europa.eu/html.cfm/index2062EN.html

Drugs in focus – policy briefing

Khat use in Europe: implications for European policy
(Cited from *Drugs in focus*, No. 21, 1st Issue, 2011)

Khat refers to the young and tender leaves and shoots of the khat tree (Catha edulis) cultivated in the highlands of the Horn of Africa, Southern Arabia and along the East African coast. It contains stimulant substances that have amphetamine-like properties. In their pure forms, they are internationally controlled substances, but the leaves are not. Excessive consumption can lead to dependence. It may also result in somatic and mental health hazards in otherwise healthy individuals. In Europe, khat is controlled in some, but not all, countries. This has resulted in both legitimate and criminal transportation networks. Khat is mainly consumed by first generation immigrants from sub-Saharan Africa, among whom it is a contested topic. Over the last three decades, khat has become a major source of employment, income and revenues in producing countries.

Conclusions and policy considerations

- The potential for the crossover of khat to the wider drug market appears limited.
- Khat consumption may lead to health and social problems. European health professionals and social workers need to be able to identify khat-related harms and have strategies in place to protect vulnerable user groups.
- European khat markets appear to be growing but data sources are weak, pointing to a need to improve monitoring.
- Development and drug control policies for khat-producing countries require co-ordination and an awareness of the potential impact of European control measures.
- Khat is primarily used by migrant communities in Europe. These communities need to be better informed about its potential health, social and legal consequences.
- The number of khat users in Europe appears to be growing, yet the scale and nature of the problem is poorly understood. Research studies are therefore required to better assess the market for the drug, evolving patterns of use, as well as the extent of any socio-economic and health consequences.

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

If you would like a hard copy of the current or future issues of either publication, please contact:
Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2.
Tel: 01 2345 148; Email: drugnet@hrb.ie

In brief

On 27 October 2010 the **New Zealand Law Commission** published its report ***Compulsory treatment for substance dependence***. It concludes that compulsory treatment for alcohol and drug dependence is only justified when a person's dependence has seriously impaired his or her capacity to make choices about ongoing substance use and personal welfare; care and treatment is necessary to protect the person from significant harm; no other less restrictive means are reasonably available for dealing with the person; the person is likely to benefit from treatment; and the person has refused treatment. The report includes proposals to make the existing law relating to compulsory treatment more user-friendly while also providing greater safeguards for people forced to undergo compulsory treatment. www.lawcom.govt.nz

On 13 December 2010 the **British–Irish Council** held its 15th summit meeting, attended by senior political leaders from the eight member administrations, including Ireland. It received an update on the work of the Misuse of Drugs workstream during 2010, which included meetings on the policies of the eight administrations in tackling alcohol misuse, substance misuse in prisons, and headshops, as well as new directions for drug and alcohol policy and community action in dealing with drugs, alcohol and anti-social disorder. In 2011 the group will discuss the new UK National Drugs Strategy. www.gov.je/BritishIrishCouncil

On 24 January 2011 the **Children's Rights Alliance** released its third ***Children's report card 2011***. Alcohol gets an 'F' grade again, no change from last year. The assessors comment that although progress had been made in prioritising and intensifying measures to tackle alcohol misuse among young people, and doubling the penalties for all related statutory offences, the focus has been wrong. Greater emphasis is needed on enforcement and implementing evidence-based policy solutions. www.childrensrights.ie

On 21 February 2011 **STAR awards**, which recognise and celebrate collaborative work undertaken in adult learning initiatives in local communities, were awarded to two drug-related adult learning projects. The **School of Applied Social Science in UCD** in conjunction with **Merchants Quay Ireland (MQI)**, **An Cosan (Tallaght)** and **Urrus (Ballymun)** were the nationwide winners for the Partnership Education Initiative in Drug Prevention Education and Research Capacity, i.e. two diploma programmes provided through local service providers. Soilse, whose participants all come from a drug addiction background, topped the Dublin region for its Service User Involvement (SUI) programme. Highly commended in the Dublin region was **RADE Ltd (Recovery through Art, Drama and Education)**, which engages recovering drug users in arts activities. www.adultlearnersfestival.com/starawards

On 28 February 2011 the **Children's Rights Alliance** published ***Ten years on: did the National Children's Strategy deliver on its promises?*** It reports progress on Action 40 to expand specialist drug treatment for under-18s, although 'the impact on children's lives is unknown as impact of funding on services is unclear'. Progress is also reported on Action 78 'to provide an adequate emergency response to young homeless people (including day service, education and training, drug treatment)'. However, the supports available and responses to homelessness among children are deemed 'still patchy and ad hoc across the country'. www.childrensrights.ie

On 23 March 2011 the **World Health Organization (WHO)** launched the **ASSIST package** of screening and brief interventions to help health professionals detect and respond to alcohol, tobacco and other psychoactive substance use. It comprises a brief questionnaire, a guide for health professionals on how to use the questionnaire in detecting and responding to substance use and a self-help manual for cutting down or stopping substance use. It is WHO's response to the growing demand for guidance on how to manage substance use problems in non-specialist health care settings. www.who.int/topics/substance_abuse/en

In April 2011 the results of the first **Your Dublin, Your Voice** survey were published. An opinion panel of almost 2,300 members has been formed to find out their views on living, working and studying in the city region. The first iteration of the survey was undertaken in October–December 2010. Respondents were asked to describe unprompted and in their own words the worst thing about Dublin. Over 2,200 comments showed a very strong consensus, with over one in three respondents (36%) describing anti-social behaviour (particularly drink and drug-related behaviour, crime and safety issues) as being the worst thing about Dublin. There were over 400 mentions of drugs and drug use in the open responses. An initiative of Dublin City Council, in collaboration with the Dublin Regional Authority and the other Dublin local authorities, panel members will be invited to participate in regular ongoing surveys. www.yourdublinyourvoice.ie or www.facebook.com/yourdublinyourvoice

On 3 May 2011 the **New Zealand Law Commission** published its report ***Controlling and regulating drugs – a review of the Misuse of Drugs Act 1975***. Among the key proposals contained in the report are (1) a mandatory cautioning scheme for all personal possession and use offences that come to the attention of the police, removing minor drug offenders from the criminal justice system and providing greater opportunities for those in need of treatment to access it; (2) a review of the current drug classification system in order to address inconsistencies and to develop a system based solely on assessing a drug's risk of harm, including social harm; and (3) making separate funding available for the treatment of offenders through the justice sector, in order to support courts when they impose rehabilitative sentences to address alcohol and drug dependence problems. www.lawcom.govt.nz

On 4 May 2011 **Europol** published ***Organised crime threat assessment 2011 (OCTA)***, its bi–annual report assessing current and expected trends in organised crime affecting the European Union. It contains eight pages on drugs, including sections on heroin, cocaine, synthetic drugs, cannabis and qat. Drug crime groups are described as becoming increasingly 'multi-commodity' and 'poly-criminal', for example, dealing in more than one type of drug, engaging in other criminal activities such as producing counterfeit, co-operating with other groups in sharing loads or bartering drugs for other illicit goods such as stolen property and firearms. The benefits of such diversification include greater resilience in face of drug market fluctuations, less visibility and consequently less risk of detection, and greater profits. www.europol.europa.eu

Compiled by Brigid Pike

Recent publications

Books

Books recently acquired by the National Documentation Centre on Drug Use.

Understanding Limerick: social exclusion and change
Edited by Niamh Hourigan
Cork University Press (2011); ISBN 978-185918-457-8
www.drugsandalcohol.ie/15274

Drugs and culture: knowledge, consumption and policy
edited by Geoffrey Hunt, Maitena Milhet and Henri Bergeron
Ashgate (2011); ISBN 978-140940-543-6
www.drugsandalcohol.ie/15302

Journal articles

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

Acute liver failure following recreational use of psychotropic ''head shop'' compounds

Fröhlich S, Lambe E and O'Dea J
Irish Journal of Medical Science, 2011; 180(1): 263–264
www.drugsandalcohol.ie/15368

This report describes the case of a 28-year-old male with bipolar affective disorder but otherwise healthy who presented with acute psychosis and subsequent hepatic failure following ingestion of butylone (a phenethylamine derivative) and methylenedioxypyrovalerone (MDPV, a noradrenaline and dopamine reuptake inhibitor). This is the first case report associating these compounds with acute liver failure.

The great Irish head shop controversy

Ryall G and Butler S
Drugs: education, prevention and policy, 2011; 18(4): 303–311
www.drugsandalcohol.ie/15360

This research describes and analyses recent policy developments in Ireland in relation to the practice of selling psychoactive substances which, while not themselves illegal, mimic the effects of commonly used illegal drugs. These so-called 'legal highs' had been sold in Ireland through an increasing number of 'head shops' which in late-2009 and early-2010 became the subject of considerable public controversy, culminating in legislative measures aimed at their closure. Based on semi-structured interviews with some of the main stakeholders in this process and set against a background of saturation media coverage of this phenomenon, this article presents and assesses competing perspectives on the head shop issue. From a conventional drug control perspective, recent legislative measures in Ireland may be seen as representing effective cross-cutting activity between the health and criminal justice sectors. From a harm reduction perspective, however, this policy response may be seen as an example of moral panic in that media portrayals greatly exaggerated the ill effects of head shop products, in the process stoking public anger rather than encouraging rational debate.

Anxiety and depression among opiate users who misuse substances during treatment

Stapleton R and Comiskey C
Irish Journal of Psychological Medicine, 2011; 28(1): 6–12
www.drugsandalcohol.ie/14869

This paper sought to describe and model anxiety and depression outcomes during opiate substance misuse treatment. This was the first national, longitudinal treatment outcome study of 404 opiate users entering a new episode of inpatient or outpatient treatment and followed up at one and three years and assessed using the Maudsley Addiction Profile instrument.

A total of 404 opiate users were recruited, representing approximately 8.2% of all new treatments and 17% of all new methadone treatments in Ireland in 2003. At three years 97% (392) were followed up. At one year, analysis revealed the odds of experiencing depression was between five and 15 times the odds for opiate users who also used cocaine than non-cocaine using opiate users, but this had decreased at three years. At three years those who were drug free, that is, not in treatment and not using illicit drugs, were less likely to experience feeling hopeless about the future than those in treatment or those not in treatment and using illicit drugs, but they were also more likely to experience feeling tense. Those in treatment were more likely to feel lonely.

The concurrent misuse of cocaine and other substances during opiate treatment and the stage of the treatment pathway are associated with anxiety and depression among opiate users in treatment. These client factors need to be considered when implementing individualised treatment care plans.

A new mixed mode solid phase extraction strategy for opioids, cocaines, amphetamines and adulterants in human blood with hybrid liquid chromatography tandem mass spectrometry detection

Dowling G and Regan L
Journal of Pharmaceutical and Biomedical Analysis, 2001; 54(5): 1136–1145
www.ncbi.nlm.nih.gov/pubmed/21194869

A rapid method has been developed to analyse morphine, codeine, 6-monoacetylmorphine, cocaine, benzoylecgonine, dihydrocodeine, cocaethylene, 3,4-methylenedioxyamphetamine, ketamine, 3,4-methylenedioxymethamphetamine, pseudoephedrine, lignocaine, benzylpiperazine, methamphetamine, amphetamine, methadone, phenethylamine and levamisole in human blood.

Blood samples were cleaned up using mixed mode solid phase extraction using Evolute™ CX solid phase extraction cartridges and the sample aliquots were analysed by hybrid triple quadrupole linear ion trap (QTRAP) mass spectrometry with a runtime of 12.5 min. Multiple reaction monitoring (MRM) as survey scan and an enhanced production (EPI) scan as dependent scan were performed in an information-dependent acquisition (IDA) experiment. Finally, drug identification and confirmation was carried out by library search with a developed in-house MS/MS library based on EPI spectra at a collision energy spread of 35 ± 15 in positive mode and MRM ratios.

Recent publications *(continued)*

The method was validated in blood, according to the criteria defined in Commission Decision 2002/657/EC. At least two MRM transitions for each substance were monitored in addition to EPI spectra. Deuterated analogues of analytes were used as internal standards for quantitation where possible. The method proved to be simple and time efficient and was implemented as an analytical strategy for the illicit drug monitoring of opioids, cocaines, amphetamines and adulterants in forensic cases of crime offenders, abusers or victims in the Republic of Ireland.

Prevalence of oral mucosal abnormalities in addiction treatment centre residents in Southern Ireland

O'Sullivan EM
Oral Oncology, 2011; Epub ahead of print

The study examined the prevalence of oral mucosal lesions and conditions among addiction treatment centre residents in southern Ireland and explored the feasibility and acceptability of a targeted oral cancer screening programme for such individuals.

Four alcohol addiction treatment centres were visited periodically over a 12-month period. Two hundred and twenty residents (78% of 283 targeted) were interviewed regarding their alcohol, tobacco and drug habits (type, quantity, duration), and attitudes to dental care. Comprehensive oral examinations were performed. All potentially sinister soft tissue lesions or symptoms were referred for further investigation. Ten participants who said that they did not have a history of alcohol or other drug addiction were excluded from the main study. The remaining 210 participants comprised 148 males (70%) and 62 females (30%), ranging from 18 to 73 years of age; 60% were under 40 years. High rates of tobacco and alcohol usage were recorded, 53% reported dual addiction (alcohol and another drug), 44% alcohol only, 3% drug only. The prevalence of mucosal abnormalities was 29% with 84 mucosal abnormalities or symptoms detected in 61 subjects, comprising 28 extra-oral lesions or symptoms and 56 intra-oral lesions. Residents with mucosal abnormalities were older (average 41.8 years; SD 14.3) than those without such lesions (mean 36 years; S.D. 13.3), ($p<0.05$). The most common oral mucosal abnormality was candidiasis or oral thrush (3.8%), followed by facial scaring or laceration (3.8%), intra-oral lumps or swellings (2.9%), lymphadenopathy (2.9%) and hoarseness (1.9%). Four red areas suggestive of erythroplasia and two leukoplakic lesions were detected.

The study addresses the paucity of data on the prevalence of oral mucosal lesions in addicted persons in Southern Ireland. Despite the relatively poor follow-up compliance rate (33%), two premalignant lesions were confirmed in the main study group, yielding a detection rate of 0.9%. Inclusion of oral cancer screening in the routine medical examination given to residents of addiction treatment centres may provide an efficient and effective way to detect potentially malignant lesions in these high-risk individuals.

Upcoming events

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

September

19 September 2011
Making progress in dual diagnosis – refocusing and re-energising service improvement for the next decade

Venue: ORT House Conference Centre, London NW1
Organised by / Contact: Pavilion, in partnership with Progress
Email: info@pavpub.com
www.pavpub.com

Information: This conference will focus on developments in service delivery and integration of treatment for people with a dual diagnosis of mental health and co-existing substance misuse,.with the aim of sharing new techniques and identifying future direction. Key speakers will include David Burrowes MP, Prof. Christine Barrowclough and Prof. Charlie Brooker.

21–22 September 2011
The future of harm reduction and drug prevention in the UK

Venue: Glasgow/Edinburgh
Organised by / Contact: Addiction Debates
Email: Christopher at chris@addictiondebates.com
http://addictiondebates.com

Information: Prof. Stanton Peele and Prof. Neil McKeganey will meet in Glasgow and Edinburgh on September 21st and 22nd, 2011, to debate the future of the harm reduction and prevention approaches to drug policy and treatment in the UK. These debates will be moderated by Mike Ashton (Editor of Drug & Alcohol Findings) and Dr Roy Robertson (University of Edinburgh). Issues that will be debated include:

- The individual and community health impact of harm reduction strategies
- Drug prevention strategies aimed at reducing supply and demand
- Drug criminalisation, decriminalisation, legalisation, and regulation
- Abstinence-based drug and alcohol treatment programs
- Methadone maintenance, needle exchange, and safe injection sites
- The policy implications of treating addiction as a brain disease

October

8 October 2011
Parish prevention of substance misuse

Venue: Clonliffe College, Drumcondra, Dublin 3
Organised by / Contact: Crosscare Drug & Alcohol Programme and the Irish Bishops Drugs Initiative
Tel: (01) 836 0911
Email: info@crosscare.ie
www.crosscare.ie

Upcoming events *(continued)*

Information: The aims of this conference are to show positive and simple ways in which a parish can play a part in prevention and awareness of drug and alcohol misuse, and to highlight supports available to parishes within the Dublin Diocese in relation to education and training. Booking is essential as places are limited.

18 October 2011
Achieving a Rehabilitation Revolution – a national policy conference
Venue: London
Organised by / Contact: Policy Communications
Email: info@policycommunications.co.uk
www.policycommunications.co.uk/conferences.html

Information: This one-day policy conference, supported by the Probation Association, will explore the coalition government's reforms to the criminal justice system — examining plans for changes to the sentencing framework, how the 'rehabilitation revolution' aims to transform punishment and reduce reoffending, and how decentralising control and applying new models of commissioning will work in practice.

November

2 November 2011
Delivering drug and alcohol services: Rising to the challenge
Venue: London N1 9RL
Organised by / Contact: DrugScope
Email: conferences@drugscope.org.uk
www.drugscope.org.uk

The sheer weight and speed of government activity which will directly or indirectly impact on our sector has left many breathless and not a little bewildered. There is the drug strategy itself, the localism and recovery agendas, welfare and NHS reforms, payment by results, election of police commissioners, the formation of Public Health England, the list goes on. This conference is an opportunity to step back and take stock of all these developments in the company of distinguished speakers, workshop leaders and panelists – your chance to debate the issues and share concerns with colleagues from across the UK.

3–4 November 2011
Drug Interventions: What Works? National Drugs Conference of Ireland 2011

Venue: Radisson Blu Royal Hotel Dublin 8
Organised by / Contact: Conference Steering Group /Irish Needle Exchange Forum
Email: tim@inef.ie
http://inef.ie

Information: This year's conference will build on the success of the 2010 conference, bringing together a range of national and international speakers from across the spectrum of addiction research, service provision and policy. The conference is sponsored by the HSE's National Addiction Training Programme (NATP), which 'welcomes this joint working with the Conference Steering Group, (representatives from the Irish Needle Exchange Forum, Ana Liffey Drug Project, Coolmine Therapeutic Community and the Irish Association of Alcohol and Addiction Counsellors)'

Confirmed speakers include:
Mr Joao Goulao – Drug policies in Portugal: was decriminalisation helpful?

Thomas McLellan PhD – former deputy director of the US Office of National Drug Control Policy, and founder and career researcher for 35 years with the Treatment Research Institute

Dr Andrew Tatarsky has specialised in the field of substance use treatment for over 30 years as a psychologist, supervisor, program director, lecturer and author.

Dr Paolo Deluca – How the Internet and social media are driving the legal highs phenomenon: findings from the ReDNet project

Mr Greg Purvis – If you build it they will come but if you don't sustain it they will leave: implementing and sustaining evidence-based practice

Mr Martin Woods has worked in the anti-money laundering space since 1984 when the first drug trafficking legislation was introduced in the UK.

Mr Brian Dalton has worked in health and social care for 13 years managing services across a variety of treatment sectors.

Mr Martin Brown has worked in drug and alcohol treatment in London for over 25 years.

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