drugnet IRELAND

Issue 43
Autumn 2012

Alcohol and Drug Research Newsletter

Children in state care

See pages 12 and 16

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Public support for measures to address alcohol use

Alcohol consumption

The results of a new survey, *Alcohol: Public knowledge, attitudes and behaviour*,[1] show a strong belief among 1,020 survey respondents (85%) that the current level of alcohol consumption in Ireland is too high, and a general perception (73%) that Irish society tolerates high levels of alcohol consumption. The survey was commissioned by the Health Research Board and done by Ipsos MRBI.

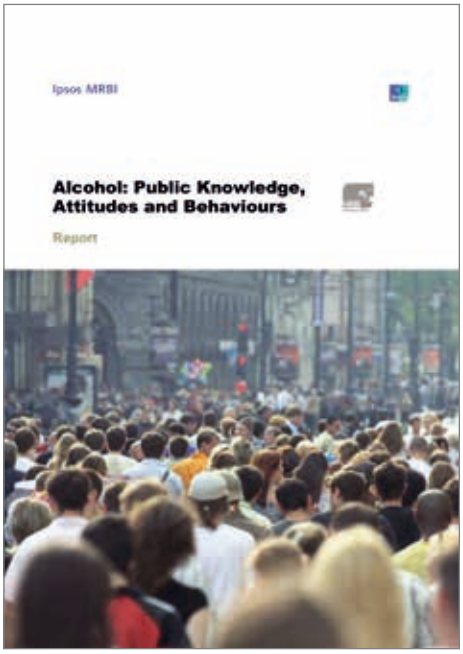
A considerable majority of respondents (72%, 744) say they know someone who, in their opinion, drinks too much alcohol, and of those, 42% say that the person is an immediate family member. Almost 6 out of 10 (58%) do not think that the government is doing enough to reduce alcohol consumption, while only 19% think that the government is doing enough. Over three-quarters (78%) believe that the government has a responsibility to implement public health measures to address high alcohol consumption, and there is support for implementing some of the specific measures in the recently published *Steering group report on a National Substance Misuse Strategy*.[2]

Measuring personal alcohol consumption

People have difficulty measuring their own drinking using the standard drink measure, but almost 6 out of 10 (58%) have heard of the term 'standard drink'. One in ten respondents correctly identified the number of standard drinks in each of the four measures of alcohol asked about in the survey. Only one in ten (9%) people know the recommended maximum number of standard drinks (proxy for low-risk drinking) that they can safely consume in one week, 14 for women and 21 for men.

Alcohol pricing

Around three-quarters (76%, 777) have bought alcohol in a supermarket in the past few years. Just over half (52%) of these respondents believe that the price of alcohol has fallen in supermarkets, with almost one quarter (23%) believing that it has remained at the same price and 17% believing that the price has increased. Of those noticing a decrease in the price of alcohol, one-quarter (25%) say that they have increased the amount they buy and this is more common among those aged 34 years or under (at 34%). Overall, 24% would buy more alcohol in supermarkets if the price were to decrease. Half of those aged 18–24 years claim they would buy more alcohol if supermarkets decreased prices.



It would require a 25% price increase to get at least two-thirds (67%) of those who bought alcohol in a supermarket to reduce the amount that they bought.

Opinion is somewhat divided on whether short-term price promotions encourage respondents to buy more alcohol than usual, with 45% agreeing that they buy more alcohol at such times and 39% disagreeing. Those aged 18–24 years are most likely to respond to such promotions, with almost two-thirds (65%) saying that they buy more when alcohol is on special offer or when the price is reduced.

Almost 6 out of 10 (58%) respondents support minimum unit pricing for alcohol. Support is strongest among those aged 35–64 years, at 65%. Over one-fifth (21%) would not support a minimum price for alcohol, with the lack of support (at 33%) highest among those aged 18–24 years. It is generally accepted that the greater the increase in alcohol prices the greater the reduction in purchasing, and that this has most effect on younger and heavy drinkers.

Forty-seven per cent agree that the government should reduce the number of outlets selling alcohol, while 28% disagree; agreement is

Public support for measures to address alcohol use *(continued)*

strongest among women (50%) and those over 44 years (54%). Forty per cent agree with selling alcohol in separate premises from food and other household products, while 32% disagree. The majority (66%) believe that distance sales are an easy way for young people to obtain alcohol and only 15% believe that distance sales are strictly monitored.

Alcohol advertising

The majority support restricting certain forms of alcohol advertising, and two-fifths (40%) would support a ban on all alcohol advertising. Almost 8 out of 10 (78%) believe that alcohol advertising should be limited to the product itself rather than being associated with images of the type of person who consumes the brand. Eighty per cent support banning alcohol advertising in cinemas before screening movies rated as suitable for viewing by those aged 17 years or under. Seventy-six per cent support banning any alcohol advertising on TV and radio before 9.00pm. In total, 70% support banning alcohol advertising on social media and 57% support a ban on alcohol advertising on billboards and at bus stops

Alcohol industry sponsoring sporting events

Overall, two-fifths (42%) support a ban on the alcohol industry sponsoring sporting events, and over one-third (37%) support a ban on sponsoring musical events. Support is somewhat higher among women (49% for sport and 45% for music) and in those 45 years or over (47% for sport and 46% for music). The main lack of support for discontinuing sponsorship is among men (54% for sport and 57% for music) and those under 44 years of age (51% for sport and 59% for music).

Information labels on alcohol products

There is a desire for better labelling of alcohol containers, with very strong support for all four suggested forms of information on the labels of alcohol containers. The vast majority of respondents want information on the alcohol strength (98%), the number of calories (82%), details of alcohol-related harms (95%) and a list of ingredients (91%).

Alcohol consumption and driving

There is good knowledge about the dangers of driving a vehicle under the influence of alcohol and there is strong support for measures to detect and deter such driving practices. Ninety per cent do not agree that it is safe to drive after two alcoholic drinks; 75% do not agree that it is safe to drive after one alcoholic drink. There is near universal support (94%) for the mandatory testing of the alcohol levels of drivers involved in traffic accidents. Over 8 out of 10 (84%) agree that those convicted of drink driving on more than one occasion should have an 'alcohol lock' fitted in their car.

Paying for the consequences of alcohol consumption

There is support for the suggestion that alcohol consumers and the alcohol industry should contribute to the health-related costs of excess alcohol consumption. Sixty one per cent believe that people who drink alcohol should contribute, and 42% believe that the alcohol industry should contribute to these costs. Only 27% believe that the State, through taxation, should contribute to these costs.

As with the health-related costs of excessive drinking, the majority believe that those who drink alcohol (71%) followed, to a lesser extent, by the alcohol industry (30%) and then the State through taxation (22%) should contribute to the costs of alcohol-related public disorder, relationship difficulties and financial loss.

Conclusions

The findings in this survey are consistent with those of the general population survey,[3] surveys among school children[4] and other public opinion surveys.[5]

Methods

This survey was conducted for the Health Research Board by Ipsos MRBI in May 2012 using a standard quota sample method in order to ascertain the knowledge, views and behaviours of 1,020 people. The age, gender and place of residence of the sample selected are representative of the 2011 Census population. The proportion of people who do and do not drink alcohol is consistent with the 2007 SLAN survey. The questionnaire was drafted by the Health Research Board and finalised in collaboration with Ipsos MRBI. The HRB asked Ipsos MRBI to analyse the questions by gender and age.

(Jean Long and Deirdre Mongan)

1. Ipsos MRBI (2012) *Alcohol: public knowledge, attitudes and behaviours.* Dublin: Health Research Board www.drugsandalcohol.ie/18022
2. Steering Group on a national substance misuse strategy (2012) *Steering group report on a National Substance Misuse Strategy*. Dublin: Department of Health. www.drugsandalcohol.ie/16908
3. Morgan K, McGee H, Dicker P, Brugha R, Ward M, Shelley E *et al.* (2009) *SLAN 2007: survey of lifestyle, attitudes and nutrition in Ireland. Alcohol use in Ireland: a profile of drinking patterns and alcohol-related harm from SLAN 2007*. Dublin: Department of Health and Children. www.drugsandalcohol.ie/12664
4. Hibell B, Guttormsson U, Ahlström S, Balakireva O, Bjarnason T, Kokkevi A and Kraus L (2012) *The 2011 ESPAD report: substance use among students in 36 European countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group of the Council of Europe. www.drugsandalcohol.ie/17644
5. Fanning M (2010) *Have we bottled it? Behaviour and attitudes survey*. PowerPoint presentation at the 'Have we bottled it? Alcohol marketing and young people conference' organised by Alcohol Action Ireland in Dublin on 15 September 2010. www.drugsandalcohol.ie/14122

The National Documentation Centre on Drug Use: survey results

As part of an ongoing evaluation of our website and library services, the staff of the National Documentation Centre on Drug Use (NDC) recently conducted an online survey of our users. We received 441 responses. Thank you to everyone who took part.

Key findings

- Over half (54%) of respondents visit our site at least once a month.
- Over half (53%) of respondents currently studying are at postgraduate level.
- The majority (73%) of respondents use the NDC for work (Figure 1).

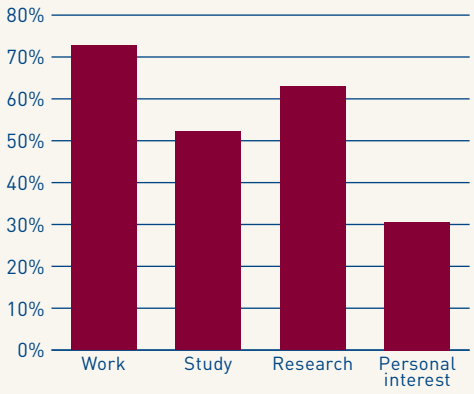


Figure 1 Why do you use the NDC website?

Note: Participants could choose more than one option

In the course of the survey, respondents provided observations on various aspects of our resources and services. We grouped these comments into the following categories:

- Satisfaction with service responsiveness of NDC staff (44 comments);
- Satisfaction with website and resources (29 comments);
- Literature searching (4 comments);
- Marketing and promotion of the service (5 comments);
- Suggested additions to the service (7 comments).

Satisfaction with service responsiveness

Forty-one per cent of respondents had contacted the NDC staff with a query and, of these, 97% were either satisfied or very satisfied with the response they received. All 44 comments about the responsiveness of NDC staff were favourable; 30 of them contained the word 'helpful'.

> ***Extremely helpful to me in my work & research. One of the better elements of service delivery within the overall addiction service.***

> ***Having used the services and also getting great support from your team through telephone support for the past two years I have found the service invaluable in my work and research. Thank you.***

Satisfaction with website and resources

Sixty-one per cent of respondents found the website easy to use. All sources of information available from our homepage were reported as being useful or very useful by the majority of respondents. For example, drug data (treatment tables) (78%), evidence-based resources (85%) and the online directory of training courses (68%).

Similarly, all our key resource publications were rated as useful or very useful by the majority, including our own recently updated factsheets (84%), *Drugnet Ireland* (86%) and the annual national reports on the drug situation in Ireland (88%).

Comments indicated that respondents were generally satisfied with the NDC:

> ***The NDC is a crucial resource for information and research on drug and alcohol related publications and debates.***

> ***I found this site invaluable for research studies, one of the best, and have recommended it too. It is an excellent and valuable resource. Thank you for providing a source of quality information for all in Ireland and beyond.***

> ***Having the resource to use when so many others in Europe have been closed down is invaluable.***

One respondent wanted more full texts of publications online:

> ***It is an excellent resource, but some texts are unavailable online. It would be great if you made more texts available online.***

Unfortunately, some publications, particularly journal articles and books, cannot be made available on our website due to copyright law. We do however offer a document delivery service where you can request the full text of a published article in hard copy.

Literature searching

Eighty-seven per cent of respondents agreed or strongly agreed that, overall, the advanced search page was easy to use. However, comments confirm that some respondents have difficulty in finding what they want, or in sorting search results:

> ***It can be confusing and unclear as to how to use the search engine and I don't always get what I need.***

> ***Can be difficult to access the relevant information.***

> ***The search results need to be better organised especially when you try to view all results. It can be extremely difficult to identify results when they are all packed together.***

To address this, we plan to provide an online tutorial on how to use the advanced search option. This tutorial will also give advice on sorting search results – by year, by author, by title or by type of publication. The NDC staff are available by telephone or in person (by appointment) to guide you through any difficulties you have with searching our site.

NDC survey results *(continued)*

The need to access regional data was also expressed:

> ***Would be beneficial if research was available or searchable based on regional areas. A lot of research is national, but if one is trying to get a local picture the current format does not allow to categorise research in a local regional format.***

We have recently added a field in the advanced search page called 'geographical area' that allows searching by county or country. The treatment data can also be searched by county or region.

Marketing and promotion of the service

Some respondents would like more regular updates and promotion of specific resources:

> ***You need to promote the evidence based research section more as I don't think people use it enough.***

> ***More regular updates sent via email to inform users of new additions to website.***

To keep up to date with alcohol and drug research and related issues, you can sign up for the NDC monthly electronic newsletter which compiles recent news items and new acquisitions, providing links where possible. The newsletter also has a link to recent Dáil debates. To receive this valuable resource, click 'NDC newsletter' on the homepage and enter your email address.

Suggested additions to the service

A few respondents made suggestions about features they would like to see available from the NDC:

> ***Tutorial on how to use site displayed prominently on front would be useful.***

> ***It is useful, much needed. Would like to see update figures for drugs etc. and beds available etc.***

We plan to produce online tutorials for the key resources on our website. We are also looking at ways to make drug-related data more readily available to our users. We will take on board all the suggestions and comments made by respondents so that we can continue to improve our resources. Thanks again to everyone who took part in our survey. The NDC website is at www.drugsandalcohol.ie

(Mairea Nelson, Mary Dunne and Brian Galvin)

Report of the Strategic Response Group – 'A better city for all'

The outgoing mayor of Dublin, Cllr Andrew Montague, launches the SRG report in the Oak Room of the Mansion House; also shown are SRG members (l to r): Mel MacGiobhúin, North Inner City LDTF; Richard Guiney, Dublin City BID; Niamh Randall, Dublin Simon Community; Des Crowley, City Clinic Amiens Street; and Ruaidhrí McAuliffe, UISCE.

The Strategic Response Group (SRG) is a partnership set up to address public substance misuse and perceived anti-social behaviour in Dublin city centre. In June 2012, following a year-long process of research and consultation, it published a report aimed at addressing this issue in the long term.[1]

The report was officially launched by the lord mayor of Dublin, Councillor Andrew Montague, in one of his last engagements as mayor. The issue of anti-social behaviour related to substance misuse in Dublin city centre has long been a focus of media attention and public concern.

Report of Strategic Response Group *(continued)*

Following the establishment in 2010 of the Dublin City Local Business Policing Forum, this issue became a recurring item of discussion. A number of agencies and organisations were invited to make presentations on the topic. Arising from this, the Strategic Response Group (SRG) was formed with the objective of developing ways to build sustainable street-level drug services and address related public nuisance. The SRG is independently chaired and its membership includes representatives of: the four main drug treatment centres in Dublin city centre (Ana Liffey Drug Project, the City Clinic, Drug Treatment Centre Board, Merchants Quay Ireland); An Garda Síochána; Dublin City Business Improvement District; Dublin City Council; Dublin Simon Community; the North Inner City Local Drugs Task Force; the South Inner City Local Drugs Task Force and the Union for Improved Services, Communication and Education (UISCE).

The SRG commissioned a study to provide an evidence base to assist it in developing its response and recommendations.[2] The study used a Rapid Assessment Research (RAR) method to assemble an evidence base around perceived anti-social behaviour associated with the provision of drug treatment in Dublin's city centre upon which to build a strategic response incorporating short/medium/long term goals and actions within the area. The RAR combined various research methods and data sources in order to construct an overview of the problem by cross-checking and comparing the information from several different sources, which included the following:

- A critical review of literature.
- PULSE data for the research area was analysed and provided by An Garda Síochána.
- A mapping exercise inclusive of an environmental visual assessment using digital photographs to view the geographical distribution of drug- and alcohol-related public nuisance was undertaken to assess levels of 'hotspots' for public nuisance, anti-social drug- and alcohol-using congregations, drug-related littering, alcohol retail outlets and placement of drug treatment, housing, policing and community services in the area.
- Interviews and focus groups were conducted with business and transport stakeholders (n=19), community, voluntary and statutory stakeholders (n=19), and service users (n=23). Random street intercept surveys were conducted with passers-by (n=25) and with drug users (n=26).

Research limitations

The research is exploratory and limited by small sample size. However, despite the small numbers of participants, the validity and accuracy of the findings are optimised by the use of triangulated data sources from PULSE data relevant to the area, service-user perspectives, business and transport, community, voluntary and statutory stakeholder perspectives, passers-by and street problematic drug-user perspectives, photographical and environmental mapping analysis.

Key findings

Definitions and experiences of anti-social behaviour

A continuum of acceptable versus non-acceptable forms of public behaviours, and level of impact between anti-social, nuisance and criminal elements of the behaviours was described in the research. A range of definitions of anti-social behaviour was recorded in the interview narratives, with anti-social behaviour deemed to be (typically) illegal, causing interference, visual and physical intimidation, and feeling unsafe, impacting negatively on businesses, services, customers, tourists and individuals accessing the area whether on foot, in private transport or on public transport. Particular anti-social activities mentioned included; visible drinking and drug use, intoxication, aggressive and loud behaviour, youth and child drinking and drug dealing on the streets, phone snatching, graffiti, night-time alcohol abuse, mobile phone theft, harassment, street assaults, begging/'tapping' on the street and at Luas ticket machines, car break-ins, pick-pocketing and other petty crimes. Pulse data reflected drug crime detections which correspond closely with typical business hours, peaking between the hours of 10am and 5pm. A clear distinction between specific quadrants is presented in terms of crime profile, which corresponds to the predominant commercial activity of these areas, retail and night-time entertainment respectively. Quadrant 6 is significantly different to all other areas of the study, due to the inclusion of Temple Bar, which has its own specific crime profile. Property crime is associated with the retail areas and public order offences are associated with the night-time entertainment areas.

Perceptions of threat and intimidation in the research area

Negative media portrayal of anti-social behaviour in the research area was described. The urban design and poor lighting of certain streets was mentioned in the interviews and focus groups as contributing to perceptions of fear and lack of safety. Tourists and visitors who were spoken to during 'walkabouts' in the research area had not observed any forms of anti-social behaviour, and reported feeling safe and happy with the Garda presence in the area. However, those working in the area had all observed anti-social behaviour, had felt intimidated, and reported feeling unsafe in the area both during the day, and at night time.

The SRG, in seeking to address perceptions of drug-related crime and anti-social behaviour, acknowledges that for historical reasons there is a clustering of drug treatment and homelessness services in or adjacent to the inner city. While these services play a major role in the provision of effective treatment to problematic drug users, the report recommends that there should be greater access to prompt provision of treatment options nationally and that people should be treated and accommodated in the most appropriate setting for their circumstances and provided with support services as close to their home as possible.

The report takes a holistic approach to addressing the issues of the city centre. The group has set out its recommendations in the short, media and long term and under the headings of treatment, rehabilitation, homelessness, policing responses, planning and urban design, legislation and regulation and implementation. The SRG is currently developing an implementation plan for its recommendations.

(Johnny Connolly)

1. Strategic Response Group (2012) *A better city for all: a partnership approach to address public substance misuse and perceived anti-social behaviour in Dublin city centre*. Dublin: Strategic Response Group. www.drugsandalcohol.ie/17769
2. An executive summary of the research is provided in the SRG report. The SRG intends to publish the full report at a later date.

EU drugs policy – what next?

In the past few months the European Commission (EC)[1] and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[2] have published reports intended to inform the development of the next EU drugs strategy, which the European Council is due to adopt by the end of 2012.[3] Although drug policy lies within the competence of individual member states,[4] the EU drugs strategy can play an important role by supporting and providing guidance to member states.

The independent assessment commissioned by the EC concludes that there has been 'little change in the demand for and availability of drugs in the EU' over the lifetime of the current EU drugs strategy, and drug-induced deaths have remained at 'historically high levels'. The authors state that they cannot conclude that any improvements in the EU drugs situation have been 'unequivocally' due to the implementation of the strategy. Comparing trends in 2011 with trends that were emerging in 2004, when the current strategy was being developed, the EMCDDA also suggests little has changed: '… many of the problems and solutions seen as pertinent in 2011 have their roots in 2004 or earlier' (p. 11). (A summary of the EMCDDA trend report 2011 is provided in a separate table in this issue of *Drugnet Ireland*.)

The authors of the independent assessment commissioned by the EC conclude, however, that the EU drugs strategy has had a 'discernible impact on the process of drugs policy formulation and adoption in individual member states', with the content and structure of national policy documents converging with the EU strategy, and the process of evaluating, revising and updating national drugs policy documents becoming a more firmly embedded and common practice. The authors also argue that a drugs strategy at EU level can add 'considerable value' at national level because it supports and strengthens international co-ordination and co-operation between member states, and because the mutual learning and exchange of best practice eliminates the need to reinvent the wheel. In short, the strategy has:

> … provided a forum and a decisionmaking process for consensus building, developed a shared language and understanding and provided a platform for information sharing and mutual learning. (p. 96)

In May 2012 the European Council issued its preliminary conclusions with regard to these two reports and the shape of the next strategy.[5]

Policy framework

Although the independent assessment called for a shorter-term strategy with a reduced number of priorities and an integrated action plan, the Council has expressed a preference for the same format as before:

- an eight-year strategy (2013–2020);
- the same five thematic areas – coordination, demand reduction, supply reduction, international cooperation, and research, evaluation and information;
- implementation organised through two consecutive four-year action plans; and
- 'an integrated, multidisciplinary and balanced approach'.

The Council proposes that each Presidency will prepare an overview of progress against the action plan, in other words, a six-monthly progress report, and an evaluation will be undertaken at the expiry of each action plan and of the strategy.

Challenges and threats

The European Council lists the 'challenges' and 'threats' that should be prioritised in the new strategy as follows:

- polydrug use, including the combination of illicit drugs and alcohol,
- the rapid spread of new psychoactive substances,
- ensuring access to and addressing the misuse of prescribed controlled medications,
- the dynamics in the drug markets, including the use of the internet as a facilitator for the distribution of illicit drugs,
- the diversion of precursors used in the illicit manufacture of drugs,
- the quality of demand reduction services, and
- the high incidence of blood-borne diseases, especially HCV, among injecting drug users and potential risks of outbreaks of HIV epidemics and other blood-borne infections related to injecting drugs use.

Despite a recommendation in the independent assessment that an integrated policy approach across illicit and licit substances (including 'legal highs', alcohol and cigarettes) be developed, the Council did not include this in its list of challenges to be addressed in the next seven years.

Supply reduction

Activities under this pillar will remain focused on co-operation between law enforcement authorities, including exchange of information and joint operations and investigations, and on co-ordination of law enforcement initiatives. The Council sees a need to expand and improve the knowledge base around supply reduction and to develop accurate indicators of progress.

Demand reduction

As in the previous strategy, the demand reduction pillar will cover the whole gamut of demand reduction interventions, including special initiatives in prison settings and steps to improve quality standards. The Council acknowledges that there has been some success in promoting an evidence-based approach. However, it sees a need for greater uniformity across all member states in implementing harm reduction and treatment measures. Moreover, member states need to meet the persistent challenges with regard to implementation and co-ordination of national strategies, particularly in an economic downturn.

In a separate article in this issue of *Drugnet Ireland*, alternative approaches to developing EU-level drug policy are outlined.

(Brigid Pike)

1. Culley DM, Skoupy J, Rubin J, Hoorens S, Disley E and Rabinovich L (2012) *Assessment of the implementation of the EU drugs strategy 2005–2012 and its action plans*. Technical Report prepared for European Commission Directorate General for Justice. Santa Monica, CA: RAND Corporation. www.drugsandalcohol.ie/17312
2. EMCDDA (2011) *EMCDDA trend report for the evaluation of the 2005–2012 EU drugs strategy*. Lisbon: EMCDDA.
3. See account of process in Pike B (2012) EU drug policies under review in 2012. *Drugnet Ireland*, (41): 8. Available at www.drugsandalcohol.ie/17269
4. This is known as the principle of 'subsidiarity'.
5. Council of the European Union (25 May 2012) *Draft Council conclusions on the new EU drugs strategy*. 10231/12 CORDROGUE 37 SAN 121 ENFOPOL 145 RELEX 455. http://register.consilium.europa.eu/pdf/en/12/st10/st10231.en12.pdf

EMCDDA trend report for the evaluation of the 2005–2012 EU drugs strategy

Main trends and changes in the European drug situation and in the responses developed by the EU member states, 2005–2012*

Strategic pillar and aim	Finding
Drug use and drug-related problems A measurable reduction in the use of drugs, of dependence and of drug-related health and social risks	■ Heroin still the biggest problem drug ■ HIV risks low, but ongoing risk of outbreaks among drug injectors ■ HCV levels high but modest declines in new cases ■ High and stable numbers of drug-induced deaths ■ Cocaine levels steady or decreasing in high prevalence countries and low elsewhere ■ Methamphetamine partly replaces amphetamine in some northern European countries ■ Cannabis use stable or reducing but continues to be Europe's most popular drug ■ Gradual increase in number of cannabis and cocaine users entering treatment ■ GHB, ketamine generally low prevalence, higher in certain sub-groups
Drug supply and new drugs A measurable improvement in effectiveness, efficiency and knowledge base of law enforcement interventions and actions targeting production, diversion of precursors, drug trafficking and the financing of terrorism, and money laundering	■ Evidence of both stability and droughts in the heroin market ■ Diversification in cocaine trafficking routes and methods ■ Increasing domestic production of cannabis ■ Scarcity and possible bounce-back for MDMA ■ Increasing sophistication in techniques to bypass precursor rules ■ Record numbers of new psychoactive substances notified ■ Increase in number of 'legal highs' available in Europe
Drug policies Ensure a balanced and integrated approach is reflected in national policies … evaluations should continue to be an integral part of an EU approach to drugs policy	■ National drugs strategies in place ■ Increasing evaluation of drug policies ■ Trends towards lower penalties for possession ■ Innovation in policy responses to 'legal highs' ■ Impact of recession on Europe's drug responses – not possible to assess exact impact as yet
Drug demand reduction The development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures	■ Slow take-up of evidence-based prevention approaches ■ Opioid substitution treatment (OST) provision in all member states ■ OST coverage varies widely ■ Core harm reduction interventions in all countries ■ Drug-related problems in prison increasingly targeted ■ Increasing use of guidelines and standards in Europe

Source: EMCDDA (2011) *EMCDDA trend report for the evaluation of the 2005–2012 EU drugs strategy*. Lisbon: EMCDDA. This report was compiled as a supporting document for the evaluation of the 2005–12 EU drugs strategy and its two action plans: 2005–08 and 2009–12.

*Table compiled by Brigid Pike

Alternative ways forward for EU drugs policy

Just as the European Council was agreeing the broad parameters of the EU's next drugs strategy (see separate article in this issue), the UK's House of Lords and the EU's Civil Society Forum on Drugs (CSF) published their views on how the EU should tackle the drugs issue. Their conclusions differ from those of the European Council.

House of Lords[1]

The House of Lords EU Committee invited written and oral submissions on what had been achieved by the EU drugs strategy 2005–2012 and what should come next. The committee also collected evidence during visits to Brussels (Commissioner for Justice, Fundamental Rights and Citizenship) and Lisbon (European Monitoring Centre for Drugs and Drug Addiction). While acknowledging the value of an EU-level policy framework for illicit drugs in providing guidance to member states, the committee believes that the aims of demand reduction and supply reduction are 'too broadbrush to be useful'. It recommends that the new strategy should concentrate on three areas where the EU can make a difference (p. 47):

1. *Coordination of the fight against drug trafficking* – on the legislative front, the EU should focus more closely on money laundering and strengthen provisions on the seizure of the proceeds of crime, while on the operational and research fronts, efforts should continue to be supported. The committee concludes: 'We believe that working on these fronts will be more productive than revising existing legislation on maximum penalties and newly developed psychoactive substances' (p. 5).
2. *Information* – the strategy should concentrate on the improvement of the collection, analysis, evaluation and distribution of information so that member states, while retaining the freedom to formulate their own policies, can learn from each other's experiences and benefit from each other's research.
3. *Public health orientation* – impressed by the evidence of the effectiveness of Portugal's public-health-orientated national drugs strategy, the committee recommends the strategy should cite the EU's public health obligations to encourage all member states to include harm reduction measures in their national policies. The committee concludes: 'It should be recognised that health policy is as important as law enforcement policy in this field and that education also has an important role to play' (p. 46).

In responding positively to the recommendations of the Committee, the British government emphasised that a public health orientation should focus not just on harm reduction measures but also on 'sustained recovery':[2]

> We would view it as a missed opportunity were a new EU Drug Strategy to restrict its discussion of treatment to harm reduction measures alone. The UK in common with other Member States is keen for people to achieve sustained recovery from drug dependence, and a new EU Drug Strategy should contribute to that goal too. We recognise that each individual recovery journey will be unique and that for some individuals, medicinally-assisted recovery may be part of that journey.
>
> Tackling drug dependence should remain a key strand of the EU Drugs Strategy as an important crime reduction, public health and wider public impact issue. It is only through getting individuals off drugs for good that a permanent change occurs which results in them ceasing offending, stopping harming themselves and their communities and successfully contributing to society.

Civil Society Forum on Drugs (CSF)[3]

Set up in 2007 by the European Commission and currently comprising 35 member organisations, the CSF serves as a platform for the informal exchange of views and information between the European Commission and civil society organisations in the EU. It represents a diverse group of European organisations (none from Ireland) that provide health and social services, advocate for more effective drug policies, and represent affected communities. Its proposals for the new strategy were produced following a one-year consultative process and represent a consensus position.

The document lists nine 'general principles for drug policies' and makes 16 recommendations for action related to these principles. Issues particularly highlighted by the CSF are respect for human rights, and targeting the needs of vulnerable groups, including those experiencing poverty, deprivation, social inequality, discrimination and stigma; children and young people; and problem drug users. It also promotes the 'minimum quality standards' for drug demand reduction programmes developed within the EQUS project.

General principles (and recommendations)

1. Drug policies and practices must be balanced, integrated, evidence based and focused on public health. (Recommendation 5)
2. Human rights must be fully respected in drug policies and practices and all drug control activities that are undertaken or promoted should be in line with human rights obligations including those under the relevant EU and UN Charters, including EU Charter of Fundamental Rights. (Recommendations 10 and 11)
3. Drug policies should renew their focus and attention onto the needs of vulnerable groups. This includes but is not exclusive of people who use drugs, young people and children, as well as women, migrants and mobile populations, prisoners, sex workers, LGBT people exposed to environments where drug use occurs and members of social-economic vulnerable communities who may be disproportionately affected by drugs and drug policies. (Recommendations 4, 12 and 14)
4. Drug policies should renew their focus on evidence based demand reduction approaches, including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration. (Recommendation 5)
5. There should be more coherence between drug policies and practices. This entails that drug policies should be fully implemented in practice, and practice should be routinely monitored and evaluated, with lessons learnt incorporated into policy as needed. (Recommendation 13)

Alternative ways forward for EU drugs policy *(continued)*

6. Drug policies should incorporate learning and sharing of knowledge and experience across local, national, EU and international levels in order to improve drug policies according to evolving practices and knowledge.
7. More emphasis should be given to providing drug related services within the criminal justice system, including continuation of services and interventions during the post-release period. (Recommendations 6, 7,8 and 9)
8. Drug policies should be developed and implemented at the EU level through improved coordination of all relevant stakeholders, including Member States, relevant Directorates-General, the European Parliament and civil society. (Recommendation 3)
9. Evaluation should be considered as an essential element of effective drug policy. (Recommendation 15)

ENCOD (European Coalition for Just and Effective Drug Policies), a member of the CSF, did not sign the document because it considered the proposal should have included a reference to alternatives to prohibition. Seventeen NGOs supported a separate statement on the need to decriminalise the possession of drugs for personal use.[4]

(Brigid Pike)

1. House of Lords European Union Committee (2012) *The EU drugs strategy report*. 26th report of session 2012–2012. HL Paper 270. London: The Stationery Office Ltd.
2. Henley, Lord, Minister of State for Crime Prevention and Anti-Social Behaviour Reduction (2012) *EU drugs strategy: government response to each of the recommendations*. Letter and attachment containing the UK government's response to the House of Lords Committee recommendations. London: Home Office.
3. Civil Society Forum on Drugs (April 2012) *Proposal to the EU member states and the European Commission for inclusion in the new EU drugs strategy and action plan*. Available at www.drugsandalcohol.ie/18220
4. Sarosi P (2012, 20 April) 'Civil society demands involvement'. Item submitted by 'sarosip' to Drug Reporter, the drug policy website of the Hungarian Civil Liberties Union. Accessed 27 June 2012 at http://drogriporter.hu/en/csfd2012apr

Measuring the performance of drugs task forces and evaluating projects

In September 2011 the Minister of State in the Department of Health with responsibility for Primary Care, Róisín Shortall TD, initiated a review of drugs task forces. In October a consultation process was initiated with government departments and statutory bodies, with community and voluntary bodies and with the drugs task forces (DTFs), and in February 2012 an interim report summarising the responses of these three groupings to six 'key questions' was issued.[1] Responses with regard to the questions about key performance indicators (KPIs) and evaluation of projects are summarised below.

What are the key performance indicators that we need for drugs task forces?

The responses of the three categories of respondents to this question differed considerably. Respondents from departments and statutory agencies believed that the KPIs in the National Drugs Strategy (NDS) could form the basis for measuring the performance of DTFs, and that the annual work plans of the DTFs should be examined to determine the extent to which DTFs have achieved their objectives and delivered outcomes. They also suggested that agencies and projects funded through the DTFs should provide information on their local area to enhance analysis and performance assessment, and that the provision of this data should be a condition of funding. Finally, they suggested data on the following topics could facilitate performance measurement:

- outputs and outcomes, including evidence of progression and individual achievement;
- reasons for exit from treatment;
- number of treatment centres and barriers to access, if any;
- number of rehabilitation places;
- number of prevention projects being undertaken;
- number of awareness programmes developed;
- number of arrests; and
- number of seizures.

Respondents from the community and voluntary sectors advocated the development of a valid and reliable outcome measurement system, with targets not just for outputs, but for short and medium term impacts, and KPIs established for each area. They also recommended that DTFs adopt a logic-model approach to their work based on implementation of the NDS. Respondents from the community and voluntary sectors suggested a series of process-oriented KPIs:

- extent to which DTFs provide accessible information on drug use and misuse services;
- extent to which a DTF is community-focused;
- extent to which a DTF makes strategic decisions in the funding of projects;
- evidence that the local/regional plan is linked to the NDS;
- evidence that the DTF network is influencing policy;
- evidence of how DTFs share information and promote best practice;
- evidence of DTF involvement in other social inclusion initiatives;
- percentage of funding spent directly to help drug misusers and recovering drug users;
- extent of community engagement in DTF principles, goals, plans and strategies;
- increase in local leadership and local capacity; and
- level of allocation of resources to community engagement activities.

Respondents from among the DTFs noted that while there are KPIs for DTFs in the NDS, these KPIs are designed to measure the effectiveness of the NDS (including the co-ordination function), and not the performance of any one agency. Therefore, DTF respondents proposed the

Measuring performance and evaluating projects *(continued)*

following KPIs, including a mix of both process and content measurements:

- adequacy and appropriateness of representation on DTFs;
- responsiveness of DTFs at local level to national decisions;
- interagency working, local coordination and participation, level of project staff involvement;
- impact of DTF on communities;
- qualitative and quantitative measures of Treatment outcomes, e.g. client numbers, waiting times; programme retention and completing times;
- qualitative and quantitative measures of emerging drugs use trends;
- process indicators
- compliance with QuADS;
- training results;
- health monitoring;
- value for money.

Respondents from this category suggested that a small group of task force co-ordinators be established to devise KPIs along the lines of Provan and Milward's framework.[2] It was also proposed that the DTF forms should be evidence-based and follow a logic model.

How could we achieve a standardised evaluation of drugs task force projects?

There was a general consensus among respondents from all three categories that a standardised evaluation mechanism for DTF projects is needed; respondents from among the DTFs also called for a common reporting/evidencing framework. It was suggested that the Drugs Programmes Unit in the Department of Health should develop an evaluation tool in 'close consultation' with DTFs and the channels of funding, and that, rather than trying to reinvent the wheel, existing tools, e.g. from the EMCDDA best practice portal or the WHO, should be used as a starting point. Other suggestions were that the evaluation tool should be based on the objectives of the core work of the funded projects and linked to the objectives of the relevant DTF, e.g. through use of the LDTF 1 form; that the theory of change and/or logic model should provide the basis for a standard evaluation tool; that a logic-based evaluation template should be developed to reflect the QuADS standards; and that a common web-based computer database with standardised questionnaires and agreed KPIs for DTFs and projects be adopted.

Evaluation criteria based on the following types of evidence were suggested by one statutory agency:

- appropriateness of drug-focused interventions;
- strategic fit with NDS actions, DTF work-plan and fitness for purpose;
- range and type of activities/services delivered;
- progression and individual achievements;
- impact on the individual service user and added value to community; and
- project capability and sustainability.

Respondents from among the DTFs also suggested that it was important to measure the work being done by workers, as well as changes in clients and families. The use of new technology, such as the client relationship management system being researched by some DTFs, was mentioned in this regard.

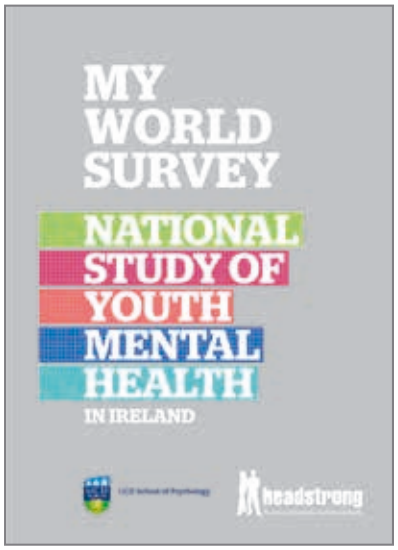
Final report

The final report and recommendations are still awaited. In thinking about how performance measurement and evaluation systems may develop in the future, it should be borne in mind that the interim report states that one priority of the review is to identify where it would be appropriate to transfer responsibility for projects to statutory agencies, thus reducing the number of projects supported by DTFs in the future.

(Brigid Pike)

1. Drugs Programmes Unit (2012) *Report on the consultation process in relation to the review of the structures underpinning the National Drugs Strategy*. Dublin: Department of Health. www.drugsandalcohol.ie/17027
2. Provan K and Milward HB (2001) Do networks really work? A framework for evaluating public-sector organizational networks. *Public Administration Review*, 61(4): 414–423.

National survey of youth mental health



Researchers at University College Dublin and Headstrong, the non-profit support organisation, completed a national survey which examined youth mental health.[1] The researchers estimated the proportion of young people experiencing common mental health problems and explored the known risk and protective factors that are associated with mental health status. The survey population comprised second-level students aged 12–19 years (6,085) and young adults aged 17–25 years (8,221). In total, 14,306 participants completed questionnaires. Fifty-one per cent of the participants randomly selected at second-level schools were female, and 65% of young adults purposively selected through third-level colleges, employers, training centres and unemployment centres were female.

The main findings revealed that the majority of young people (aged 12–25) were functioning well, but that sizeable proportions experienced risk factors.

- One in ten second-level students and between 12% and 16% of young adults reported high-levels of anger.
- Five per cent of second-level students and 10% of young adults were very or severely stressed. The main sources of stress for second–level students were school, friends and family, and for young adults were college, money, work and family.

National survey of youth mental health *(continued)*

- Eleven per cent of second-level students and 14% of young adults had severe or very severe anxiety.
- Eight per cent of second-level students and 14% of young adults had severe or very severe depression.
- A small proportion second-level students reported avoidance strategies.
- Two-fifths of second-level students experienced bullying at some point in their life and 77% of bullying episodes occurred at school.
- Five per cent of second-level students ranked themselves at the bottom of their class and these students were more likely to experience anxiety and depression.
- One-fifth of young adults had deliberately hurt themselves at some point in their life and seven per cent had attempted suicide.

Alcohol was used by considerable proportions of young people, and those who consumed alcohol drank it in an unhealthy manner. Alcohol users were more likely to experience severe forms of stress, anxiety and depression than their non-drinking counterparts.

- Four-fifths (79%) of second-level students (aged 12–19 years) consumed alcohol within the normal adult limits (below 8 on the AUDIT scale).
- One-fifth (21%) of second-level students consumed alcohol in excess of the normal adult limits (8 or above), with 15% scoring as problem drinkers, 3% as hazardous or harmful drinkers and 3% as dependent drinkers.
- Two-fifths (39%) of young adults (aged 17–25 years) were classified as drinking within safe limits;
- Three-fifths of young adults were classified as drinking in excess of normal limits, with 41% scoring as problem drinkers, 10% as hazardous or harmful drinkers and 10% as dependent drinkers.
- Binge drinking (drinking six or more standard alcoholic drinks, 60g, in a single sitting) was common among both second-level students and young adults (Figure 1). Binge drinking weekly or more often increased with increasing age up to 21 years and then decreased somewhat.
- At least eight per cent of the young people in this study aged 14–25 years drank 10 or more standard drinks on a typical drinking day. Drinking 10 or more standard alcoholic drinks on a typical drinking day is an indicator of harmful or dependent drinking.

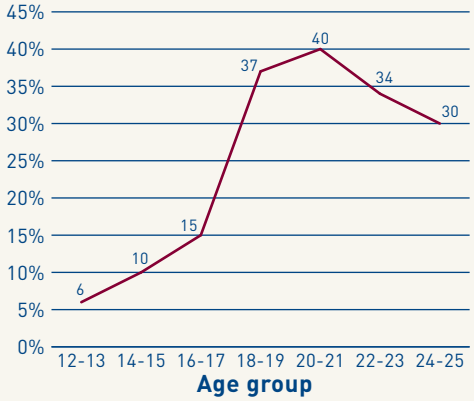


Figure 1 Proportion of survey respondents who consumed 60 grams of alcohol or more in a single sitting weekly or more often (binge drinking), by age

Cannabis use was less common than alcohol use. Nevertheless considerable proportions reported using cannabis at some point in their life and its use increased with increasing age (Figure 2). Forty-five per cent of young adults (aged 17–25) used cannabis. Young adult males (52%) were more likely to report cannabis use than their female counterparts (42%). Over three quarters (77%) reported that they took cannabis for the first time between 15 and 19 years of age.

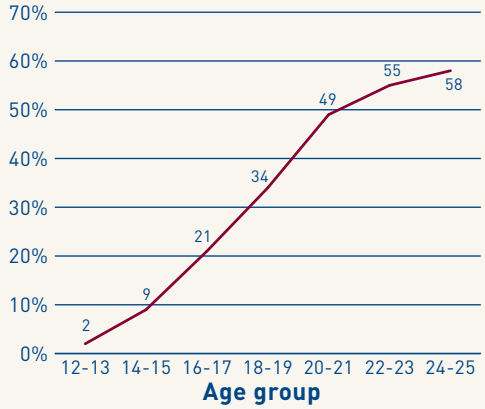


Figure 2 Lifetime prevalence of cannabis use among survey participants, by age

A six-item, yes/no response scale called CRAFFT was used to measures levels of substance misuse; a score of 2 or more indicates a high level of substance misuse. One-quarter of second-level students and half of the young adults scored 2 or more on the CRAFFT scale.

Self-esteem, optimism, resilience, problem solving and social networks were the protective factors associated with mental health. Having support from a special adult was beneficial.

(Jean Long)

1. Dooley B and Fitzgerald A (2012) *My world survey: national study of youth mental health*. Dublin: UCD and Headstrong. www.drugsandalcohol.ie/17589

Deaths among children and young people in state care, after care or known to the HSE

In June 2012 the report of the Independent Child Death Review Group (ICDRG) was published.[1] The review group investigated the deaths (between 1 January 2000 and 30 April 2010) of 196 children and young people who were in care, in receipt of aftercare or known to the child protection services in Ireland at the time of their death. Of the 196 deaths, 112 were due to non-natural causes. The breakdown of deaths over the ten-year period was as follows:

Children (aged 4–17 years) in care: 36 deaths

- 19 deaths from natural causes
- 17 deaths from non-natural causes

Young people (aged 18–23 years) in aftercare: 32 deaths

- 5 deaths from natural causes
- 27 deaths from non-natural causes

Children (aged <1–17 years) known to the HSE: 128 deaths

- 60 deaths from natural causes
- 68 deaths from non-natural causes

The ICDRG examined the files and reports of the HSE in respect of all 112 children and young people who died of non-natural causes and provided a comprehensive case summary for each individual, together with summaries of aspects of good practice and causes for concern in each case.

The ICDRG found that 17 of the 112 children and young people had a history of problem alcohol use and 29 a history of problem drug use. Thirty (27%) of the 112 non-natural deaths were directly drug-related, and of these, the greatest proportion occurred among young people in aftercare:

- children (aged 4–17 years) in care: 5 (29% of 17 deaths in this category)
- young people (aged 18–23 years) in aftercare: 14 (52% of 27 deaths)
- children known to the HSE (aged <1–17 years): 11 (16% of 68 deaths)

The review group did not give details as to which drugs caused the deaths.

The other causes of non-natural death were:

- 28 (25%) owing to suicide;
- 17 (15%) owing to road traffic collisions;
- 16 (14%) were unlawfully killed; and
- 21 (19%) owing to other accidental or unknown causes.

Many of the 196 children had also lived with problem alcohol use (n=37) or problem drug use (n=19) in the home. The ICDRG noted the HSE was aware of drug and alcohol misuse problems among the families:

> … the HSE was aware of drug and alcohol abuse within a number of families, in particular by parents, which must as a natural consequence have given rise to concerns as to the welfare of the children, yet the HSE closed their files in a number of these cases despite the drug and alcohol abuse continuing. Children are vulnerable by their very nature and not to continue to attend to these issues and the implications for their welfare is to expose them to too great a risk of harm. Risk indicators such as this were not followed up adequately, or at all, by the HSE in a number of the files. In some cases no social worker was assigned to these families. (p. xxiii)

The ICDRG made the following recommendations with regard to how social workers should involve drug and alcohol services, and conversely how drug and alcohol services should work with the child welfare and protection services:

> In a significant number of cases, it was evident that drug and/or alcohol abuse by parents was having a very damaging effect on their ability to consistently parent their child. Indeed, in some cases, drug and/or alcohol abuse was the key factor in the child/young person being referred to the HSE or being taken into care. This is a problem which has to be tackled. When a Social Worker comes into contact with a family where drug/alcohol abuse is significantly disrupting familial life, it is essential that such abuse is addressed in a robust manner. The effect on the children has to be recognised and the parents must be made aware of the support and treatment options that are available. Parents must be encouraged and enabled to take up those supports.
>
> Furthermore, drug and alcohol services must be actively integrated into the child protection system. These services have the capacity to alert Social Workers to potentially devastating events happening between parents with drug and/or alcohol problems and their children often before the children are ever referred to the HSE. There must be open channels of communication between drug and alcohol services and the child protection system so that where these services become aware of child protection concerns, this information is quickly conveyed to the child protection system. The planning around these children and families must actively engage each part of the system. (p. 409)

The ICDRG report is not the first to highlight the vulnerability of children and young people, particularly those leaving state care. The plan to implement the recommendations contained in the Ryan Report (the report of the Commission to Inquire into Child Abuse) acknowledged the association between state care and future poor outcomes for children:[2]

> Those with a care history continue to be over-represented among those who are, for example, accessing addiction services, coming into contact with the criminal justice system and experiencing homelessness in adulthood. (p. xii)

Deaths among children and young people in state care *(continued)*

The implementation plan included an appraisal of the gaps in service provision around pre-release planning and called on the HSE to ensure that care plans included aftercare planning for all young people of 16 years and older (Action 67). The implementation plan also highlighted the gaps in aftercare services for young people. While acknowledging that some attempts to provide aftercare had been effective in the past, it stated:

> Aftercare services are not provided consistently to all children across the State. Some HSE areas have dedicated aftercare workers, but most do not. …The provision of aftercare by the HSE should form an integral part of care delivery for children who have been in the care of the State. It should not be seen as a discretionary service or as a once-off event that occurs on a young person's 18th birthday, but rather a service that he or she may avail of up to the age of 21. (p. 48)

The implementation plan included two actions to provide for, and monitor the provision of, an enhanced system of aftercare, which, if implemented consistently and effectively, would contribute to a reduction in youth homelessness and a concomitant reduction in exposure to substance use.

> *Action 64*: The HSE will ensure the provision of aftercare services for children leaving care in all instances where the professional judgment of the allocated social worker determines it is required.
>
> *Action 65*: The HSE will, with their consent, conduct a longitudinal study to follow young people who leave care for 10 years, to map their transition to adulthood.

(Brigid Pike)

1. Shannon G and Gibbons N (2012) *Report of the independent child death review group 2000–2010*. Dublin: Government Publications. Available at www.drugsandalcohol.ie/17774
2. Office of the Minister for Children and Youth Affairs (2009) *Report of the Commission to Inquire into Child Abuse, 2009: implementation plan*. Dublin: Stationery Office. Available at www.omc.gov.ie/viewdoc.asp?Docid=1173

Parental responsibilities and drug treatment outcomes

A recently published analysis of data from the ROSIE study[1] aimed to establish whether having children in their care at intake affected the treatment outcomes of opioid users.[2]

Of the 404 opiate users recruited in 2003/4 to the ROSIE study, 212 (53%) had children aged 17 or under (a total of 370 children). Ninety-two of these participants had primary responsibility for one or more of their children. Women were significantly more likely than men to have primary responsibility for their children, 59% compared to 15.2%. At one-year follow-up completed questionnaires were obtained from 74 of the original 92 clients with children in their care at intake and from 213 of those not caring for children at intake.

This study compares the groups at intake, and the outcomes at one year, rather than those at three years, based on evidence that 'in general the greatest changes in outcome occur early in treatment, and that longer term outcomes do not exhibit further improvements'. As a limitation of the study, the author points out that a proportion of the participants were recruited through prisons or residential rehabilitation centres, and therefore could not have had children in their care. Additionally, participants were not randomly allocated to the different treatment modalities, which may have also affected the results.

Comparison at intake

At intake there was no significant difference in drug use between the two groups, with the exception of the rate of benzodiazepine use, which was lower among the group of participants with children in their care.

Comparison at one-year follow-up

At one-year follow-up significantly fewer of the group with responsibility for children were using heroin, benzodiazepines or cannabis. This group were also using heroin on significantly fewer days compared to the group without responsibility for children. However regression modelling revealed that having responsibility for children was a significant and positive predictor for using other opioids. Having responsibility for children was also a positive, but non-significant. predictor of use of alcohol, illegal methadone and tobacco.

While both groups had experienced a reduction in psychological symptoms at one year, a greater number of significant reductions were experienced by the group who did not have responsibility for children. The analysis also showed that the group with responsibility for children experienced significantly more panic attacks.

Conclusions

The author concludes that having responsibility for children significantly improves the outcome of a client's treatment for heroin use. The results did suggest some worrying trends, including the use of alcohol and other opioids among the group with responsibility for children, which may indicate that this group had been substituting other substances for heroin. While the effects of parental substance misuse on children have been studied, the ways in which having custodial care of one or more children may affect a client's drug treatment outcomes has not been widely researched. The author recommends that further research in this specific area would improve the effectiveness of drug and alcohol treatment and provide the maximum benefit to both the parent and the child.

(Suzi Lyons)

1. The ROSIE study was Ireland's first national, prospective, longitudinal drug treatment outcome study. It aimed to 'evaluate the effectiveness of treatment and other intervention strategies for opiate use'. In 2003/04, 404 opiate users who entered treatment were recruited, of whom 72% completed follow-up questionnaires one year and three years later. The reports on the ROSIE study are available at www.nacd.ie.
2. Comiskey C (2012) A 3 year national longitudinal study comparing drug treatment outcomes for opioid users with and without children in their custodial care at intake *Journal of Substance Abuse Treatment* Early online. www.drugsandalcohol.ie/17577

Drugnet digest

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

President opens new centre for Finglas service

The Finglas Addiction Support Team (FAST) new facility was officially opened by President Michael D Higgins in May 2012. The centre works with drug users, recovered users, their families and the community in the Finglas area to provide the highest standard of addiction support.

President Higgins officially opens the new FAST centre in Finglas, with Barbara Condon, general manager

Set up by volunteers in 2004 in temporary accommodation, FAST (www.fastltd.ie) developed and expanded its service over the years. Supported by government funding and in partnership with community stakeholders, the Finglas/Cabra LDTF and Dublin City Corporation, FAST moved to its impressive new premises on Wellmount Road at the end of 2011. Last year the centre worked with 368 individuals, including substance users, family and community members. FAST aims to dispel the stigma of addiction and to offer a comprehensive treatment with the best possibilities for long-term recovery. The treatment focuses on the mental, emotional and physical components of addiction.

Speaking at the launch, Barbara Condon, general manager of FAST, said:

> It is well established that for every person caught in addiction, an average of eight people consequently suffer. Our centre here at FAST hopes to alleviate the effects of addiction for all – both the substance abuser and family members – and to help those affected to build a stronger family unit. Recovering as a family allows healing, encourages forward movement and provides the recovering drug user with a support structure that is essential to his or her success.

FAST also announced the introduction of its Recovery Coach Programme, a 12-month part-time course offered in partnership with Dublin City University's School of Nursing and Human Sciences. The only course of its kind in Ireland, it trains people in recovery from drug addiction to help others who are struggling with the process of recovery, journeying from detox through to aftercare. On completion of the course, the coaches will work on a voluntary basis with FAST.

FAST was short-listed for Biomnis Healthcare Innovation Awards 2012; it has also been nominated in the Allianz Business to Arts Awards 2012 and has been shortlisted in two categories – Best Creative Staff Engagement and the Jim McNaughton Perpetual Award for Best Commissioning Practice.

Fall in numbers on waiting lists for methadone treatment

Newly published data from the HSE[1] show a reduction in the number of people waiting for methadone treatment in Ireland between March 2011 and April 2012. At the end of April 2012 there were 187 people waiting for treatment, compared to 230 in March 2011.

Most of the 48 clinics listed reported a reduction in waiting times and also in the number of people waiting for treatment; 22 centres reported no waiting list. The average waiting time was 0.8 months. These figures include data from new clinics in Kilkenny, Tullamore and Wexford that were set up in 2011. The clinic in Portlaoise reported the longest waiting list, with 24 people waiting for treatment at the end of April 2012, and an average waiting time of 5.7 months.

In a press release on publication of the new data[2] Minister of State Róisín Shortall TD stated: 'At a time of cut-backs, HSE management and frontline staff deserve credit for making good progress and for doing more with less. … With the data now available we can assess more accurately the areas where treatment provision needs to be boosted further and I will work to address these needs over the coming months.'

Implementing an IT system in drug and alcohol services

On 14 June 2012 Progression Routes Initiative (PRI) hosted a one-day seminar on information technology (IT) system implementation in addiction services. Merchants Quay Ireland hosted the event in their new premises in Dublin.

The objectives of the seminar were:

- to provide an overview of IT systems which have:
  - capacity to support the national rehabilitation framework for case management and Quality Standards in Alcohol and Drug Services (QuADS),
  - proven functionality,
  - capacity to communicate with the National Drug Treatment Reporting system (NDTRS);
- to explore how IT systems can support continuous quality improvement in addiction services;
- to outline how learning networks and logical model can support IT implementation and reduce costs.

Fran Thompson, who works in information and communication technology (ICT) services in the HSE, provided an overview of the HSE's development plans in this area. The keynote speaker, Martin McCormick, ICT director at Beaumont Hospital, addressed issues such as information storage, business continuity, data ownership, security, data standards and compliance with EU standards. Following this presentation a number of workshops explored how IT systems can support client work as well as staff, management and stakeholder requirements.

Four IT system providers, EPS, Icarus, Hanlon and eCASS, presented overviews of individual systems, covering: visual display of user interfaces; case management and other functionality; outcome reporting across a variety of service provision areas; and flexibility for adaptation and cost.

PRI has prepared a document to assist organisations in identifying their needs and selecting the most appropriate IT system provider. This document describes the systems currently in use and covers issues such as system

Drugnet digest *(continued)*

functionality, data storage, security, data protection compliance and cost. For more information please contact Caroline Gardner, PRI co-ordinator, at caroline.gardner@aldp.ie.

Lord mayor's commission on antisocial behaviour

A commission on antisocial behaviour established by the former lord mayor of Dublin, Councillor Andrew Montague, issued its final report in June 2012.[3] Commission members included elected councillors and representatives of Dublin City Council, An Garda Síochána, the Irish Prison Service, the Probation Service, the Health Service Executive, the Youth Justice System within the Department of Justice and Equality, the Northside Partnership, Ballymun Drugs Task Force, the Ana Liffey Drug Project, Dublin City Business Improvement District, and an academic from the Department of Social Work and Policy in Trinity College Dublin.

The Commission met nine times between October 2011 and May 2012 and also organised a conference on the theme of preventing and responding to anti-social behaviour attended by over 300 people.[4] The report and recommendations of the commission are presented across a range of themes, including the following: early intervention and prevention, education, discrimination and prejudice, management of offenders and alternatives to prison, alcohol and other drugs, city centre issues, and design.

Specific recommendations in relation to drugs include the following:

- Prevention and education
  - Deliver a national awareness campaign on the dangers of using alcohol, cannabis and other drugs during pregnancy and ensure that clear drug and alcohol policies are developed and implemented in each school.
- Drug-related crime and intimidation
  - Assist the roll-out of locally based systems of support which address issues related to family intimidation and drug debt in areas with concentrated drug problems and which build on the north east inner city pilot project.
  - Expedite plans to identify key Garda personnel at district and divisional level who would be designated officers for families and individuals requiring support as a result of intimidation.
  - Establish local and national intelligence systems to gather information on drug debt and liaise directly with the Criminal Assets Bureau.
  - Develop a system of notification between Gardaí and HSE Children's Services for the early identification of children who become involved in criminal activity (often related to drug dealing).
  - Identify effective systems of family intervention and supports in this regard.
  - Empower the gardaí to prosecute in cases where offenders are found to be trading prescription drugs.

Government revises poverty targets

In its update on Ireland's national reform programme,[5] published in April 2012, the government announced it was abandoning the national ambition to eliminate 'consistent poverty'[6] in Ireland, as set out in the *National Action Plan for Social Inclusion 2007–2016*.[7] This decision was made following public consultation, engagement with key stakeholders, and an EU peer review on the setting of national poverty targets, an event which Ireland hosted in June 2011, and which was attended by nine member states, the European Commission and European stakeholders. The table below summarises the change in ambition.

Targets for reduction of consistent poverty, Ireland, 2007 and 2012

	2012	2016	2020
National Action Plan for Social Inclusion 2007–2016	2–4%	0%	–
National Reform Programme for Ireland: 2012 Update	–	4% max.	2% max.

Sources: Office for Social Inclusion (2007); Department of the Taoiseach (2012)

Explaining the change in its update, the government stated that between 2008 and 2010, ' … numbers in consistent poverty rose from 186,000 to 277,000, representing an increase of almost 50% on the 2008 figure … the rise in the numbers in consistent poverty over that period reflects the impact of the economic and fiscal crisis in Ireland, and in particular almost a trebling of the unemployment rate from 4.5% in 2007 to 13.6% in 2010. There was also an effect from the programme of fiscal consolidation on social welfare adult and universal child payment rates' (p. 15).

The policy approach to meeting the poverty target remains that set out in the *National Action Plan for Social Inclusion 2007–2016*, based on three inter-connecting themes of income support, activation and services. The government also asserts that improving the position of vulnerable groups, including children, lone parents, people with disabilities, and jobless households will remain critical to the achievement of the national poverty target.

(Contributors: Finglas Addiction Support Team, Suzi Lyons, Ita Condron, Johnny Connolly and Brigid Pike)

1. Data on the waiting lists can be accessed at: http://healthupdate.gov.ie/wp-content/uploads/2012/07/Summary-NWL-April-12-v-March11.pdf
2. Shortall R (2012, 25 July) Minister Shortall welcomes significant fall in numbers waiting for opioid substitution treatment. Press release issued by the Department of Health on publication of new HSE data on methadone treatment waiting lists. www.dohc.ie/press/releases/2012/20120725.html
3. Lord Mayor's Commission on antisocial behaviour (2012) *Lord Mayor's Commission on antisocial behaviour*. Report. Dublin: Dublin City Council.
4. Video footage of presentations at the conference is available at http://drugs.ie/multimedia/video/conference_preventing_and_responding_to_anti_social_behaviour
5. Department of the Taoiseach (2012) *National reform programme for Ireland: 2012 update under the Europe 2020 strategy*. Dublin: Department of the Taoiseach. www.drugsandalcohol.ie/15850
6. 'Consistent poverty' is defined by the Social Inclusion Division in the Department of Social Protection as' the proportion of people, from those with an income below a certain threshold (less than 60% of the median income), who are deprived of two or more goods or services [an 11-item index] considered essential for a basic standard of living'.
7. Office for Social Inclusion (2007) *National action plan for social inclusion 2007–2016*. Dublin: Stationery Office. www.drugsandalcohol.ie/13378

The views of children and young people in state care

The Department of Children and Youth Affairs (DCYA) recently published a report detailing a consultation process with 211 children and young people in state care; participants ranged in age from 8 to 23 years.[1] Fifteen consultations were undertaken in Cork, Dublin, Galway and Sligo. The young participants came from the following state care settings: prison and detention centres (43), residential disability care (10), foster care (58), aftercare (17), residential care (48), separated children seeking asylum (34) and young people under section 5 of the Child Care Act (1). The report provides a useful insight into the main issues that concern young people in care, the difficulties they experience in expressing these concerns through current structures and their ideas on how such concerns can be articulated in the future.

Alcohol and drugs

According to the DCYA, the role played by alcohol and drugs in the lives of some of the participants was a recurring theme throughout the consultations. This theme emerged primarily from consultations with participants in St Patrick's Institution (36) and in detention centres (7). Many of the participants spoke about using alcohol and/or drugs as a means of 'escaping' from the traumatic experiences in their lives and few indicated any intention to stop using substances in the future. Many also recalled the adverse role that alcohol and drugs played in the lives of their parents, which had contributed largely to their being placed in state care in the first instance. The adverse experience of parental alcohol and drug use was also highlighted by the 58 children aged 8–12 who were in foster care.

Views on social workers

The majority of participants from all care settings expressed predominantly negative attitudes to and experiences of social workers, with older participants tending to be more critical than their younger counterparts. Overall, participants did not feel that social workers listened to them or acted in a manner that took account of their views. They also talked about social workers being constantly unavailable to meet with them, aside from instances when the young people were being disciplined or moving to another placement; they did acknowledge that social workers can be overburdened with caseloads of work.

Views on care plan reviews

The vast majority of participants from all care settings were highly critical of the care plan review process and did not see the review as an opportunity to have their concerns taken seriously; they described the atmosphere of the review as intimidating due to the large number of officials present.

Elements of disruption

Participants from most care settings voiced great concern at the constant movement between care placements they were forced to endure, with many citing this concern as a further destabilising factor in their lives. Some participants recalled having to move between 20 and 30 times, which meant constantly moving between institutions, families, houses and schools. This meant losing contact with established networks of friends and with siblings, which greatly troubled the young people. They also complained about the constant moving of staff, such as key workers and/or social workers, which added to their unsettling experiences and further instability.

The birth family

The vast majority of participants across all care settings deemed it important to have access to their birth family, with participants in foster care and residential care especially favouring this option. Some participants expressed a preference to be consulted on this issue and not to have the decision to meet with their family foisted on them.

Confidentiality and privacy

Many of the young participants from all care settings expressed concern at the lack of privacy they experienced, they were critical of the constant observation they were under and the level of record-keeping that constantly documented their behaviours. Participants were also concerned at the lack of confidentiality they experienced citing the numerous adults and agencies that had access to, and appeared to willingly share, information that was specific to the young people.

Concerns specific to young people in residential/detention settings

Participants from residential care and prison and detention settings expressed a range of views on their interaction with staff in these settings. Most young people viewed the role of the relationship between themselves and members of staff as potentially supportive; however, not all agreed that their experience of these relationships was positive. Where staff members were supportive and respectful to young people, this was acknowledged and appreciated and the young people benefited greatly from such experiences. On the other hand, there were many instances of participants citing negative encounters with members of staff, and such occurrences appeared to have a lasting negative impact on these young people.

Concerns specific to young people in foster care

One of the main concerns of young people in foster care was the need to be treated as an equal in the foster family. Many felt that they were not treated by the foster family in the same way as the birth children. Examples of being treated differently included being sent to residential respite care while the birth children were taken on holiday. Participants also questioned why they had to be removed from the foster family when they turned 18, particularly if they felt happy and settled there. According to the DCYA, when with this did occur 'many young people felt that they had merely been a transaction in a business arrangement' (p.85).

Conclusion

A general consensus emerged from the consultations that young people in care would like more meaningful consultation on key decisions that impact on their lives; few believed that the current structures of the care plan review process or the input of social workers were adequate forums for such meaningful consultation. The report recommends that both the care plan review system and aspects of the social worker service for young people in care be re-examined. Support mechanisms, including a dedicated telephone line, a 'mentor' system and counselling services for young people in care, are also recommended. These recommendations are grounded in the concerns and experiences of young people in care as articulated in the consultations reported on above. In this regard, the report recommends that 'the agencies responsible for children in the care of the state must listen to the voices of the consultation participants and, more importantly, heed their recommendations' (p.3).

(Martin Keane)

1. Department of Children and Youth Affairs (2011) *Listen to our voices: hearing children and young people living in the care of the state.* Dublin: Stationery Office. www.drugsandalcohol.ie/15654

Non-fatal overdoses and drug-related emergencies 2010

Data extracted from the Hospital In-Patient Enquiry (HIPE) scheme were analysed to determine trends in non-fatal overdoses discharged from Irish hospitals in 2010. There were 4,562 overdose cases in that year, of which 40 died in hospital. The 4,522 discharged cases are included in this analysis. The number of overdose cases increased by 8% between 2009 and 2010, following a decrease of 13% between 2008 and 2009 (Figure 1).

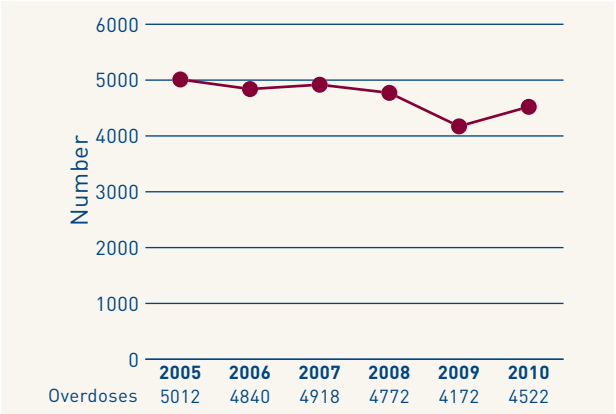


Figure 1 Overdose cases by year, 2005–2010 (N=28,236)

Source: Unpublished HIPE data

Characteristics of cases

Gender

In the years 2005–2010 there were more overdose cases among females than among males (Figure 2), with females accounting for 53% of all overdose cases in 2010.

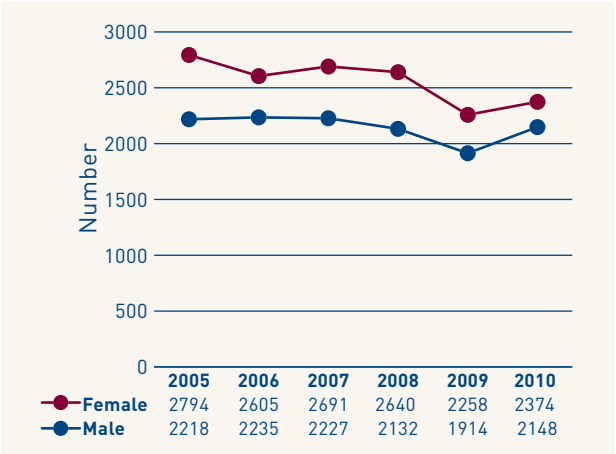


Figure 2 Overdose cases by gender, 2005–2010 (N=28,236)

Source: Unpublished HIPE data

Age group

One quarter of all overdoses between 2005 and 2010 occurred in those aged 15–24 years, with the incidence of overdose decreasing with age (Figure 3). However, the number of under-25s was lower in both 2009 and 2010 than in previous years. In 2005, 40% of cases were aged under 25 years, compared to 34% in 2010.

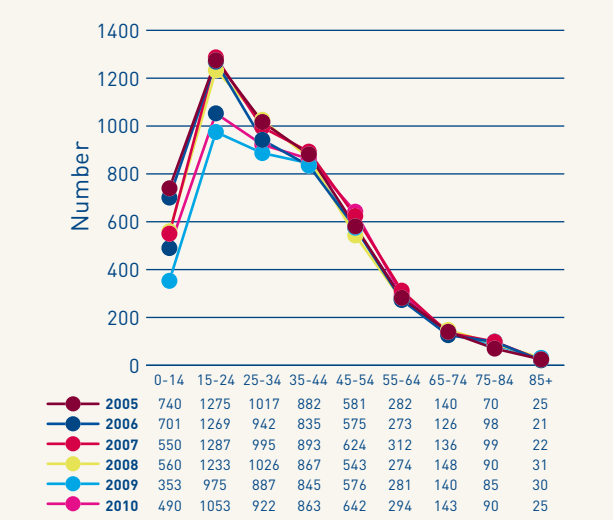


Figure 3 Overdose cases by age group, 2005–2010 (N=28,236)

Source: Unpublished HIPE data

Area of residence

In 2010 there were 1,003 (22%) overdose cases among people resident in Dublin (city and county), 3,492 (77%) cases among people resident outside Dublin, and 77 cases recorded as having no fixed abode or being resident outside of Ireland.

Drugs involved

Table 1 presents the positive findings per category of drugs and other substances involved in all cases of overdose in 2010. Non-opioid analgesics were present in 34% (1,552) of cases. Paracetamol is included in this drug category and was present in 27% (1,129) of cases. Psychotropic agents were taken in 22% (1,000) and benzodiazepines in 24% (1,086) of cases. There was evidence of alcohol consumption in 12% (561) of cases. Cases involving alcohol are included in this analysis only when the alcohol was used in conjunction with another substance.

Non-fatal overdoses *(continued)*

Table 1 Category of drugs involved in overdose cases, 2010 (N=4,522)

Drug category	Positive findings per drug category* n	%
Non-opioid analgesics	1552	34.3
Benzodiazepines	1086	24.0
Psychotropic agents	1000	22.1
Narcotics and hallucinogens	588	13.0
Anti-epileptic / Sedative / Anti-Parkinson agents	563	12.5
Alcohol	561	12.4
Other chemicals and noxious substances	282	6.2
Cardiovascular agents	152	3.4
Systemic and haematological agents	147	3.3
Anaesthetics	118	2.6
Hormones	115	2.5
Autonomic nervous system agents	99	2.2
Systemic antibiotics	96	2.1
Gastrointestinal agents	67	1.5
Diuretics	56	1.2
Topical agents	37	0.8
Muscle and respiratory agents	36	0.8
Other gases and vapours	33	0.7
Anti-infectives / Anti-parasitics	22	0.5
Other and unspecified drugs	945	20.9

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.

Source: Unpublished data from HIPE

Overdoses involving narcotics or hallucinogens

Narcotic or hallucinogenic drugs were involved in 13% (588) of overdose cases in 2010. Figure 4 shows the number of positive findings of drugs in this category among the 588 cases. The sum of positive findings is greater than the total number of cases because some cases involved more than one drug from this category. Opiates were used in 80% of the cases, cocaine in 16% and cannabis in 8%.

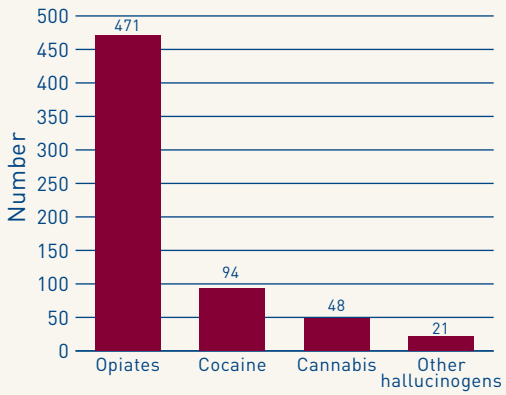


Figure 4 Narcotics and hallucinogens involved in overdose cases, 2010 (N=588)

Source: Unpublished data from HIPE

Overdoses classified by intent

In 67% of cases the overdose was classified as intentional (Figure 5).

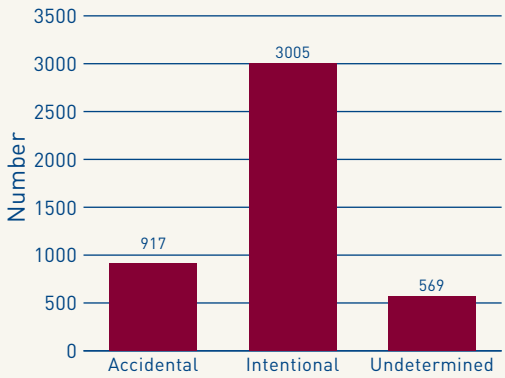


Figure 5 Overdose cases by classification, 2010 (N= 4,491)

Source: Unpublished data from HIPE

Table 2 presents the positive findings per category of drugs and other substances involved in cases of intentional overdose in 2010. Non-opioid analgesics were involved in 42% (1,258) of cases, benzodiazepines in 28% (832) and psychotropic agents in 27% (820).

Table 2 Category of drugs involved in intentional overdose cases, 2010 (N=3,005)

Drug category	Positive findings per drug category* n	%
Non-opioid analgesics	1258	41.8
Benzodiazepines	832	27.7
Psychotropic	820	27.3
Anti-epileptic / Sedative / Anti-Parkinson agents	459	15.3
Alcohol	387	12.9
Narcotics and hallucinogens	293	9.7
Cardiovascular agents	99	3.3
Systemic and haematological agents	92	3.1
Other chemicals and noxious substances	87	2.9
Hormones	78	2.6
Autonomic nervous system agents	68	2.3
Systemic antibiotics	68	2.3
Gastrointestinal agents	52	1.7
Anaesthetics	37	1.2
Diuretics	34	1.1
Muscle and respiratory agents	19	0.6
Anti-infectives / Anti-parasitics	16	0.5
Topical agents	11	0.4
Other gases and vapours	<5	~
Other and unspecified drugs	588	19.6

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.

Source: Unpublished data from HIPE

(Deirdre Mongan)

Poisoning and clinical toxicology: a template for Ireland

A recently published article reviewed poisons information and clinical toxicology in Ireland.[1] There are two centres in Ireland from which information on poisons is accessible 24 hours a day: the Poisons Information Centre of Ireland in Dublin, and the Regional Medicines and Poisons Information Service in Belfast. These centres are supported by a consultant toxicologist advisory service.

The Poisons Information Centre of Ireland (01 8092566) offers a telephone information service for healthcare professionals on a 24/7, 365-days-a-year basis. Enquires are answered by poisons information officers between 8.00am and 10.00pm; calls outside of these hours are automatically diverted to the UK National Poisons Information Service at no extra charge.

The public poisons information service (01 8092166), also based in the Poisons Information Centre of Ireland, is for the general public, in particular parents and carers of young children. This service is available between 8.00am and 10.00pm daily. Outside of these hours the general public should contact their general practitioner or a hospital emergency department.

Toxbase, an online clinical toxicology database in the UK, has been available to Irish health professionals since 2001. Since then it has become the main source of information on poisons, with usage increasing annually. It is available to health professionals in emergency department and intensive care units; 99% of queries come from emergency departments. Toxbase is not available to laboratory staff.

The information most commonly accessed on Toxbase by health professionals in Ireland relates to paracetamol, diazepam, analgesics and psychoactive compounds (Table 1).

Table 1 The ten most frequently accessed Toxbase enquiries from all sources in Ireland, 2010/2011

Rank	Drug	Count (% of total)
1	Paracetamol	1431 (5.8)
2	Diazepam	679 (2.7)
3	Zopiclone	592 (2.4)
4	Ibuprofen	552 (2.2)
5	Escitalopram	436 (1.8)
6	Paracetamol/codeine compound	393 (1.6)
7	Salicylates	387 (1.6)
8	Quetiapine	376 (1.5)
9	Venlafaxine	369 (1.5)
10	Alprazolam	359 (1.4)
Source: Tormey and Moore (2012)		

The authors state that data from the National Drug-Related Deaths Index (NDRDI) is the most accurate available information on toxicological deaths in Ireland.[2] They suggest a more detailed review of the 'Other prescription medication' involved in poisoning deaths as recorded by the NDRDI in order to identify factors to prevent fatal overdoses from these medications in the future.

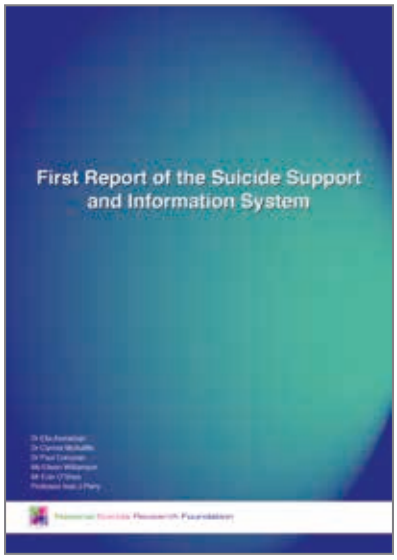
In conclusion, the authors recommend the following:

- provision by the HSE of a web-based, open-access Toxbase or equivalent as a public service;
- co-location of poisons information and laboratory clinical toxicology;
- establishment of a national clinical toxicology institute for Ireland;
- a list of accredited medical advisors in clinical toxicology available for consultation in Ireland;
- multidisciplinary case conferences in complex toxicology scenarios for coronial cases;
- development of a template of standard scenarios on common findings in biochemical toxicology for coronial cases;
- establishment of a national clinical toxicology referral out-patient service in Dublin; and
- tracking changing patterns in the use of drugs of abuse in Ireland – clinically, biochemically and through access to treatment.

(Ena Lynn)

1. Tormey WP and Moore T (2012) Poisonings and clinical toxicology: a template for Ireland. *Irish Journal of Medical Science*, Online First. 22 May 2012. www.drugsandalcohol.ie/17598
2. Health Research Board (2011) *Drug-related deaths and deaths among drug users in Ireland: 2009 figures from the National Drug-Related Deaths Index*. www.drugsandalcohol.i.e/16365

First report of National Suicide Support and Information System



The first report of the national Suicide Support and Information System (SSIS) was published in July 2012 and presented the results of a pilot implementation of the system in Co Cork between September 2008 and March 2011.[1]

The specific objectives of the SSIS are to: provide better support to the bereaved family members; identify and better understand the causes of suicide; identify and improve the response to clusters of suicide and extended suicide; describe the incidence of and explore patterns of suicide in Ireland; and identify individuals who present for medical treatment due to deliberate self-harm and who subsequently die by suicide.

The SSIS operates a two-step approach which involves:

1. Pro-active facilitation of support for family members bereaved by suicide, and;
2. Obtaining information from the different sources who had been in contact with the deceased in the year prior to death or at the time of death, including coroners' records, family informants and medical professionals.

The research team identified 178 cases of suicide and 12 deaths with open verdicts in Co Cork between September 2008 and March 2011. Initial contact with family members of the deceased was made by letter, explaining about the SSIS and offering support, with one or more follow-up phone calls from senior research psychologists on the team in 124 cases.

In relation to these 124 cases, two-fifths (40%) of close family members participated in bereavement support facilitated by the SSIS team. Just under half (48%) had obtained bereavement support prior to contact with the team. A small proportion (8%) welcomed further contact with a member of the team but did not want formal bereavement support. One in twenty (5%) family members did not wish to receive further contact following the initial invitation letter from the team.

In relation to the 190 fatalities, data on 189 cases were obtained from the checklists completed on the basis of the coroners' records, further information was obtained from psychological autopsy interviews with family members for 70 (37%) cases and from questionnaires completed by medical professionals for 64 (34%) cases.

Suicide cases

The vast majority (178) of those who had died with a verdict of suicide were men (81%). The average age was 38 years and men were significantly younger at the time of death (36 years) than women (45 years). The majority were Irish (92%), single (56%), and living in a house or flat (96%). Just under two-fifths (38%) were unemployed, one-fifth (21%) were living alone and 4% were living in a supervised hostel. In terms of occupation, one-third (33%) had been working in the construction sector.

The majority (71%) of the 178 suicide cases died by hanging, 11% by drowning and 10% (19) by intentional drug overdose. Legal drugs used in the overdose cases included both prescribed (17%) and non-prescribed (83%) medication. Illegal drugs used included cocaine and heroin. Eighteen per cent of the total number of cases had taken medication and/or drugs in combination with other methods, such as hanging and drowning Over one-third (36%) had consumed alcohol at the time of suicide. A minority had used other methods, including cutting or stabbing, carbon monoxide poisoning, firearms and self-immolation. Forty-six per cent of cases had left a note, in the form of a letter, e-mail or text message.

Three-fifths (61%) of the suicide cases had a family history of mental disorder and the same proportion had a personal or family history of substance abuse. Over 39% of cases had either a personal experience of significant physical, sexual or emotional abuse or a family history of such abuse. Ten per cent of fatalities had a parent or sibling who had a non-natural death, such as suicide, homicide or accident

At some time before their death, 45% of cases had engaged in at least one act of deliberate self-harm. Of these, 50% had engaged in one act, 21% in two acts and 29% in three or more acts. Just under half (48%) had engaged in deliberate self-harm in the 12 months prior to ending their lives, 24% less than a week before and 12% less than a day before.

Over two-thirds (68%) of the suicide cases were known to have experienced suicidal behaviour (fatal and/or non-fatal) by family members or friends at some point in their lives. Of these, 7% had experienced the event less than 12 months prior to their own death.

A psychiatric assessment was known to have taken place in 31% of the cases. In the majority (61%) of these cases, mood disorder (such as depression or bipolar) was the primary diagnosis, followed by anxiety disorder (13%), schizophrenia (9%) and alcohol dependence (9%).

In the year prior to death, 52% of the cases had abused alcohol and/or other drugs. Of these cases, 44% had abused alcohol only, 34% had abused both alcohol and other drugs and 16% had abused other drugs only.

First SSIS report *(continued)*

Two-thirds (65%) of the fatalities were reported to have experienced significant loss in the month prior to death (such as relationships, family members/friends, prestige and finances), 47% experienced a significant disruption to a primary relationship, 34% experienced significant life changes, 24% had legal trouble or difficulties with the Gardaí (24.2%), 23% experienced an event that was perceived as traumatic, and 19% experienced the anniversary of a death or other important loss.

In the year prior to suicide, more than half of the cases had had serious relationship problems for more than a year (53%). Loneliness over a long period of time in the year prior to suicide was reported for 47%. Other commonly reported negative events in the year prior to suicide were serious financial problems (44%), problems with eating (33%), unemployment (31%), problems bringing up children (28%), mental maltreatment by a partner (28%) and failure in achieving an important goal (20%).

The most commonly reported negative events that occurred earlier in the lives of people who died by suicide were serious relationship problems lasting for more than a year (66%), problems in bringing up children (44%), addiction to alcohol, other drugs or medication (41%), serious financial problems (40%), the experience of loneliness over a long period of time (38%) and a sudden and unexpected emergency (37%).

The majority (81%) of the deceased had been in contact with their GP or a mental health service in the year prior to death. Fourteen per cent had received inpatient psychiatric treatment in that year. Forty-one per cent had been offered outpatient appointments with the mental health services. However, nearly half (48%) had difficulties attending these appointments and in 65% of cases the relatives reported no apparent benefits from attending the recommended outpatient mental health services.

Fifty-seven per cent of cases had used prescription medication for a mental disorder in the year prior to death. However, a high proportion of these (46.4%) did not comply with the instructions on the medication.

Suicide patterns

During the pilot phase, the SSIS identified a cluster of 19 suicides in two small areas in Cork comprising 40,125 inhabitants (males: 19,997, females: 20,128). The cluster involved adolescent and young adult males aged 14–36 years who died by hanging between September 2008 and December 2010. In addition, the system identified another small area in Co Cork with an emerging suicide cluster. In this area six men, aged between 34 and 67 years, took their lives over a period of 13 months. The multiple sources of information contributing to the SSIS allowed the researchers to identify a number of direct and indirect relationships among the suicide cluster cases.

A matched comparison between cluster and non-cluster suicide cases in terms of mental health and social risk factors was undertaken. All except three of the young males involved in the larger cluster had used multiple drugs (prescription and street drugs), often combined with alcohol, while this was less common among the non-cluster cases. Compared to the non-cluster cases, the suicide cluster cases were less likely to communicate their suicidal intentions and they were more likely to have lost a friend by suicide.

Open verdict cases

An open verdict was returned in the case of 12 deaths. Two-thirds (67%) were men and the average age was 60 years. One-quarter were single. Only 8% were unemployed, and 42% were retired. With regard to cause of death, 42% died by drowning, 25% died by hanging and 33% had used other methods. A significant minority (46%) had consumed alcohol at the time of death. Seventeen per cent had left a suicide note, e-mail or text message prior to death. Two-fifths (42%) had a history of deliberate self-harm. A relatively high proportion (67%) had a confirmed psychiatric diagnosis. The vast majority (88%) had a mood disorder. One-quarter had a history of alcohol abuse. In the year prior to death, 58% had used psychotropic medication.

The open verdict cases, when compared with the suicide cases, were more likely to be male, older, retired and have a history of depression or alcohol dependence. They were less likely to be single and unemployed. They were also more likely to die by drowning and less likely to die by hanging. The number of open verdict cases is small and comparisons need to be interpreted with caution.

(Jean Long)

1. Arensman E, McAuliffe C, Corcoran P, Williamson E, O'Shea E and Perry IJ (2012) *First report of the Suicide Support and Information System*. Cork: National Suicide Research Foundation. www.drugsandalcohol.ie/18081

National Registry of Deliberate Self Harm annual report 2011

The tenth annual report from the National Registry of Deliberate Self Harm was published in July 2012.[1] The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in 2011, giving complete national coverage of cases treated.

There were 12,216 recorded presentations of deliberate self-harm, involving 9,834 individuals, in 2011. This implies that one in five (2,382, 19.5%) of the presentations were repeat episodes. The rate of presentations decreased from 217/100,000 of the population in 2010 to 215/100,000 in 2011, a 4% decrease.

Concordant with previous reports, 48% of self-harm presentations in 2010 were men and 47% were aged under 30 years. Four hundred and seventy-three (4%) self-harm presentations were living in homeless hostels or had no fixed abode, a 53% increase on the number of such presentations in 2010. Presentations peaked in the hours around 10pm and were highest on Sundays and Mondays; 31% of episodes occurred on these two days. There was evidence of alcohol consumption in 39% (4,773) of all presentations and this was more common among men (40%) than women (38%).

Drug overdose was the most common form of deliberate self-harm, occurring in 69% (8,409) of all such episodes reported in 2011. Overdose rates were higher among women (75%) than among men (62%). In 73% of cases the total number of tablets taken was known; an average of 30 tablets was taken in these cases. The average among men was 32 tablets and among women 29 tablets. Forty-three per cent of all drug overdoses involved a minor tranquilliser (most commonly benzodiazepines), 26% involved paracetamol-containing medicines, 22% involved anti-depressants or mood stabilisers (most commonly SSRIs) and 10% involved a major tranquilliser. The number of deliberate self-harm presentations involving street drugs decreased by 27% (to 479) in 2011 when compared to 2010 (645). Men (10%) were much more likely than women (3%) to self-harm using street drugs.

The next steps, or referral outcomes for the deliberate overdose cases were: 46% discharged home; 33% admitted to an acute general hospital; 8% admitted to psychiatric in-patient care; a small proportion (1%) refused admission to hospital; and 13% discharged themselves before receiving referral advice.

The report provides information on what is being or can be done to reduce the number of self-harm cases. In January 2012, the National Office for Suicide Prevention established a National Working Group on Restricting Access to Means with a priority on restricting access to minor tranquillisers. The authors recommend that this working group also review the implementation of the paracetamol legislation and prescribing patterns of SSRIs.

The authors report that alcohol continues to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, around the hours of midnight. These findings underline the need for on-going efforts to:

- intensify national strategies to increase awareness of the risks involved in the use of alcohol starting at pre-adolescent age;
- intensify national strategies to reduce access to alcohol and drugs;
- enhance health service capacity at specific times and increase awareness of the negative effects of alcohol use such as increased depressive feelings and reduced self-control;
- arrange active collaboration between the mental health services and addiction treatment services in the best interest of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).

The authors report that there was variation in the next care recommended to deliberate self-harm patients, and in the proportion of patients who left hospital before a recommendation, from 8% in the Southern Hospitals Group to 24% in the Dublin North East Hospitals Group.
In 2012, a sub-group of the National Mental Health Clinical Programme Steering Group produced *National guidelines for the assessment and management of patients presenting to Irish emergency departments following self-harm*. The authors recommend 'that these guidelines be implemented nationally as a matter of priority'.

(Jean Long)

1. National Suicide Research Foundation (2012) *National Registry of Deliberate Self Harm annual report 2011*. Cork: National Suicide Research Foundation. www.drugsandalcohol.ie/18082

Fifth ESPAD survey report published

The European School Survey Project on Alcohol and Other Drugs (ESPAD) has conducted surveys of school-going children every four years since 1995, using a standardised method and a common questionnaire (see www.espad.org). The fifth survey was conducted in 36 European countries during 2010/11[1] and collected information on alcohol, tobacco and illicit drug use among 15–16-year-old students.

The rationale for the ESPAD surveys is that school students are easily accessible and are at an age when onset of substance use is likely to occur. Early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented in this survey, so the results do not indicate the extent of alcohol and other drug use among all 15–16-year-old children. ESPAD survey information is valuable in planning prevention initiatives.

This article concentrates on the findings from the survey conducted in Ireland in 2010/2011, when 2,207 students from 72 randomly selected schools completed valid questionnaires. Fewer schools and students participated in 2010 than in 2007 or 2003.

Four-fifths of the students (80% boys and 81% girls) reported that they had consumed alcohol at some point in their life, and 73% (72% of boys and 73% of girls) had drunk alcohol in the year prior to the survey. Half (48% boys and 52% girls) had drunk alcohol in the 30 days prior to the survey, a decrease of six percentage points since the 2007 survey (56%). Two-fifths (40%) reported having had five or more drinks on a single occasion in the month prior to the survey. Almost one-quarter (23%) reported that they had had one or more episodes of drunkenness in the 30 days prior to the survey, a decrease of three percentage points since the 2007 survey (26%). Nine per cent of the girls and 13% of the boys had their first episode of drunkenness at or before the age of 13 years. The 2011 European average for alcohol consumption in the last 30 days was 57% (7 percentage points higher than Ireland), while the European average for drunkenness in the last 30 days was 17% (6 percentage points lower than Ireland).

Beer (40%), spirits (35%) and cider (33%) were the most common types of alcohol drunk in the month prior to the survey. Respondents reported drinking an average of 6.7 centilitres of alcohol on the last alcohol-drinking day prior to the survey, which places Ireland (and the UK) joint fifth highest. Those who drank alcohol at some point in their life were asked to rate their level of intoxication during the last alcohol drinking day on a scale of one to ten; the average rate for Irish students was 3.8, which places Ireland third highest after the UK and the Faroe Islands.

Eighty-four per cent of the students reported that alcohol was easy or fairly easy to acquire in Ireland. Over one-quarter (26%) had bought alcohol for their own consumption in an off-trade outlet in the 30 days prior to the survey; 37% had done so in an on-trade outlet. Sixty five per cent reported that they were likely to experience positive consequences of alcohol consumption, while 35% were likely to experience negative consequences. Some of the negative consequences reported were: getting into trouble with the police (22%), not being able to stop drinking (20%), and doing something they regretted (48%). Ten per cent of boys and six per cent of girls had experienced delinquency problems as a result of their alcohol use in the year prior to the survey. Delinquency problems included being involved in a physical fight (16% boys and 7% girls), being a victim of robbery or theft (4% of boys and 3% of girls), and being in trouble with the police (11% of boys and 8% of girls).

The lifetime use of alcohol decreased by 10 percentage points in 15 years, falling from 91% in 1995 to 81% in 2011, and alcohol use in the month prior to the survey decreased by 19 percentage points, from 69% in 1995 to 50% in 2011. The proportion reporting having had five or more drinks on one occasion during the last 30 days decreased by only four percentage points, from 23% in 1995 to 19% in 2011. The consumption of five or more drinks in the one sitting is an indicator of the harmful use of alcohol.

Over two-fifths (43%) of the students (42% of boys and 45% of girls) reported that they had smoked cigarettes at some point in their life, and 21% (19% of boys and 23% of girls) had smoked cigarettes in the 30 days prior to the survey. Over one-fifth had their first cigarette at or before the age of 13 years. Five per cent were smoking daily at or before the age of 13 years. The 2011 European average for smoking cigarettes in the last 30 days was 28% (7 percentage points higher than Ireland), while the European average for smoking cigarettes daily at age 13 or under was 6% (one percentage point higher than Ireland). Three-quarters reported that cigarettes were easy or fairly easy to acquire in Ireland. Over one-fifth thought that people who smoked cigarettes occasionally were at great risk of harming themselves; 67% thought that smoking one or more packs a day constituted a great risk.

The reduction in cigarette use is larger than the reduction in alcohol use, and alcohol is easier to acquire than cigarettes. The rate of lifetime use of cigarettes decreased by 31 percentage points, from 74% in 1995 to 43% in 2011, and use in the month prior to the survey decreased by 20 percentage points, from 41% in 1995 to 21% in 2011. The proportion who reported smoking cigarettes on a daily basis by age 13 years decreased by 13 percentage points, from 18% in 1995 to 5% in 2011.

The Irish data show a fall of 3 percentage points in the rate of lifetime use of any illicit drug between 2007 (22%) and 2011 (19 (Table 1). Boys (23%) were more likely than girls (15%) to use illicit drugs at some point in their life. As the majority of 15–16-year-olds who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use may be explained by the fall in the number of students who had tried cannabis at some point in their lives, from 20% in 2007 to 18% in 2011 (just above the European average of 17%). Boys (22%) were more likely than girls (15%) to use cannabis at some point in their life. Fourteen per cent of respondents had used cannabis in the year prior to the survey (above the European average of

ESPAD survey *(continued)*

12%). Only two per cent had used ecstasy at some point in their life and the proportion was the same in the year prior to the survey, indicating recent introduction to the use of this drug. In the case of cocaine powder, 3% had used it in their lifetime, just above the European average of 2%. Nine per cent of respondents reported that they had taken prescribed tranquillisers or sedatives at some point in their lives, and a further three per cent had taken them without a prescription. One in twenty had taken alcohol with pills 'in order to get high'. Lifetime use of solvents/inhalants decreased considerably, from 15% in 2007 to 9% in 2011, and the rate is now the same as the European average (9%).

Forty per cent of the students reported that cannabis was easy or fairly easy to acquire in Ireland, while lower but considerable proportions reported that amphetamines (14%), ecstasy (21%) and sedatives (17%) were easy or fairly easy to acquire. Alcohol and cigarettes are easier to acquire than illicit drugs.

Table 1 Respondents in Ireland who reported lifetime use of drugs in the ESPAD surveys of 1995, 1999, 2003, 2007 and 2011

Lifetime use	1995 %	1999 %	2003 %	2007 %	2011 %
Any illicit drug*	37	32	40	22	19
Cannabis	37	32	39	20	18
Inhalants (solvents)	n.a.	22	18	15	9
Ecstasy	9	5	5	4	2
Cocaine powder	2	2	3	4	3
Amphetamines	3	3	1	3	2
Prescribed tranquilisers or sedatives	n.a.	11	10	10	9
Non-prescribed tranquilisers or sedatives	7	5	2	3	3

* includes amphetamines, cannabis, cocaine, crack, ecstasy, heroin and LSD or other hallucinogens
n.a. = not available

(Jean Long)

1. Hibell B, Guttormsson U, Ahlström S, Balakireva O, Bjarnason T, Kokkevi A and Kraus L (2012) *The 2011 ESPAD report: substance use among students in 36 European countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group of the Council of Europe. www.drugsandalcoohol.ie/17644

Drug use among the general population, by regional drugs task force area

On 19 June a new bulletin was published outlining drug prevalence data by regional drugs task force (RDTF) area based on findings from the 2010/2011 National Advisory Committee on Drug's general population survey on drug use.[1] This is the third of these surveys, previously done in 2002/3 and 2006/7. Drug prevalence surveys of the general population are important in that they can shed light on the patterns of drug use, both demographically and geographically and, when repeated, can track changes over time. The Irish survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The commentary in this article concentrates on the prevalence of drug use in the year prior to the survey (described as 'recent' use) as this is the most useful measure for policy makers and service planners.

- Recent (or last-year) illicit drug use among the 15–64-year-old population stabilised or decreased marginally in most RDTF areas between 2006/7 and 2010/11, with no area showing a significant increase (Table 1). As expected, recent use is higher among men than women and higher among those aged 15–34 years than among their older counterparts.
- Cannabis was the most commonly reported illegal drug used in each of the RDTF areas, with rates of recent use ranging between 2.8% in the North West and 9.4% in North Dublin (Table 2 and Figure 1). Rates have stabilised or fallen in six RDTF areas (though not statistically significantly) and increased significantly in one area, the Western RDTF.
- Recent ecstasy use decreased somewhat in all RDTF areas (significantly so in the East Coast area only), with proportions ranging between 0% in the North West and 1.3% in North Dublin. (Table 3). Anecdotal reports of seizures and adverse events through early warning reports indicate that the ecstasy use increased in late 2011 and 2012.
- Cocaine was the second most common illicit drug used in the year prior to the survey (Table 4). Its use was highest in the North Dublin, South West and East Coast RDTF areas. Recent cocaine use stabilised or decreased somewhat in nine areas and increased significantly in only one, the South West (SW Dublin, W Wicklow and Kildare).
- Recent use of new psychoactive substances was reported in all RDTF areas. The rate of use was highest in the East Coast (7.7%) and lowest in the North West (1.5%). It has been suggested that new psychoactive substances may take the place of other stimulants, which may account for the marginal decrease in cocaine and ecstasy use since 2006/7.[2] Anecdotally, the use of new psychoactive substances appears to have decreased, which is evidenced by a reduction in the number

Drug use among the general population, by RDTF area *(continued)*

of adverse events reported since the introduction of relevant legislation.

- Recent use of sedatives and tranquillisers (such as benzodiazepines and zopiclone, both prescribed and non-prescribed) has increased significantly in three RDTF areas (North Dublin, South West and North Eastern) and decreased significantly in the North West. Sedatives and tranquilisers are among the four most common drugs used in all RDTF areas (Figure 1).
- The definition of the category 'other opiates' was broadened in successive surveys, to be consistent with the definition used in Northern Ireland, and to include substances that contain codeine (an opiate). Consequently, data from the 2010/11 survey on recent use of 'other opiates' is not comparable with data for that category in previous surveys In 2010/11 the rate of recent use of other opiates is high in all RDTF areas, ranging from 19.1% in the North West to 37.5% in the Western area (Figure 1).

(Jean Long and Justine Horgan)

1. National Advisory Committee on Drugs and Public Health Information and Research Branch (2012) *Drug use in Ireland and Northern Ireland. Drug Prevalence Survey 2010/11: Regional Drug Task Force (Ireland) and Health and Social Care Trust (Northern Ireland) Results*. Bulletin 2. Dublin: National Advisory Committee on Drugs. www.drugsandalcohol.ie/17753
2. Horgan J (2011) *Drug use in Ireland and Northern Ireland. First results from the 2010/11 Drug Prevalence Survey*. PowerPoint presentation of findings on publication of Bulletin 1 of the survey. Dublin: National Advisory Committee on Drugs. www.drugsandalcohol.ie/16450

Table 1 Proportion of respondents aged 15-64 years who reported lifetime and last-year use of illegal drugs, by regional drugs task force area of residence

	Percentage that used any illegal drugs*					
RDTF area of residence	Ever in lifetime			Year prior to survey		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Ireland	18.5	24.0	27.2	5.6	7.2	7.0
East Coast (of Dublin, and East Wicklow)	25.9	38.4	38.0	6.3	12.4	9.2
North Dublin City & County	29.5	32.2	34.6	8.4	12.8	10.5
South West (of Dublin, West Wicklow, and Kildare)	24.0	25.6	36.3	7.5	7.4	11.1
South East	18.5	25.5	25.3	6.9	7.9	5.9
North Eastern	18.9	22.1	23.9	6.4	5.4	4.0
Midland	11.0	19.6	19.1	2.8	4.4	4.8
Mid West	12.0	18.0	18.7	3.2	5.8	5.1
Southern	12.1	16.3	24.2	4.7	4.9	6.1
Western	12.5	20.4	23.8	2.9	4.2	5.1
North West	10.6	14.6	16.6	2.6	3.0	2.8

* Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Data source: National Advisory Committee on Drugs and Public Health Information and Research Branch (2012)

Table 2 Proportion of respondents aged 15-64 years who reported lifetime and last-year use of cannabis, by regional drugs task force area of residence

	Percentage that used cannabis					
RDTF area of residence	Ever in lifetime			Year prior to survey		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Ireland	17.3	21.9	25.3	5.1	6.3	6.0
East Coast (of Dublin, and East Wicklow)	24.5	35.9	36.2	6.1	11.3	7.7
North Dublin City & County	26.9	28.8	30.2	7.7	11.9	9.4
South West (of Dublin, West Wicklow, and Kildare)	23.2	24.0	33.4	7.3	6.7	8.7
South East	16.8	23.3	24.2	5.8	5.1	4.1
North Eastern	17.8	19.2	20.5	5.2	4.3	3.3
Midland	10.7	17.0	17.4	2.8	4.1	4.3
Mid West	10.9	17.0	17.9	3.0	4.7	5.0
Southern	11.6	15.0	23.3	4.4	4.6	5.5
Western	12.0	18.4	23.0	2.0	3.9	4.9
North West	9.3	13.0	16.1	2.2	3.0	2.8

Data source: National Advisory Committee on Drugs and Public Health Information and Research Branch (2012)

Drug use among the general population, by RDTF area *(continued)*

Table 3 Proportion of respondents aged 15-64 years who reported lifetime and last-year use of ecstasy, by regional drugs task force area of residence

RDTF area of residence	Percentage that used ecstasy					
	Ever in lifetime			Year prior to survey		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Ireland	3.7	5.4	6.9	1.1	1.2	0.5
East Coast (of Dublin, and East Wicklow)	5.4	7.6	9.4	2.5	2.3	0.3[U]
North Dublin City & County	6.5	11.2	11.3	1.6	2.9	1.3
South West (of Dublin, West Wicklow, and Kildare)	5.9	4.1	10.4	1.3	0.5	0.7
South East	4.3	6.5	6.4	1.3	1.9	0.6
North Eastern	2.6	5.2	4.9	0.5	0.8	0.1
Midland	2.0	5.8	3.0	0.9	0.9	0.0
Mid West	1.7	2.9	4.9	0.6	0.8	0.4
Southern	2.8	3.5	5.7	0.9	0.6	0.4
Western	1.8	3.9	3.7	0.3	0.7	0.4
North West	0.3	2.3	3.6	0.0	0.3	0.0

Data source: National Advisory Committee on Drugs and Public Health Information and Research Branch (2012)

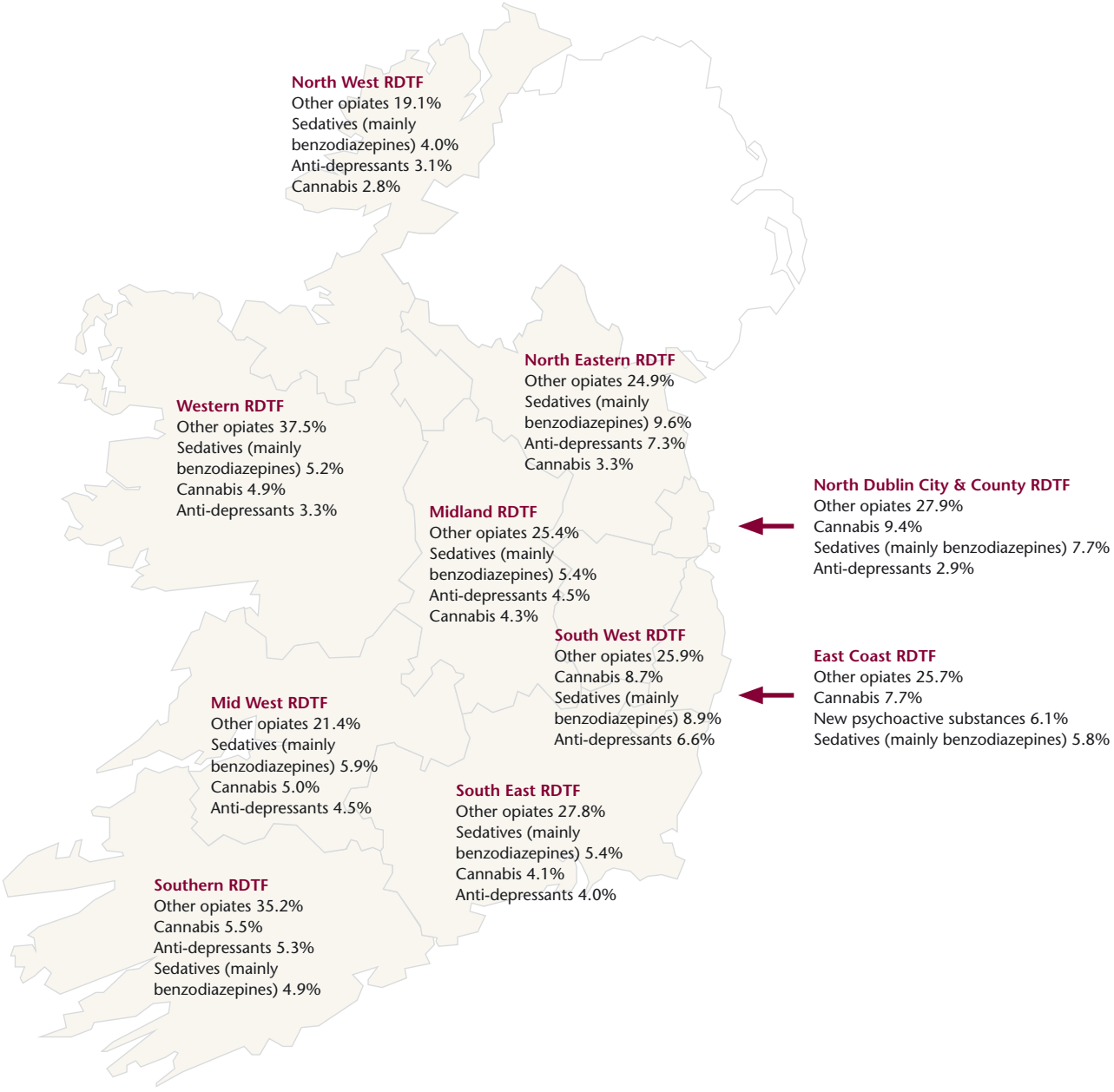


Figure 1 Last-year prevalence among the general population of the most commonly used legal and illegal drugs (excluding alcohol), by regional drugs task force area, 2010/11

Data source: National Advisory Committee on Drugs and Public Health Information and Research Branch (2012)

Drug use among the general population, by RDTF area *(continued)*

Table 4 Proportion of respondents aged 15-64 years who reported lifetime and last-year use of cocaine, by regional drugs task force area of residence

RDTF area of residence	Percentage that used cocaine*					
	Ever in lifetime			In year prior to survey		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Ireland	3.0	5.3	6.8	1.1	1.7	1.5
East Coast (of Dublin, and East Wicklow)	6.3	9.1	10.1	2.3	3.1	2.7
North Dublin City & County	5.2	11.0	11.9	1.7	3.3	2.6
South West (of Dublin, West Wicklow, and Kildare)	5.0	3.8	9.6	1.5	0.8	2.9
South East	2.5	6.7	5.5	1.7	2.4	1.5
North Eastern	1.2	5.4	5.3	0.0	1.4	0.5
Midland	1.3	4.4	4.0	0.3	1.7	0.7
Mid West	1.1	2.9	4.5	0.7	1.0	0.4
Southern	1.9	3.1	4.9	0.7	1.1	1.0
Western	1.7	3.1	5.5	0.7	1.5	0.8
North West	0.0	1.6	2.7	0.0	0.3	0.3

* Includes cocaine powder and crack cocaine.
Data source: National Advisory Committee on Drugs and Public Health Information and Research Branch (2012)

Unmet needs and benzodiazepine misuse among people in treatment

Many problem opiate users in treatment also misuse other substances. This presents a challenge to addiction services as often one single service cannot address the complex needs of such clients. A study carried out in the Drug Treatment Centre Board examined clients' perceptions of unmet needs and the association between misuse of non-prescribed benzodiazepines and extent of unmet needs.[1]

The authors used the Camberwell Assessment of Need Short Appraisal Schedule – Patient-rated version (CANSAS-P) as the measurement tool for this study.[2]

CANSAS-P provides scores based on the client's ratings of 22 items in terms of total needs, unmet needs and met needs. Unmet needs can be used as a predictor of perceived quality of care. The authors believe this is the first study to use this tool to assess unmet needs among clients of addiction services.

Clients who were opiate dependent and receiving methadone for at least three months were eligible to participate in the study. Clients with acute or end-stage medical problems were excluded. Over half (107, 56%) of 191 eligible clients took part. There were no statistically significant differences between the socio-demographic characteristics of those who took part and those who did not.

Of the 107 participants, 52 (49%) reported using non-prescribed benzodiazepines in the previous month. Of these, only one reported both oral and intravenous use. The mean number of days on which benzodiazepines were used was 14, and 90% had benzodiazepine-positive urine samples in the previous month. The group who misused benzodiazepines had statistically more frequent use of both cocaine (mean 2.4 days versus mean 1.6 days) and heroin (mean 12.3 days versus mean 5.3 days) compared to the group who did not misuse benzodiazepines. Table 1 shows the mean number of met and unmet needs in both groups.

The highest proportions of unmet needs related to the following items in the assessment tool: substance misuse treatment, daytime activities, social company, money budgeting and benefits, psychological distress, and physical health. There were statistical differences between the two groups in relation to substance misuse and daytime activities. Needs that were generally rated as met included accommodation, food, telephone access, self-care, childcare and transportation.

Multivariate linear regression showed that a higher number of days of benzodiazepine misuse was significantly associated with a higher unmet needs rating. The authors stress that this was a study of needs assessment and that it 'does not propose that fulfilling unmet needs will necessarily alter benzodiazepine misuse among opioid users'. They recommend a more formal and active assessment of the needs of clients on methadone treatment and rapid access to evidence-based treatment for benzodiazepine misuse.

(Suzi Lyons)

1. Apantaku-Olajide T, Ducray K, Byrne P and Smyth PB (2012) Perception of unmet needs and association with benzodiazepine misuse among patients on a methadone maintenance treatment programme. *The Psychiatrist*, 36(5): 169–174. www.drugsandalcohol.ie/17746
2. The CANSAS-P tool was chosen as it has good reliability and validity for measuring unmet needs and has been positively evaluated by clients. Ratings of unmet needs by clients have been found to be more reliable than those by staff.

Table 1 Mean number of client needs, met and unmet, and association with benzodiazepine use

	Benzodiazepine misuse (n = 52)	No benzodiazepine misuse (n = 55)	
Mean number of needs	7.8	6.4	p = 0.02
Mean number of met needs	1.8	1.6	p = 0.53
Mean number of unmet needs	5.9	4.7	p = 0.02

Trends in alcohol and drug admissions to psychiatric facilities

Activities of Irish psychiatric units and hospitals 2010, the annual report published by the Mental Health Information Systems Unit of the Health Research Board, shows that the total number of admissions to inpatient care has continued to fall.[1]

In 2010, 1,798 cases were admitted to psychiatric facilities with an alcohol disorder, of whom 637 were treated for the first time. Figure 1 presents the rates of first admission between 1990 and 2010 of cases with a diagnosis of alcohol disorder.[2] The trend of recent years has continued, with again a reduction in the rates of admission for alcohol disorders in 2010. Thirty nine per cent of cases hospitalised for an alcohol disorder stayed just under one week, while 22% were hospitalised for between one and three months.

In 2010, 966 cases were admitted to psychiatric facilities with a drug disorder, of whom 412 were treated for the first time. Since 2006 there has been a continuous increase in the rate of first admission of cases with a diagnosis of a drug disorder. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 2 presents the rates of first admission between 1990 and 2010 of cases with a diagnosis of drug disorder.

Other notable statistics on first admissions for a drug disorder in 2010 include:

- The majority were to psychiatric units in general hospitals (259, 63%), followed by admissions to psychiatric hospitals (102, 25%) and to private hospitals (51, 12%).
- 6% were involuntary admissions.
- The rate was higher for men (14.2 per 100,000) than for women (5.2 per 100,000).

The majority of cases hospitalised for a drug disorder stayed just under one week (54%), while most were discharged within three months.

(Suzi Lyons)

1. Daly A and Walsh D (2011) *Activities of Irish psychiatric units and hospitals 2010: main findings*. HRB Statistics Series 15. Dublin: Health Research Board. www.drugsandalcohol.ie/16329
2. Annual reports from the National Psychiatric In-patient Reporting System (NPIRS) for the years 1990 to 2010 are available on the Health Research Board website at www.hrb.ie/publications/mental-health

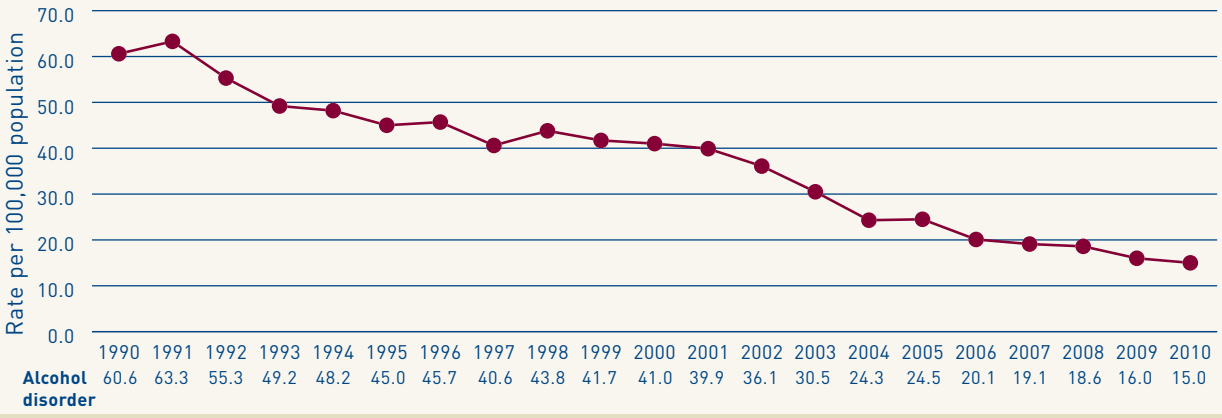


Figure 1 Rates of psychiatric first admission of cases with a diagnosis of alcohol disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–20102

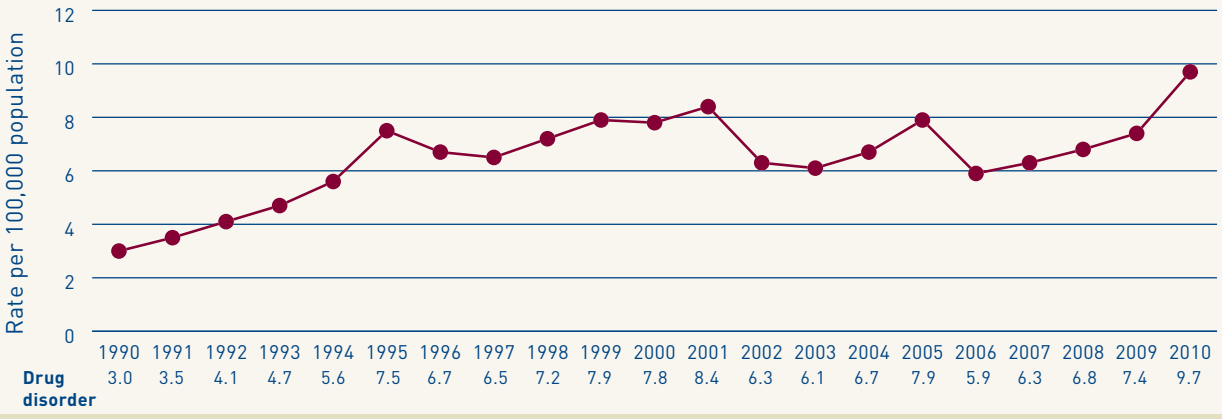


Figure 2 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–2010

Drugs and crime data 2012

This article looks at trends in reported drug offences and drug seizures for various periods between 2003 and 2011. It should be noted that drug offence and seizure data are primarily a reflection of law enforcement activity. Consequently, they are affected in any given period by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of drug users and drug traffickers to law enforcement activities. Having said that, drug seizures are seen as indirect indicators of the supply and availability of drugs.

Figures 1 and 2 show trends in proceedings for drug offences from 2004 to 2010. As can be seen from Figure 1, criminal proceedings for the possession of drugs for personal use (simple possession) decreased in 2009 for the first time since 2004. This decrease continued throughout 2010. Possession offences accounted for 69.1% of total drug offences in 2010. Proceedings for drug supply increased slightly, from 2,824 in 2009 to 2,881 in 2010.

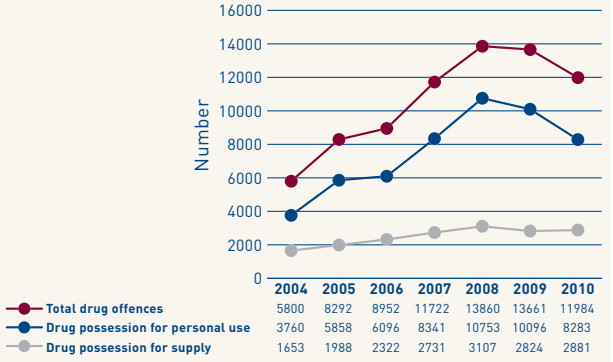


Figure 1 Trends in relevant legal proceedings for total drug offences, drug possession for personal use and for supply, 2004–2010

Source: Central Statistics Office (2012) unpublished data

Obstruction offences often involve an alleged offender resisting a drug search or an arrest or attempting to dispose of drugs to evade detection. Such offences continue to account for the largest number of prosecutions, although the number declined slightly in 2010 following an increase in 2009. A similar trend can be observed in relation to the offence of being in possession of forged/altered prescriptions.

Of particular significance is the large increase in the offence of cultivating/manufacturing controlled drugs. Proceedings for this offence have continued to increase since 2005, when there were 29 related proceedings, reaching 167 in 2009 and almost doubling to 301 in 2010. It is unclear whether this increase reflects a genuine growth in the commission of such offences or whether it reflects a sustained concentration of law enforcement on their detection. For example, in 2010, the Garda Síochána conducted Operation Nitrogen, a nationwide investigation by district and divisional drug units into cannabis cultivation sites.[1] This specific focus may have had an impact on the data presented here.

Drug driving offences

Figure 3 shows the trend in prosecutions for driving under the influence of drugs (DUID) between 2003 and 2010. Between 2006 and 2009 the number of prosecutions for DUID increased from 74 to 703, an increase of more than 900%. It is unclear why this increase has occurred. It could be due to an increase in the incidence of DUID or, the more likely possibility, to an increase in targeted police activity in this area. In 2010 the number of such offences decreased significantly, to 456 offences.

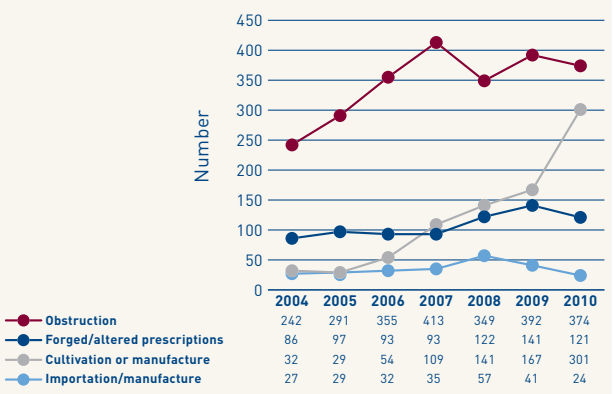


Figure 2 Trends in relevant legal proceedings for selected drug offences, 2004–2010

Source: Central Statistics Office (2012)

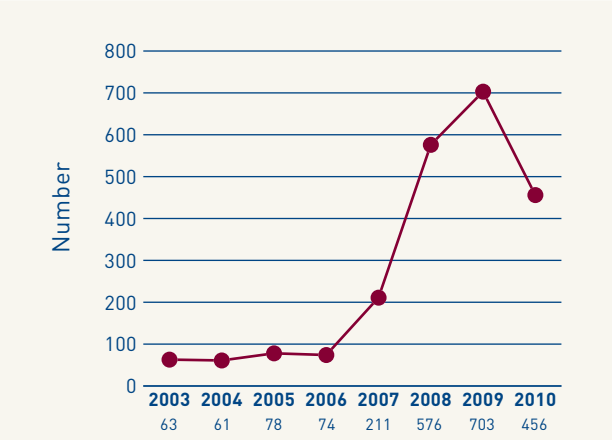


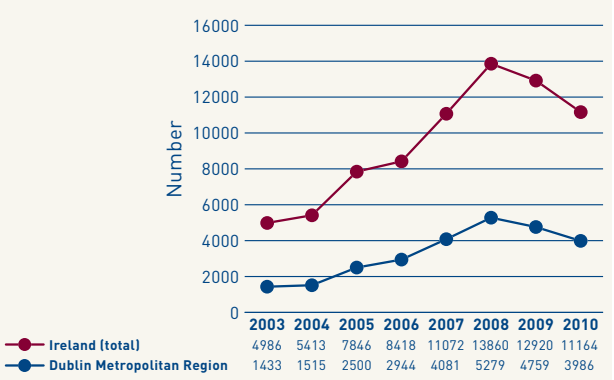
Figure 3 Trend in relevant legal proceedings for driving in charge of a vehicle while under the influence of drugs, 2005–2010

Source: Central Statistics Office (2012) Interactive tables online

Drug offence data can assist us in understanding aspects of the operation of the illicit drug market in Ireland.[2] Data on drug offence prosecutions by Garda division are a possible indicator of national drug distribution patterns. While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, when compared with other sources, such as drug treatment data, for example, they can show us trends in market developments throughout the State. Such data can also indicate trafficking patterns by showing whether there is a concentration of prosecutions along specific routes. Figures 4 and 5 show trends in relevant legal proceedings for possession of drugs by Garda region. It should be noted that possession includes possession for personal use and possession for the purpose of supply. It is not possible to distinguish between these two offences in the data reported by Garda region. However, as shown in Figure 1 above, it is generally the case that in 65%–75% of all possession cases the drugs are deemed to be for personal use.

Drugs and crime data 2012 *(continued)*

As shown in Figure 4, an upward trend since 2003 in relevant legal proceedings for possession (including for personal use and for supply) continued until 2008, and then decreased between 2008 and 2010. The majority of such proceedings were in the Dublin Metropolitan Region (DMR). The number of such offences in the DMR increased steadily from 1,433 in 2003 to 5,279 in 2008. The number then decreased to 3,986 in 2010, just below the level reported for 2007.

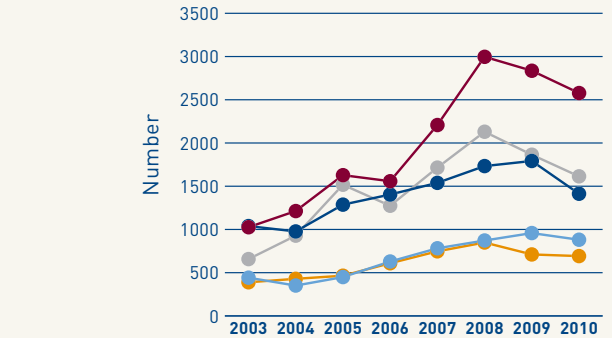


	2003	2004	2005	2006	2007	2008	2009	2010
Ireland (total)	4986	5413	7846	8418	11072	13860	12920	11164
Dublin Metropolitan Region	1433	1515	2500	2944	4081	5279	4759	3986

Figure 4 Trends in relevant legal proceedings for possession of drugs for personal use and for sale or supply, nationally and in the Dublin Metropolitan Region, 2003–2010

Source: Central Statistics Office (2012) unpublished data

Figure 5 shows trends in supply offences by Garda region, excluding Dublin. Trends in supply offences have increased in all regions since 2003. This reflects the reality that drug markets are no longer primarily a Dublin-based phenomenon.. Following this general increase throughout the country since 2003, relevant legal proceedings for drug possession (for personal use and supply) decreased in all regions between 2008 and 2010, with the exception of the Northern Region where there was a slight increase in 2009 on the previous year, followed by a decrease in 2010.



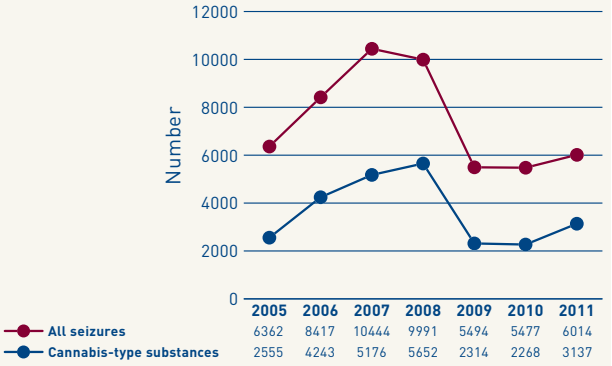
	2003	2004	2005	2006	2007	2008	2009	2010
Southern region	1026	1213	1628	1558	2208	2997	2836	2578
South eastern region	1039	977	1287	1404	1539	1733	1792	1413
Eastern region	657	928	1517	1274	1715	2130	1864	1614
Northern region	442	351	449	629	782	872	958	881
Western region	389	429	465	609	747	849	711	692

Figure 5 Trends in relevant legal proceedings for possession of drugs for personal use and for sale or supply, by region, excluding the DMR, 2003–2010

Source: Central Statistics Office (2012) unpublished data

Drug seizures

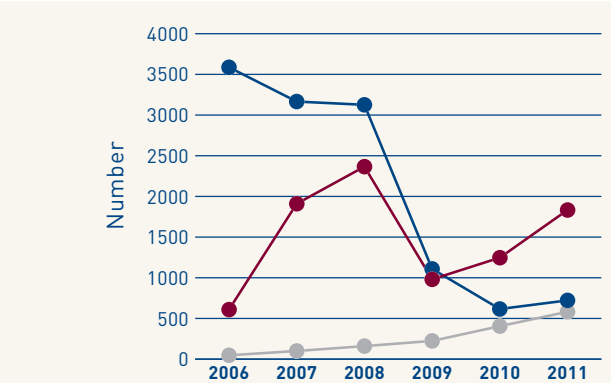
Cannabis seizures account for the largest proportion of all drugs seized. Figure 6 shows trends in cannabis-related seizures and total seizures between 2005 and 2011. The total number of drug seizures increased to a peak of 10,444 between 2005 and 2007. Between 2007 and 2010, the number almost halved, to a total of 5,477 in 2010. This decrease in total seizures since 2007 can be explained primarily by the significant decrease in the number of seizures of cannabis-type substances. It should be noted that not all drugs seized by law enforcement are necessarily analysed by the Forensic Science Laboratory, and are therefore not officially reported by the CSO. However, it is difficult to know if the reduction in cannabis-related seizures reflects a decline in cannabis use or a reduction in law enforcement activity. It may also be partly explained by a change in the nature of cannabis use, with people moving from resin use to the use of more potent forms of cannabis. For example, as shown in Figure 7, when we look more closely at cannabis-related seizures it can be seen that although seizures of cannabis resin decreased between 2009 and 2011, there has been a steady increase in seizures of cannabis plants since 2006, while herbal cannabis seizures almost doubled between 2009 and 2011, increasing from 981 to 1,833.



	2005	2006	2007	2008	2009	2010	2011
All seizures	6362	8417	10444	9991	5494	5477	6014
Cannabis-type substances	2555	4243	5176	5652	2314	2268	3137

Figure 6 Trends in the total number of drug seizures and cannabis seizures, 2005–2011

Source: Central Statistics Office (2008, 2009, 2010, 2011, 2012)



	2006	2007	2008	2009	2010	2011
Cannabis	609	1910	2366	981	1247	1833
Cannabis resin	3587	3166	3126	1109	616	722
Cannabis plants	47	100	160	224	405	582

Figure 7 Trends in the total number of cannabis seizures by cannabis type, 2005–2011

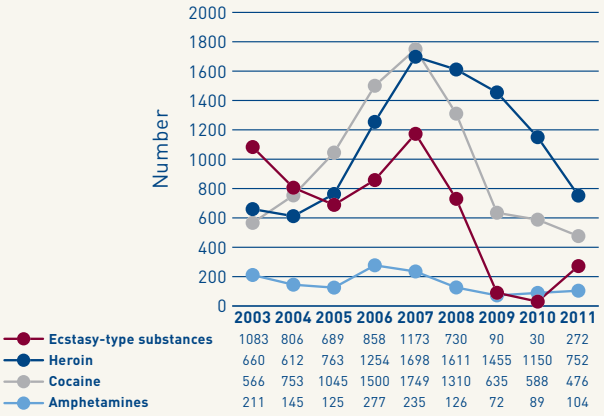
Source: Central Statistics Office (2008, 2009, 2010,2011, 2012)

Drugs and crime data 2012 *(continued)*

The reduction in the total number of reported seizures since 2007 shown in Figure 6 may also be a consequence of the reduction in the number of seizures of other drugs since 2007. Figure 8 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2011. There has been a significant decline in seizures of cocaine and heroin since 2007. Seizures of ecstasy-type substances also decreased significantly between 2007 and 2010, but increased by more than 900% in 2011.

(Johnny Connolly)

1. An Garda Síochána (2012) *Annual report 2011*. Dublin: An Garda Síochána.
2. Connolly J (2005) *The illicit drug market in Ireland*. HRB Overview Series 2. Dublin: Health Research Board. www.drugsandalcohol.ie/6018



	2003	2004	2005	2006	2007	2008	2009	2010	2011
Ecstasy-type substances	1083	806	689	858	1173	730	90	30	272
Heroin	660	612	763	1254	1698	1611	1455	1150	752
Cocaine	566	753	1045	1500	1749	1310	635	588	476
Amphetamines	211	145	125	277	235	126	72	89	104

Figure 8 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2011

Source: Central Statistics Office (2012)

Drugs in prisons

The Inspector of Prisons, Judge Michael Reilly, published a report on Limerick Prison in November 2011.[1] The report notes that 'most prisoners have addiction problems' (p.27). In relation to the availability of drugs in the prison, the report states:

> … all yards are covered by nets, a dedicated search procedure (with appropriate protocols) operates for all persons entering the prison, a dedicated drug dog is on duty, mandatory drug testing of prisoners is the norm and random targeted searches are carried out. The Operational Support Group (OSG) is the dedicated unit responsible for such initiatives. These measures have had the combined effect of reducing the amount of drugs and contraband entering the prison. (p.26)

The Inspector's report is, however, also highly critical about overcrowding and the presence of 'gangs' in the prison. It also reiterates the need for the establishment of a drug-free unit in the prison, stating that 'there are a number of prisoners, not only in Limerick prison but in all prisons in the Irish prison system, who wish to either remain drug free or try to become drug free' and that Limerick, 'in common with all closed prisons, should have a drug free support unit' (p.38). In a follow-up report, published in March 2012, the Inspector comments further in relation to a drug-free unit: 'Because of the present overcrowding in Limerick Prison it has not been possible to identify a section of the prison that could be dedicated as a drug free support unit'[2] (p.8).

Prison visiting committees are appointed to each prison under the Prisons (Visiting Committees) Act 1925 and the Prison (Visiting Committees) Order 1925. These committees report to the Minister for Justice and Equality on an annual basis. In relation to drug issues, the Wheatfield Prison visiting committee in its 2011 annual report[3] stated: 'One of the most difficult problems for prisoners was in relation to family visits. Since the introduction of dogs to curb the introduction of drugs into the prison many visitors have failed to pass the dog test and therefore are only allowed screen visits. Many prisoners are unhappy with screen visits but we have to advise them that it is in the best interest of all prisoners that drugs are kept out of the prison.' (p.4).

The Mountjoy Prison visiting committee in its annual report for 2011[4] also refers to the drug problems in the prison, including the issue of people becoming addicted in the prison. The report states:

> We are particularly concerned at the increased level of tablet availability, and the difficulty in detecting these. Also the problem of interaction between drug users and non-drug users must be addressed in 2012. The incidences of prisoners becoming addicted in Mountjoy must be dealt with in a decisive manner. A drug free environment has got to be seriously worked on. The Visiting Committee is of the view that increased measures must be put in place to eliminate the passing of tablets etc. which cannot be detected by dogs. The introduction of nets over the yards has strengthened the controls on drug supplies, but desperation leads to some amazing inventions, as has been witnessed in Mountjoy over the years. So there is no room for complacency or relaxation in pursuing new ways of dealing with the issue of supply. A programme of dealing with addiction should be set up, so as to allow for far greater availability of treatment for drug users encouraged or wishing to come off drugs. It is astounding that prisoners locked up for 23 hours per day can still avail of a constant supply of drugs/tablets.' (p.18)

With regard to the provision of treatment in the prison, the committee calls for a review of the drug treatment programme in the medical unit:

> The Medical Unit provides a primary pro-active care service, with a focus on preventive medicine. The facility provides for integrated programme for prisoners committed to becoming drug-free with a view to preparing for eventual release from prison. Prisoners wanting to participate in this programme are subject to specific qualifying considerations. We believe the programme should be widened to include all prisoners wishing to participate, who qualify. This whole area needs revision, as maybe it is time to look at the possibility of including all prisoners affected by drug addiction, in drug programmes. (p.17)

Drugs in prisons *(continued)*

The Cloverhill Prison visiting committee 2011 report[5] also refers to the need to establish a drug-free unit in the prison:

> In our 2008 report we first suggested and strongly recommended exploring the possibility of establishing a Drug Free unit within this prison and again we strongly suggest exploring the possibly of doing a feasibility study. We are disappointed to note that there has been no developments in this area but accept that this may be difficult on a Practical level in a predominately remand setting. (p.22)

The 2011 annual report of the Prison Service[6] states that supply control measures, including a security screening unit for visitors and staff members and a canine unit, 'have been particularly effective and local intelligence indicates that the availability of contraband has significantly decreased across the prison system' (p.31). The report also states that a drug-free programme, to support prisoners who are drug free and/or stable on methadone, will be in place in all closed prisons (except Arbour Hill) 'in dedicated drug free areas' by the end of 2012 (p.30).

(Johnny Connolly)

1. Inspector of Prisons (2011) *Report on an inspection of Limerick Prison by the Inspector of Prisons, Judge Michael Reilly, 25 November 2011*. Tipperary: Office of the Inspector of Prisons.
2. Inspector of Prisons (2012) *Report of second follow up inspection of Limerick Prison by the Inspector of Prisons Judge Michael Reilly, 1 March 2012*. Tipperary: Office of the Inspector of Prisons.
3. Wheatfield Prison Visiting Committee (2012) *Wheatfield Prison Visiting Committee annual report 2011*. Dublin: Department of Justice and Equality.
4. Mountjoy Prison Visiting Committee (2012) *Mountjoy Prison annual report 2011*. Dublin: Department of Justice and Equality.
5. Cloverhill Prison Visiting Committee (2012) *Cloverhill Prison Visiting Committee annual report 2011*. Dublin: Department of Justice and Equality.
6. Irish Prison Service (2012) *Irish Prison Service annual report 2011*. Longford: Irish Prison Service.

Drugs in focus – policy briefing

Drug demand reduction: global evidence for local actions
Cited from *Drugs in focus*, No. 23, 1st issue 2012

The development of evidence based demand reduction interventions is a primary drug policy objective at national, European Union (EU) and global level. A particular discourse, with its own set of concepts, is used to discuss implementation of this objective, including terms such as: best practice, quality standards, guidelines, protocols, accreditation systems and benchmarking. This paper provides readers with straightforward definitions of the terms used, whilst highlighting achievements and current challenges in transferring scientific knowledge into practice in the drug demand reduction arena. A special focus is given to 'best practice' because of this concept's increasing popularity and importance in Europe.

The briefing concludes with a series of policy considerations:

1. Different tools are used to promote evidence based practices in drug demand interventions, such as guidelines and quality standards. Nationally, dissemination and adaptation of already existing evidencebased guidelines, rather than developing new ones, is proving to be a cost effective solution that helps to ensure quality.
2. In the future, processes need to be in place to ensure that existing guidelines and standards are regularly updated as and when new evidence becomes available. In addition, the ongoing promotion and dissemination of guidelines and standards among professionals and decision makers is a key issue. Despite recent increases in the availability of scientific evidence on the effectiveness (and ineffectiveness) of drug related interventions, gaps still exist and research is required to fill these gaps. A European research agenda which gives priority to questions linked to both the effectiveness of interventions, and to improving the research practice interface, would be greatly welcomed.
3. The EMCDDA with its experience in monitoring and disseminating best practice will continue to promote and support quality improvement in the European drugs field. Proactive dissemination of evidence, mentoring of guidelines adaptation, support in goal setting and impact evaluation and fostering the exchange of experiences are some of the activities we will continue to provide to stakeholders.
www.emcdda.europa.eu/publications/drugs-in-focus

From *Drugnet Europe*

New drugs detected in the EU at the rate of around one per week
Cited from article by Roumen Sedefov and Ana Gallegos in *Drugnet Europe*, No. 78, April–June 2012

New drugs were detected in the European Union last year at the rate of around one per week, according to the *EMCDDA–Europol 2011 annual report* on new psychoactive substances, released on 26 April. A total of 49 new psychoactive substances were officially notified for the first time in 2011 via the EU early-warning system. This represents the largest number of substances ever reported in a single year, up from 41 substances reported in 2010 and 24 in 2009. In 2011, the list of substances registered was dominated by two groups: synthetic cannabinoids (23 substances) and synthetic cathinones (8 substances), [which together] make up around two-thirds of the new drugs reported last year. All of the new compounds reported in 2011 were synthetic. The number of online shops offering at least one psychoactive substance or product rose from 314 in January 2011 to 690 in January 2012.

From *Drugnet Europe (continued)*

Monitoring responses to drug problems in Europe – a systemic approach

Cited from article by Alessandro Pirona and Dagmar Hedrich in *Drugnet Europe*, No. 78, April–June 2012

In most EU countries today, social-care providers, office-based doctors and general health service professionals now complement work traditionally undertaken by caregivers from specialist drug treatment services. … Against this backdrop, the EMCDDA is adapting its treatment data collection approach and developing a new strategy for monitoring national treatment provision.

In a new project involving experts from eight countries (Bulgaria, Czech Republic, Germany, Spain, Austria, Poland, Portugal and Switzerland), EMCDDA-commissioned consultants are testing the use of a generic map of national treatment systems. Using a standardised format for all countries, this will bring together data from different sources on multiple treatment providers (availability) and treated individuals (uptake). It is also flexible enough to accommodate specific components of national systems. The initial results of this pilot exercise will be available in the second half of 2012.

Thematic paper on drug-related research

Cited from article in *Drugnet Europe*, No. 78, April–June 2012

Drug-related research in Europe: recent developments and future perspectives is the title of the next edition in the EMCDDA's series of Thematic papers. Research can help answer policy questions by investigating the most appropriate interventions to help reduce drug problems. Today scientific findings and up-to-date evidence are important bases for sound policymaking at local, national and EU level. The EMCDDA has been monitoring drug-related research since 2007. This paper, which draws on a variety of sources (e.g. Reitox national reports, EC-funded research projects), updates the EMCDDA's 2008 Selected issue on National drug-related research in Europe. The new publication reports on recent developments and current challenges in the drug-related research field and suggests future opportunities.

Market share of herbal cannabis rising

Cited from article in *Drugnet Europe*, No. 79, July – September 2012

'The market share of cannabis herb is increasing across Europe, at the expense of cannabis resin'. This is according to the first comprehensive analysis of *Cannabis production and markets in Europe*, released in the EMCDDA Insights series. The report describes a cannabis market in a 'continual state of evolution' and how Europe, a major cannabis consumer, is now an important producer of this, its most popular illicit drug. Also documented is the wide variety of products on sale and how the rise in herbal cannabis cultivation inside Europe's borders is increasingly associated with collateral damage, such as violence and criminality.

The analysis shows that, in two-thirds of Europe (30 EMCDDA countries), cannabis consumption is now dominated by herbal products (and by resin in the remaining third). Almost all (29) of the 30 reporting countries stated some cultivation of herbal cannabis. Considerable challenges posed by indoor cultivation techniques have led to a number of intelligence-led approaches to market interdiction involving new technologies and information sharing. Yet, most law enforcement attention is still focused on cannabis use rather than supply. For

Social reintegration of drug users — a neglected issue

Cited from article by Alessandro Pirona in *Drugnet Europe*, No. 79, July–September 2012

Although the quality and provision of drug treatment has improved significantly in the EU over the last two decades, most activities in this field remain predominately geared to managing or ending substance use. This has led to concerns that support aimed at (re)integrating socially excluded drug users is perhaps being neglected by current drug policies. …

Neglecting drug users' social needs can undermine the gains made in treatment. In this light, the EMCDDA will release a study this autumn reviewing recent developments and best practice in the social (re)integration of problem drug users in treatment. The report will also examine evidence on the effectiveness of a large number of interventions aimed at boosting drug users' employability and employment chances. On the same theme, a new module is under development in the EMCDDA's Best practice portal dedicated to social (re)integration interventions. Due for release this autumn, these products are designed to help policymakers and practitioners further develop coherent and inclusive strategies to promote the social (re)integration of this target population.

Latest EMCDDA Thematic papers

Drug-related research in Europe: recent developments and future perspectives

Early warning system – national profiles

Responding to drug use and related problems in recreational settings

All three available at
www.emcdda.europa.eu/publications/thematic-papers

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

In recent months a series of reviews of structures and systems supporting the operation of the voluntary and community sector in Ireland have been initiated. While no final decisions have yet been taken, findings reported to date indicate both the need for a thorough overhaul and also the complexity of the issues.

August 2011: The Central Expenditure Evaluation Unit (CEEU) in the Department of Public Expenditure and Reform published a paper on rationalising multiple sources of funding for the not-for-profit sector. The authors questioned whether using a multiplicity of bodies is an efficient model for the delivery of services. The supported organisations employ a large number of people to administer the organisation itself and the funding provided. While the state is not employing any extra people, the state's own funding methods contribute to the level of support required. They concluded:

- The funding model whereby each agency receives part-funding from different state agencies, for different or overlapping objectives, serves neither efficiency nor effectiveness.
- The number of state-to-agency transactions should be reduced, by rationalising both the number of bodies and the number of state interlocutors. In this context, one state body should be responsible for 'core' funding of each agency, and all state supports for the agency should be channelled through the one state body.

Central Expenditure Evaluation Unit (2012) ***CEEU cross-cutting paper no. 1: rationalising multiple sources of funding to not-for-profit sector.*** **Dublin: CEEU, Department of Public Expenditure and Reform.**

December 2011: The Minister for the Environment, Community and Local Government, Phil Hogan TD, established a high-level alignment steering group to review the role of local government in local and community development. In their interim report, published in December 2011, the steering group noted that existing arrangements for local development are administratively burdensome and do not lend themselves to joined-up, integrated service delivery, that the multiple structures set up by central government for service delivery at local level have, to a large extent, by-passed local government and undermined the democratic process at local level, and finally that there is considerable variation in approach, skills and standards of service delivery across both local authorities and local development companies. The group outlined their preferred 'way forward':

- a more co-ordinated and integrated approach to local service provision, based on an enhanced role for local government in planning, decision-making, oversight and, where appropriate, delivery of local development programmes within agreed structures;
- meaningful community engagement and involvement within this planning and decision-making framework as well as in the delivery of services;
- a strong national oversight role to ensure consistency of standards and approaches across the country;
- a more integrated and targeted approach to all the programmes funded and managed by all departments and agencies and delivered locally, through provision of joined-up services based on a comprehensive cross-programme and cross-government alignment; and
- central government priorities should allow greater flexibility at local level to customise programmes and policy initiatives to local needs and priorities, while the policy making role at national level should also be informed by delivery and practice at local level.

Local government / local development alignment steering group (2011) ***Interim report of the local government / local development alignment steering group.*** **Dublin: Department of the Environment, Community and Local Government.**

February 2012: The Minister of State in the Department of Health with responsibility for Primary Care, Róisín Shortall TD, initiated a review of drugs task forces, focusing on their role and composition, the national structures under which they operate and funding arrangements, and seeking, where appropriate, to transfer responsibility for funding task force projects to relevant statutory agencies and to overhaul the accountability and reporting arrangements of the drugs projects that continue to be supported by the task forces. To date, an interim report, issued in February 2012, setting out the views of departments and statutory agencies, the voluntary and community sectors, and the drugs task forces themselves, shows a general consensus on the need for reform.

Drugs Programmes Unit (2012) ***Report on the consultation process in relation to the review of the structures underpinning the National Drugs Strategy.*** **Dublin: Department of Health.**

April 2012: The European Anti-Poverty Network Ireland (EAPN Ireland) and OPEN published a case study of how the Irish government allocated grants to non-statutory organisations. Analysing the documentation held by the Department of the Environment, Community and Local Government with regard to the operation of a funding scheme supporting national organisations in the voluntary and community sector (2008–2010 and 2011–2013), the author found evidence of serious deficiencies in the quality of the administration of the scheme, details of which are reflected in his recommendations, including:

- adopt a collegial approach among departmental officials to review, assessment and appeal;
- undertake structured, strategic consultation with voluntary and community organisations;
- improve the knowledge base, so that assessment and appeal officials are familiar with key governmental, academic and research texts on the profile, topography and *modus operandi* of the voluntary and community sector;
- introduce guidelines for assessing concepts such as 'disadvantage', 'key services', 'coalface services', and 'added value';
- introduce mechanisms such as a technical assistance facility and/or a screening round to address the problem of poor applications;
- use external advisers to assist in the assessment process;
- apply the principles of administrative justice to the assessment and appeals system; and
- reinstate 'advocacy' as a factor for marking up the funding applications of voluntary organisations in the next round.

Harvey B (2012) ***Reforming grant-giving in public administration: the Funding scheme to support national organizations in the voluntary and community sector, a case study.*** **Dublin: EAPN (European Anti Poverty Network) Ireland and OPEN.**

June 2012: The Minister for Social Protection, Joan Burton TD, confirmed that she had received a copy of a review of the Community Employment (CE) scheme. The terms of the review were to examine the income and funding of sponsoring organisations in terms of their ability to continue the programme with reduced funding from the Department of Social Protection. She stated that one of the most important outcomes of the review was the identification of 'very serious savings that could be made in areas such as administration in respect of insurance charges, and audit and accountancy charges. In the case of a number of CE schemes, it is also clear that rental savings may be possible.'

Burton J (2012, 12 June) ***Parliamentary Debates Dáil Éireann*** **(Official report: unrevised): Priority questions. Community Employment schemes. Vol. 768, No. 1, p. 3. Question(s) 109, 110.**
www.drugsandalcohol.ie/18184

(Compiled by Brigid Pike)

Recent publications

Journal articles

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

Policy proposals for reducing alcohol-related harm: comparing and contrasting recent British and Irish policy documents

Butler S (2012)
Drugs: education, prevention and policy, 2012,10 July. Early online. www.drugsandalcohol.ie/18060

The UK policy document *The Government's Alcohol Strategy* (hereafter the GAS) was published in March 2012, just weeks after Ireland's Department of Health published the *Steering Group Report on a National Substance Misuse Strategy* (hereafter the SGR). Despite its ambiguous title, the SGR is solely concerned with alcohol, specifically with how alcohol might be integrated into Ireland's longstanding National Drugs Strategy, which prior to this had dealt only with illicit drugs. In a short commentary piece such as this it would be tedious, if not impossible, to present a point-by-point comparison of the two documents, but it might be of interest to readers in both jurisdictions to draw some broad comparisons between them. This will be attempted here by looking at the GAS and the SGR from three separate, if somewhat overlapping, perspectives: (1) their primary ideological content; (2) their policy status – either as proposals to government or government approved strategies and (3) the likelihood that all or most of the recommended strategies will be implemented.

Supportive text messaging for depression and comorbid alcohol use disorder: single-blind randomised trial

Agyapong VI, Ahern S, McLoughlin DM and Farren CK
Journal of Affective Disorders, 2012, 29 March. Early online. www.drugsandalcohol.ie/17916

Mobile phone text message technology has the potential to improve outcomes for patients with depression and co-morbid Alcohol Use Disorder (AUD).This randomised rater-blinded trial aimed to explore the effects of supportive text messages on mood and abstinence outcomes for patients with depression and co-morbid AUD.

Fifty-four participants were randomised to receive twice daily supportive text messages (n = 26) or a fortnightly thank you text message (n = 28) for three months. Primary outcome measures were Beck's Depression Inventory (BDI-II) scores and Cumulative Abstinence Duration (CAD) in days at three months.

There was a statistically significant difference in three-month BDI-II scores between the intervention and control groups. There was a trend for a greater CAD in the text message group than the control group. Limitations of the study include the small sample size, the potential for loss of rater blinding and the lack of long term follow-up to determine the longer term effects of the intervention. The authors conclude that supportive text messages have the potential to improve outcomes for patients with comorbid depression and alcohol dependency syndrome.

Health impacts of increasing alcohol prices in the European Union: a dynamic projection

Lhachimi SK, Cole KJ, Nusselder WJ *et al.*
Preventative Medicine, 2012,17 June. Early online. www.drugsandalcohol.ie/17915

Objective. Western Europe has high levels of alcohol consumption, with corresponding adverse health effects. Currently, a major revision of the EU excise tax regime is under discussion. We quantify the health impact of alcohol price increases across the EU.

Data and method. We use alcohol consumption data for member states, covering 80% of the EU-27 population, and corresponding country-specific disease data (incidence, prevalence, and case-fatality rate of alcohol related diseases) taken from the 2010 published Dynamic Modelling for Health Impact Assessment(DYNAMO-HIA) database to dynamically project the changes in population health that might arise from changes in alcohol price.

Results. Increasing alcohol prices towards those of Finland (the highest in the EU) would postpone approximately 54,000 male and approximately 26,100 female deaths over 10 years. Moreover, the prevalence of a number of chronic diseases would be reduced: in men by approximately 97,800 individuals with diabetes, 65,800 with stroke and 62,200 with selected cancers, and in women by about 19,100, 23,500, and 27,100, respectively.

Conclusion. Curbing excessive drinking throughout the EU completely would lead to substantial gains in population health. Harmonisation of prices to the Finnish level would, for selected diseases, achieve more than 40% of those gains.

Socio-demographic, environmental, lifestyle and psychosocial factors predict self rated health in Irish Travellers, a minority nomadic population

Kelleher C, Whelan J, Daly L and Fitzpatrick P
Health & Place, 2012, 18(2): 330–338
www.drugsandalcohol.ie/17924

Irish Travellers are an indigenous nomadic minority group with poor life expectancy. As part of a census survey of Travellers (80%participation rate),a health status interview was conducted (n=2065,43.5% male).In the final regression model, positive predictors of self-rated health (SRH were having a flush toilet (OR2.2, p=0.021), considering where one lives to be healthy (OR1.9, p=0.017),travelling twice yearly (OR2.3 p=0.026), taking a brisk walk weekly (OR 2.4, p=0.000) and non-smoking (OR 1.7, p=0.03). Conversely, SRH was negatively associated with age (p=0.000), activity-limiting ill health (OR 0.4, p=0.001), or chronic health condition (OR0.4, p=0.002).

Effectiveness of a culturally adapted Strengthening Families Program 12–16 years for high-risk Irish families

Kumpfer K, Xie J and O'Driscoll R
Child and Youth Care Forum, 2012, 41(2): 173–195
www.drugsandalcohol.ie/17347

Cochrane Reviews have found the Strengthening Families Program (SFP) to be the most effective substance abuse prevention intervention. Standardized cultural adaptation processes resulted in successful outcomes in several countries. To promote wide-scale implementation and positive outcomes in Ireland, a unique model of inter-agency collaboration was developed plus guidelines for cultural adaptation with fidelity.

250 high-risk youth and families were recruited to complete SFP and its parent questionnaire. All 21 measured outcomes had statistically significant positive results. Larger effect sizes were found for the Irish families than the USA families (d = 0.57 vs. 0.48 for youth outcomes, d = 0.73 vs. 0.65 for parenting and d = 0.76 vs. 0.70 for family outcomes). Overt and covert aggression, criminality and depression decreased more in Irish youth, but the USA youth improved more in social skills.

This study suggests that SFP 12–16 is quite effective in reducing behavioural health problems in Irish adolescents, improving family relationships and reducing substance abuse. Additionally, the Irish interagency collaboration model is a viable solution to recruitment, retention and staffing in rural communities where finding five skilled professionals to implement SFP can be difficult.

Upcoming events

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

October

18 October 2012

Pillars of Protection: Strengthening Families, Strengthening Communities

Venue: Gresham Hotel, O'Connell Street, Dublin
Organised by / Contact: Ballymun Local Drugs Task Force / Clíodhna Murphy
Email: cliodhna@ballymundtf.ie
Tel: 01 883 2124

Information: The theme of this one-day conference is 'Exploring the evidence for family based prevention through the implementation of the Strengthening Families Programme in community settings across Ireland'.

Speakers include: Henry Whiteside (Lutra Group, USA), Róisín Shortall (Minister of State, Department of Health), and representatives of the Probation Service, Le Chéile, the HSE and more. The conference is aimed at community, statutory and voluntary services and practitioners, schools, policy makers, academics, volunteers, and others with an interest in family-based prevention and/or Strengthening Families Programme.

November

6 November 2012

A question of balance: delivering an inclusive treatment and recovery system DrugScope Conference 2012

Venue: Connaught Rooms, Great Queen Street, London WC2B 5DA
Organised by / Contact: DrugScope
Email: conferences@drugscope.org.uk
www.drugscope.org.uk/events

Information: In every cliché, there is a large element of truth, so we make no apologies for emphasising that 'there are many ways into addiction and many ways out of it'. But for people to find the right path for them, all paths have to be open and we have an obligation to deliver a balanced and holistic treatment and recovery system which is not driven by either cash or ideology. To that end, we have speakers who will cover the spectrum from harm reduction and substitute prescribing to abstinence-based services, and workshops looking at the needs of special groups, such as the older user. Other topics will include: latest new drugs to hit the streets; service provision for LGBT clients; and best practice in residential rehabilitation.

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

Health Research Board

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8–9 November 2012

Society for the Study of Addiction: Annual Symposium 2012

Venue: Park Inn Hotel, York, UK
Organised by / Contact: Society for the Study of Addiction
Tel: +44 (0) 113 295 2787
www.addiction-ssa.org/ssa_10.htm

Information: The symposium will address the following themes: emerging challenges in addiction psychiatry; alcohol harms, interventions and policy; and the research base for policy. Dr Bruce Ritson will give the Society Lecture on alcohol policy and its implementation in Scotland, with an historical perspective. Dr Bridgette Bewick will present 'Delivering personalised feedback and/or social norms information via the internet: promoting change in alcohol and other drug use'. The full programme will be posted on the society's website in due course.

8–10 November 2012

2nd International NEAR Conference

Venue: Powerscourt Ritz Hotel, Enniskerry, Co Wicklow
Organised by / Contact: Toranfield House and Southworth Associates
www.nearconference.com

Information: Toranfield House and Southworth Associates will host Ireland's 2nd International Conference and Exhibition on behavioural health, including addiction disorders. Delegates will be introduced to new concepts and ideas from international and local speakers and will leave the three day conference with an understanding of what the latest neurobiological research illustrates about addiction and an understanding of the latest evidence-based practices associated with treatment.

21 November 2012

Mental health, young people and suicide

Venue: Civic Center, Mellowes Road, Finglas
Organised by / Contact: CityWide / Iris Lyle / Larry Dooley
Email: iris.lyle@tap.ie / larry.dooley@dublincity.ie
Tel: 01 851 4121 / 01 222 5404

Information: The last in a series of lectures arising from the 2011 seminar 'Promoting mental wellness for young people in Finglas'. Dr Gerry McCarney of SASSY (Substance Abuse Service Specific to Youth) will deliver this lunchtime lecture (12.30pm–1.15pm).Please email organisers if you plan to attend.

28–30 November 2012

7th Annual Manchester Women's Conference: Women and addiction

Venue: Hulme Hall, Manchester M14 5RR
Organised by / Contact: Manchester Women's Conference / Carol Rayegan
Email: carol.rayegan@manchester.ac.uk
Tel: +44 (0) 161 275 0714

Information: Men are more likely than women to become addicts. However, nearly 30% of those now in touch with services are women. This presents a real challenge for interpreting evidence, developing policy or designing services for women with addictions. The 7th Annual Manchester Women's Conference aims to develop understanding needed to create services that can address the specific needs of women with addiction.