

Ana Liffey launches
Strategic Plan
2012–2014

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Steering Group launches report on a national substance misuse strategy



At the launch of the report: Dr Tony Holohan, Chief Medical Officer and chairman of the National Substance Misuse Strategy Steering Group, and Ms Róisín Shortall TD, Minister of State at the Department of Health

The steering group report on a national substance misuse strategy¹ was launched by Dr Tony Holohan, Chief Medical Officer and chairman of the group, in the Department of Health on 7 February 2012. In 2009 the government decided to include alcohol in a national substance misuse strategy. Arising from this decision a steering group, chaired by the Department of Health, was established to advise government on a new strategy. The steering group was drawn from relevant government departments and agencies, medical professional bodies, the community and voluntary sectors and the alcohol industry.

Dr Holohan outlined the extent of harmful drinking and its related harm in Ireland. In 2010 the per capita consumption for adults aged 15 years and over was 11.9 litres of pure alcohol, which corresponds to 45 bottles of vodka. Population surveys indicate that almost one and a half million adults in Ireland drink in a harmful manner. In addition, alcohol is responsible for 88 deaths every month and for 2,000 occupied beds every night in acute hospitals, and is a contributory factor in half of all suicides. The financial cost of alcohol was €3.7 billion in 2007, a figure that is likely to be an underestimate.

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Steering Group launches report (*continued*)

The report sets out the terms of reference of the steering group (p.5):

The Steering Group will:

- having reviewed existing policies and reports, including at EU and international level, set out an evidence-based framework which identifies effective policies and actions to tackle the harm caused to individuals and society by alcohol use* and misuse. (*'alcohol use' in this context refers to the use of alcohol across the entire population. It does not imply that all alcohol use is harmful);
- decide on appropriate structures and frameworks for an effective and efficient implementation plan for the National Substance Misuse Strategy;
- align, as far as possible, these policies and actions with the existing five pillars of the National Drugs Strategy – supply, prevention, treatment, rehabilitation and research;
- make proposals for an overall National Substance Misuse Strategy to incorporate the National Drugs Strategy 2009–2016; and
- submit proposals in regard to such a National Substance Misuse Strategy to the Minister for Health and Children and the Minister for Drugs by the end of October 2010. Thereafter the proposals will be submitted to Government by the end of 2010.

Given the range of health problems that can arise from alcohol consumption, the steering group adopted a population-based approach. Such an approach, which is advocated by the World Health Organization, 'benefits those who are not in regular contact with the health services and those who have not been specifically advised to reduce their alcohol intake'.² It also helps prevent people from drinking harmful or hazardous quantities of alcohol in the first place. International evidence indicates that the higher the level of per capita consumption in a country, the higher the incidence of alcohol-related harm. Therefore, the overall aim is to reduce per capita consumption from 11.9 litres per adult aged 15 and over (2010 level) to 9.2 litres by 2016.

The main recommendations of the steering group include:

- increase the price of alcohol so that it becomes less affordable;
- introduce a legislative basis for minimum pricing, along with a 'social responsibility' levy on the drinks industry;
- commence Section 9 (structural separation of alcohol from other products in supermarkets and other mixed trading outlets) of the Intoxicating Liquor Act 2008;
- introduce legislation and statutory codes to provide for:
 - a 9.00 p.m. watershed for alcohol advertising on television and radio;
 - limiting alcohol advertising in cinemas to only being associated with films classified as suitable for over-18s;
 - prohibiting all outdoor advertising of alcohol;
 - subjecting all alcohol advertising in the print media to stringent codes, enshrined in legislation and independently monitored;
- phase out drinks industry sponsorship of sport and other large public events by 2016;
- develop a system to monitor the enforcement of the provisions of the intoxicating liquor legislation;
- establish a Clinical Directorate to develop the clinical and organisational governance framework to underpin treatment and rehabilitation services; and
- develop early intervention guidelines for alcohol and substance use across all relevant sectors of the health and social care system. This will include a national screening and brief intervention protocol for early identification of problem alcohol use.

According to Health Minister James Reilly's written answer to a Dáil question:³ 'The recommendations of the Steering Group on alcohol will encourage public debate and the Minister envisages an Action Plan being developed in advance of proposals being drafted for Government.'

(Deirdre Mongan)

1. Department of Health (2012) *Steering Group report on an National Substance Misuse Strategy*. Dublin: Department of Health. www.drugsandalcohol.ie/16908
2. Department of Health (2012) *Launch of the report of the National Substance Misuse Strategy Steering Group*. Press release issued by the Department of Health on 7 February 2012. www.dohc.ie/press/releases/2012/20120207.html?lang=en
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Steering Group's recommendations on minimum pricing, marketing and sponsorship

The steering group report on a national substance misuse strategy¹ contains 45 recommendations under the pillars of supply, prevention, treatment and rehabilitation, and research. The recommendations that have generated most debate relate to the introduction of a minimum price for alcohol, restricting alcohol marketing and phasing out sponsorship of sports and other cultural events by the drinks industry. This article aims to describe the rationale behind each of these recommendations.

Minimum pricing

Alcohol is price sensitive – increasing the cost of alcohol reduces its consumption and decreasing the cost of alcohol increases its consumption. Price is therefore often used as a policy lever to reduce alcohol consumption and its related health and social harms. The steering group recommends introducing 'a legislative basis for minimum pricing per gram of alcohol'. Minimum pricing is the lowest price at which any alcohol beverage can be sold. Under such a regime, the price of a container of alcohol is set (by government) based on the number of grams of alcohol content in the beverage, so the higher the number of grams of alcohol the higher the minimum price will be. This increases the price of cheap imported alcohol, rather than of high-quality beer and wine. Recent research in British Columbia has shown that a 10% increase in the minimum price reduced consumption of all alcoholic beverages by 3.4%.²

Why is minimum pricing needed?

In Ireland, alcohol has become more affordable, particularly in the off-trade sector. The introduction of more liberal licensing legislation has led to alcohol being sold in more places, including supermarkets and garage forecourts, and for longer periods of time. This has increased competition between retailers, particularly mixed trading outlets (supermarkets) who can use alcohol as a loss leader and can offer deep discounts and promotions. This results in alcohol being available at very low prices. Harmful drinkers tend to buy alcohol that is cheaper than that bought by low-risk drinkers. Cheap alcohol is also attractive to young people. So, a minimum pricing policy is beneficial in that it targets the drinkers causing the most harm both to themselves and to society, while having little effect on the spending of adult moderate drinkers. When alcohol is sold below cost price the retailer is entitled to a VAT refund on the difference between the cost price and the below-cost sale price. In effect, this means that the government is subsidising large retailers who can afford to sell alcohol at below-cost price.

Will this not just lead to more profit for the alcohol industry?

Yes, but the introduction of a social responsibility levy on the alcohol industry should offset those profits. This levy will fund the state services dealing with the harms caused by alcohol, and public health counter-advertising. As part of the Master Settlement Agreement in 1998 involving 46 states in the US, the tobacco industry must provide for the cost of

treating smoking-related illness, and of funding educational programs to reduce underage smoking. This settlement amounted to a total of \$209 billion to be paid over a period of 25 years.³

Why not just raise taxes?

An increase in taxation may not be successful in curbing the sale of cheap alcohol because some retailers, particularly supermarkets who sell cheap alcohol and use it as a loss leader, can simply absorb tax increases. In addition, taxation may have a greater impact on the on-trade, where the price of alcohol is already considerably more expensive, and where operators will be more likely to pass on the tax increase to the consumer.

What arguments are used to oppose minimum pricing, and are these arguments valid?

Opposition to minimum pricing originates mainly from the retail and drinks industries, and is broadly along the following lines:

- **Low-risk drinkers will have to pay a higher price for the actions of others.**
Alternative view: It is the harmful drinker and not the low-risk drinker who will be most affected. Harmful drinkers buy more alcohol than the average consumer and are proven to be price sensitive so this measure will affect their alcohol consumption.
- **People on low incomes will be penalised.**
Alternative view: Low-risk consumers, irrespective of income levels, will notice very little difference in terms of cost. What will be noticeable, though, is a reduction in alcohol-related deaths and illnesses among low earners who experience a lot of the harms associated with alcohol.
- **Minimum pricing contravenes EU trade law.**
Alternative view: While minimum pricing for most products is illegal, the EU treaty states that introducing a minimum price for alcohol may be allowed provided that it can be demonstrated that such a measure is both necessary and proportionate to reduce alcohol-related harm. However, the treaty states that a minimum price cannot be introduced if it is set so low that imported alcoholic products are placed at a disadvantage in relation to identical domestic products, and also that the alcohol industry should not be involved in the process of setting the minimum price.

Marketing

The steering group recommends the development of legislation to provide for a 9.00pm watershed for alcohol advertising on television and radio, limiting alcohol advertising in cinemas, and the prohibition of all outdoor advertising of alcohol.

Steering Group's recommendations (*continued*)

What is the link between marketing and alcohol use?

In a systematic review of 13 longitudinal studies with a total sample of over 38,000 young people, there was evidence that exposure to alcohol advertising and promotion predicted both the onset of drinking among non-drinkers and increased levels of consumption among existing drinkers.⁴

Why is it important to delay adolescents from drinking?

An adolescent need drink only half as much as an adult to experience the same negative effects, and even occasional binge drinking can damage the young brain. MRI (Magnetic Resonance Imaging) scans of the brains of 14–21-year-olds show that those who abuse alcohol have about 10% smaller hippocampi – the area of the brain that handles memory and learning and is responsible for decision-making and reasoning.⁵ Those who start drinking at the age of 15 are four times more likely to become dependent than those who commence drinking at the age of 21.⁶

Why are the existing Irish voluntary codes not sufficient in reducing young people's exposure to alcohol marketing?

Voluntary codes in relation to the marketing and promotion of alcohol were agreed between the Department of Health and the advertising and alcohol industries in 2005. The codes state that their purpose is to reduce the exposure of young people to alcohol advertising and marketing and to limit the overall level of alcohol advertising and sponsorship across all media in Ireland. In spite of this stated aim, there is no mention in the codes of specific targets or timeframes. Instead, the codes simply monitor adherence to initiatives which may or may not have any impact on the exposure of children to advertising.

These codes are insufficient for a number of reasons:

- They have no legislative framework.
- They fail to provide effective cover for all forms of alcohol marketing, such as new media and sponsorship.
- They do not address the increasingly common branded events which merge alcohol brands with key aspects of youth culture. A cultural or music event with an alcohol brand in the title, such as Absolut Fringe or the Jameson Dublin International Film Festival, can be advertised on radio before the watershed as this does not constitute alcohol marketing under the existing codes.
- They fail to act as a suitable deterrent to bad marketing practices because of weak enforcement and lack of stringent penalties. If a breach is upheld there is no penalty, the drinks company or advertiser is simply asked to remove the offending promotion.
- The reliance on public complaint is of limited effectiveness. In many instances, young people are the only ones aware of marketing and promotions, and they are unlikely to be a critical audience. For example, parents may not know what advertising is reaching their children through social networking sites like Facebook.

Sponsorship by alcohol companies

The steering group recommend that drinks industry sponsorship of sport and other large public events in Ireland should be phased out through legislation by 2016.

What is the link between sponsorship by alcohol companies and harmful use of alcohol?

Sports sponsorship by the alcohol industry provides an opportunity to build the alcohol brand into the name of the event through mention in sports commentaries, signage on clothing and sports grounds, and products retailed to fans. Marketing through sports sponsorship attracts young males, the group most likely to be heavier drinkers. It also accesses audiences when they are most receptive to learning about a product – while they are having a good time at an exciting branded event. Many sports events are also family affairs, and alcohol 'impressions' are also made on young people, helping form in adolescence the attitudes and preferences that are taken on into later life.

Research has shown that young people have a particularly high awareness of, and exposure to, sports sponsorship.⁷ Events are chosen to show how well the brand understands and relates to young people: in an analysis of alcohol industry documents, one Carling executive was quoted as saying: 'They [young men] think about four things, we brew one and sponsor two of them'.⁸ In a New Zealand study of over 1,200 sports players, ranging from social players to provincial/national competitors, alcohol sponsorship was reported by 48%. Those who received sponsorship at the individual, team or club level were more likely to be hazardous drinkers, and had an average AUDIT score (which measures harmful drinking) that was 2.4 points higher than that of those who received no sponsorship.⁹

(Deirdre Mongan)

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Trends in treated problem drug use in Ireland 2005–2010

A new publication in the HRB Trends Series was published in December 2011.¹ Trends Series 12 describes trends in treated problem drug use in Ireland between 2005 and 2010, based on data reported to the National Drug Treatment Reporting System (NDTRS). The analysis presented in this paper provides service planners and policy makers with valuable information in order to highlight and address problem drug use.

The main findings of the analysis are summarised below.

Numbers treated

It is important to note that each record in the NDTRS database relates to a treatment episode (a case), and not to a person. This means that the same person could be counted more than once in the same calendar year if he/she had more than one treatment episode in that year.

The number of cases entering drug treatment each year and reported to the NDTRS increased by 52%, from 5,176 in 2005 to 7,878 in 2010. The increase in the total number of people requiring drug treatment services, including previously treated cases returning to treatment, is a strong indication that problematic drug use remains a pressing issue, and presents complex and multiple challenges to those providing treatment. The clear spread and increase in treated drug use throughout the country reflect not only the extent of problem drug use but also an increase in treatment availability and compliance with the NDTRS.

Problem substances

Opiates (mainly heroin) were the most common problem drugs reported for all years, with the proportion of opiate users remaining stable between 2005 and 2008 but decreasing slightly in the following two years. The number of cases reporting cannabis as their main problem substance increased significantly over the reporting period, from 1,039 in 2005 to 1,893 in 2010. Following a steady increase to a peak in 2007, the number of cases reporting cocaine as their main problem substance decreased in the subsequent two years and remained stable in 2010. Head shop compounds were reported as a main problem substance for the first time in 2009 (17 cases), with the number increasing significantly to 213 cases in 2010, when it exceeded the numbers reporting amphetamines, ecstasy and volatile inhalants. Among new cases, benzodiazepines accounted for the highest proportional increase among the five most commonly reported problem substances (Figure 1). In 2010, cannabis became the most common main problem drug reported by new cases, ahead of opiates for the first time since 2005.

The use of more than one problem substance continues to present a challenge to the treatment services. The vast majority (68%) of cases treated between 2005 and 2010 reported problem use of more than one substance. Cannabis, alcohol, cocaine and benzodiazepines were the most common additional problem drugs reported by all cases entering treatment. The very large number of cases reporting alcohol as an additional problem substance highlights the strong links between alcohol and illicit substance use.

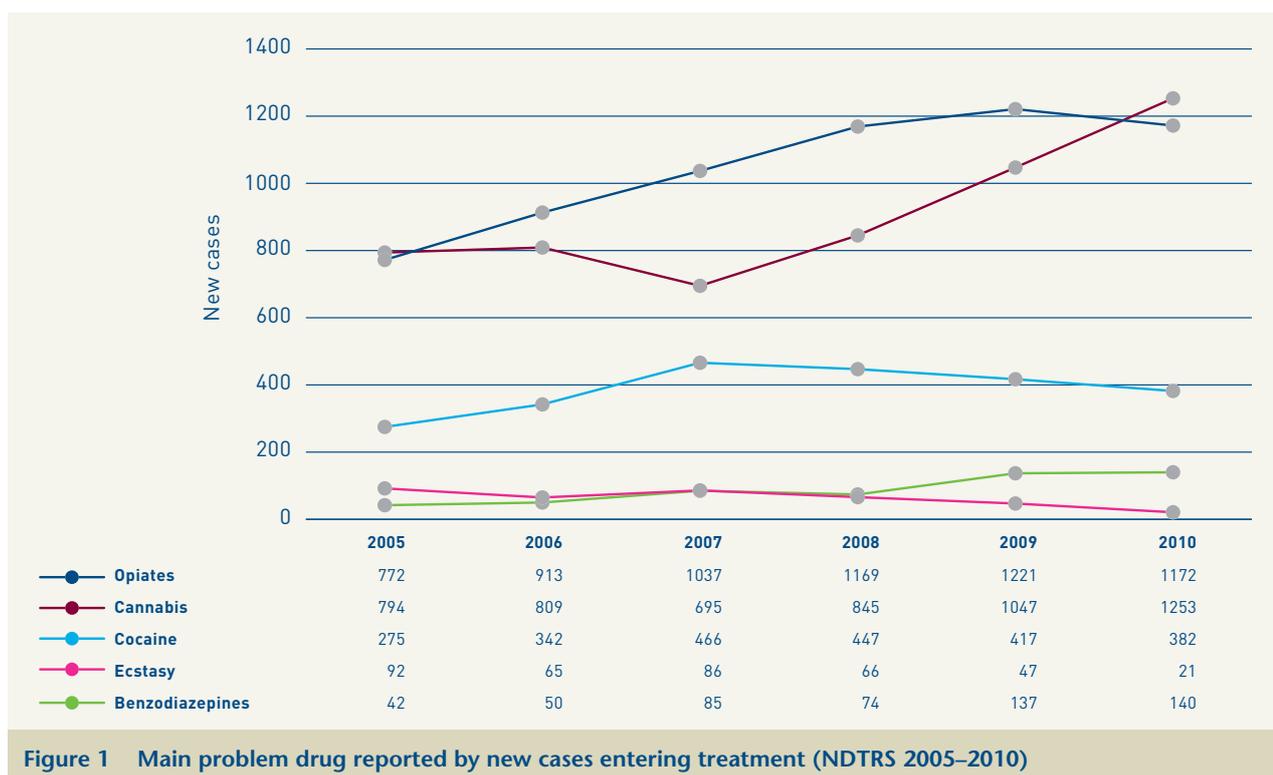


Figure 1 Main problem drug reported by new cases entering treatment (NDTRS 2005–2010)

Trends in treated problem drug use *(continued)*

Patterns of use and socio-economic characteristics

The profile of cases entering drug treatment remained stable over the reporting period; in general, problem drug users were male and in their twenties. Data show that half of the new cases entering treatment between 2005 and 2010 had started drug use at or before the age of 15 years. The proportion of new cases aged under 18 years has increased since 2007 and reached 16% in 2010. This finding highlights the need for prevention measures and initiatives specially targeted at young teenagers in an attempt to delay initiation to drug use.

Data showed a decline in injecting behaviour and, among new injectors, an increasing interval between starting drug use and starting injecting. The increase in harm reduction services and practices over the reporting period is likely to have influenced this progress.

Figures also show that there was a significant decline in employment rates among drug users, from 22% in 2005 to 9% in 2010, a direct indication of the effect of the current economic climate. These findings outline the continued importance of social and occupational reintegration interventions as part of the drug treatment process.

The growing demand for treatment for problem use of substances other than heroin, combined with the high proportion of cases using multiple problem substances,

remains a constant challenge for service providers, as drug users often require multiple treatment interventions, which in turn require a high degree of co-operation between services. This inter-agency approach to treatment and rehabilitation was highlighted as one of the priorities in the current drugs strategy.² Supported by the drugs task force structure, many services are participating to an increasing extent in local inter-agency initiatives in order to provide a wide range of interventions and a continuum of care for clients, for example, through the development of case management and key working strategies.

An online appendix to this Trends Series paper, containing additional tables and figures with supplementary data, is available on the website of the National Documentation Centre on Drug Use at www.drugsandalcohol.ie/16381

(Delphine Bellerose)

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BYAP marks its 30th year with launch of two reports

November 2011 saw Ballymun Youth Action Project (BYAP) launch two reports on substance misuse to mark the final event celebrating its 30th year. The first report, *Seen but not heard?*, documents the proceedings of a conference on substance misuse that took place in Dublin Castle in March 2011.¹ The second report, *Fact or fiction?*, looks at young people's attitudes to drugs and alcohol-related issues.²



At the BYAP launch: Christian Herbert and Cara Fennelly, authors of the *Fact or fiction?* report

The conference report, in particular, offers an insight into the experiences and issues affecting local communities, practitioners and academics. It also highlights the need for all agencies working in the field to adopt a more integrated approach in addressing the drugs problem. The second report offers an insightful picture of the experiences and attitudes of young people. It also offers a more personalised local perspective than other, larger, general research surveys carried out in Ireland.

Dermot King, director of BYAP, said at the launch, 'The voice that comes from within communities affected by drugs and alcohol will continue to provide crucial insight and understanding in how to deal with these issues.'

Founded in 1981, the Project has been offering a community-based response to drug and alcohol misuse in the Ballymun area. Congratulations to Ballymun Youth Action Project on its 30th anniversary and continued success for the future. For further information or to obtain a copy of these reports, please call 01 842 8071 or log on to www.byap.ie.

(Vivion McGuire)

1. Ballymun Youth Action Project (2011) *Seen but not heard? Thirty years of communities responding to drugs*. Dublin: BYAP. www.drugsandalcohol.ie/16442
2. Herbert C and Fennelly C (2011) *Fact or fiction? a study of attitudes to alcohol and related issues among young people in the Ballymun area*. Dublin: BYAP. www.drugsandalcohol.ie/16441

To prohibit or not to prohibit – that is no longer the question

In the past two decades drug policy researchers have sought to move away from the polarised, and increasingly unproductive, debate between those supporting the prohibition of psychoactive substances under the UN conventions and those arguing for legalisation, or some form of decriminalisation. Some of the key themes highlighted by these researchers are outlined below.¹

Acknowledge the complexity

As long ago as 1993, Mark Kleiman argued that debates about prohibition versus legalisation or treatment versus enforcement represent deeply held beliefs about human nature and the human good, which could not be ignored, but that more attention to practical detail would improve the discussion.² He emphasised the complexity of the issue: there is a large variety of psychoactive substances (including alcohol and tobacco), drug users and drug use settings, and a wide range of policy response options, including laws and programmes, and between them they result in a potentially infinite variety of outcomes. He concluded: ‘Public policy toward drugs involves so many unknown, almost unknowable facts and so many complicated issues of value that any certainty about which of two alternative policies is the better is likely to be misplaced.’ (Chapter 13).

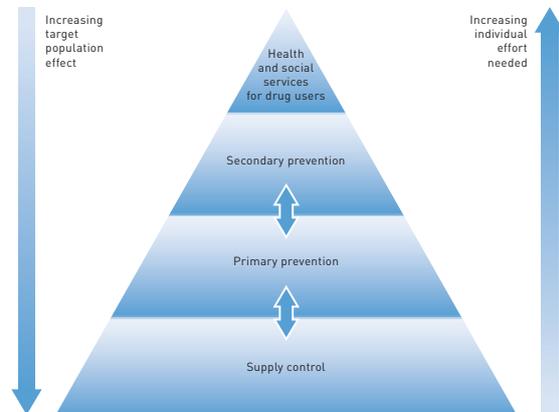
More recently Robin Room and Peter Reuter,³ discussing whether or not international drug conventions protect public health, concluded: ‘The cultural positions of different drugs vary enough to preclude universal policies on how to deal with all illicit or indeed licit drugs. From the perspective of public health, we need to move towards a control system that is more aligned with the risks that different drugs pose to users and shows an understanding of the effects of different regulatory approaches on drug use and harm.’ (p. 90).

Focus on harm rather than evil

Reviewing the arguments in favour of prohibition and legalisation respectively, Robert MacCoun and Peter Reuter concluded that the prohibitionist arguments were significantly less complex than the opposing arguments, and that it was this very complexity that had served to polarise the debate.⁴ They argued, moreover, that this allegiance to ‘prevalence reduction’, and the notion that the only defensible goal for drug policy is to reduce the number of users, hopefully to zero, had prevented two more moderate strategies from receiving serious attention from the political mainstream – ‘quantity reduction’ (reducing the quantity consumed by those who continue to use drugs) and ‘harm reduction’ (reducing the harmful consequences of drug use when it occurs).

Maximise the public good

Six experts in the drug policy field have devised a tool to help policy makers to organise the major public drug policy options in terms not only of their ‘effectiveness’, e.g. in terms of individual benefit, but also their potential to maximise the ‘public good’.⁵ The ‘public good’ is defined as ‘social benefits such as better public health, reduced crime, and greater stability and quality of life for families and neighbourhoods’.



The effect of drug policy options on the public good and individuals (Strang *et al.* 2012: p. 79).

The authors argue that this tool, comprising a four-tiered pyramid of policy options, is useful in the identification of interventions, even though the specific problems and the most appropriate type of interventions will vary over time and between societies and geographical locations. They comment: ‘A comprehensive public policy approach would implement evidence-based measures at each level of intervention and maximise the synergy between these levels. Long-term benefits of these policies would thus increase for whole communities as well as for individuals.’ (p. 80).

Shift the goalposts

British drug policy researchers have recently explored how drug policy makers might improve the likelihood of achieving desired policy outcomes by reviewing the prevailing paradigms and considering a change in the aims and objectives of drug policy accordingly. For example, on the assumption that the control of drugs is related to prevailing conceptions of freedom, Toby Seddon suggests that the drugs problem might be best viewed as a regulation and governance problem. In place of a legislative framework that seeks to use the criminal justice system to reduce or eliminate the use of drugs, he suggests that in a post-modern world characterised by networked and polycentric governance structures, a hierarchy of regulatory interventions might be more appropriate – ranging from ‘persuasion’ at the base, depending on dialogue to secure compliance, to higher levels where interventions become more punitive and demanding, depending on the drug and the context.⁶ Alternatively, Alex Stevens suggests that drug policy might be addressed within the context of a country’s equality policy, on the grounds that the distribution of drug-related harm is determined as much by how welfare policy distributes risks and benefits, as by the degree of ‘strictness’ of drug policy.⁷

Acknowledging that the traditional approaches to drug control used in the 20th century are no longer effective, as they are unable to keep pace with the changes in substances and market mechanisms, a new report has called for a new approach to policy making:⁸

The issue is one of framing. If drug policy is framed as “a war on drugs” then it is either won or lost and requires a level of national sacrifice (wars are won or lost). If it is

To prohibit or not to prohibit *(continued)*

framed as the “drug problem” then there is an implicit assumption that there is a “solution” (problems have solutions). An alternative way of looking at the issue is to use systems thinking and consider drug policy as a “wicked issue” to which there is no solution, and no winners or losers. Instead, one seeks an improvement to policy that will be supported by people who otherwise disagree about what is wrong and what the goals of policy are. (p. 12).

Based on the output from ‘soft-system workshops’ attended by a variety of stakeholders, the authors identified three broad principles for improving drug policy: (1) focus on achieving outcomes where there is consensus, (2) ensure a more balanced decision-making process and debate, and (3) consider other regulatory options for control.

(Brigid Pike)

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EU drug policies under review in 2012

On 1 January 2013 Ireland will take on the EU presidency, just as the current EU drugs strategy (2005–2012) comes to an end. It last held the presidency in 2004, when the current strategy was being prepared.¹ An external evaluation of the 2005–2012 strategy has been commissioned and was due to be completed by the end of 2011. This evaluation will inform the development of the new strategy, which will be adopted by the European Council.

In a separate initiative launched on 25 October 2011, and undertaken in the context of its commitments under the 2010–2014 Stockholm Action Plan,² the European Commission announced an overhaul of the EU’s legal instruments in the fight against illicit drugs.³ Calling for a strengthening of the EU’s response to drugs, the Commission noted that the EU’s two main anti-drugs legal instruments, one relating to drug trafficking (2004/757/JHA) and one to the emergence of new psychoactive substances (2005/387/JHA), were both over six years old. The Commission considers that new challenges, including new ways of trafficking drugs and drug precursors, the emergence of new drugs, and innovative distribution channels, all justify the development of new legal instruments. Moreover, the Commission believes the entry into force of the Lisbon Treaty and the dismantling of the pillar structure in EU policy-making provide fresh opportunities for integrating all policy areas relevant to the drugs problem.

The European Commission is proposing:

1. a legislative package revising the Council Framework Decision on drug trafficking and the Council Decision on new psychoactive substances;
2. legislative proposals on drug precursors;
3. legislative proposals on the confiscation and recovery of criminal assets and on strengthening mutual recognition of freezing and confiscation orders; and
4. new legislative measures to combat money laundering.

In addition, the Commission is proposing:

5. indicators to monitor drug supply, drug-related crime and drug-supply reduction to help improve the effectiveness of supply-reduction measures; and
6. minimum quality standards to improve drug prevention, treatment and harm reduction services.

In launching this plan of action under the Stockholm Programme for the next two years, the European Commission has invited the European Parliament and the European Council, civil society and other important stakeholders to take part in a debate on effective responses to illicit drugs and new psychoactive substances. On 28 October 2011 the Commission launched a 12-week online public consultation aimed at gathering the opinions of individuals and stakeholders as to the EU-level actions on which the Commission should focus in order to best tackle illicit drugs and the emergence of new substances that imitate them. This consultation closed on 20 January 2012.

Future issues of *Drugnet Ireland* will provide updates on progress in developing the EU drugs strategy and the outcome of the European Commission’s public consultation.

(Brigid Pike)

1. Pike B (2004) Groundwork for new EU drugs strategy to be laid during Irish presidency. *Drugnet Ireland*, (10): 1.
2. On 10–11 December 2009 the European Council adopted the Stockholm Programme, a comprehensive framework of initiatives in justice and home affairs. The political objectives in this programme were translated into concrete actions for adoption in 2010–2014 (COM (2010) 171 final). In the Stockholm Action Plan the European Commission is tasked with introducing measures to reinforce protection against serious and organised crime.
3. European Commission (2011) *Towards a stronger European response to drugs*. COM (2011) 689/2.

Drugnet digest

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

Amphetamine: a report on the illicit market in Europe

This joint publication by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the European Police Agency, Europol, is an in-depth study of the illicit market in amphetamine.¹ Combining law enforcement data on measures such as drug seizures and detections of clandestine laboratories with drug-use prevalence data, the report shows that Europe is the world's number one producer of amphetamine and a major consumer market. The highest levels of amphetamine use in Europe are reported in Norway, Denmark, Latvia and the UK, and the lowest levels in Greece, Cyprus, Malta and Romania. Ireland does not feature prominently in the report. Amphetamine seizures in Ireland decreased from 277 in 2006 to 89 in 2010.²

Cannabis, possible cardiac deaths and the coroner in Ireland

A recently published article examined the role of cannabis in cardiac deaths in Ireland.³ Of the 3,193 coronial cases processed between 2009 and 2010 by the Department of Chemical Pathology based in Beaumont Hospital, 99 had a positive screening immunoassay for cannabis in the urine. Thirteen of these cases had enough clinical information provided to indicate a cardiac cause of death, and were included in the study.

This group of cases had a median age of 47 years (range 17 to 61 years), and 11 were male. Myocardial infarction was the primary cause of death in 54% (7) of cases. In only one

case was cannabis mentioned on the death certificate, and then not as a cause of death. Other causes of death included sudden adult death syndrome, sudden death in epilepsy, and poisoning by alcohol and diazepam. The author states: 'To attribute death due to cannabis smoking, published evidence indicates that the trigger window is about 2 h [two hours] and that plasma cannabis values are required to estimate the time of cannabis usage.' None of the cases included in this paper had plasma tetrahydrocannabinol (THC) measured.

In conclusion, the author suggests that plasma THC should be measured where urine cannabinoids are positive. He states: 'A positive urine cannabinoids immunoassay alone is insufficient evidence in the linkage of acute cardiac death and cannabis.'

(Contributors Johnny Connolly and Ena Lynn)

1. EMCDDA and EUROPOL (2011) *Amphetamine: a European Union perspective in the global context*. Luxembourg: Publications Office of the European Union. www.emcdda.europa.eu/publications/joint-publications/amphetamine
2. Irish Focal Point (2011) *2011 National Report (2010 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues*. Dublin: Health Research Board.
3. Tormey WP (2012) Cannabis, possible cardiac deaths and the coroner in Ireland. *Irish Journal of Medical Science*, Online First. 10 January 2012. www.drugsandalcohol.ie/16772

British–Irish Council discusses recovery from problem drug use

On 13 January 2012 the British–Irish Council (BIC) held its 17th summit meeting, hosted by the Irish government, in Dublin Castle.¹ The Council welcomed a discussion paper on recovery from problem drug use. Policy ministers discussed drug treatment measures and strategies that have been put in place in each administration to facilitate the path of recovery. The Council noted that a more ambitious approach was needed involving individual care plans and inter-agency working to better address the holistic needs of clients. The Council also noted the Misuse of Drugs workstream's commitment to include a renewed focus on recovery from drug dependence in any future drugs strategies, with a view to maximising the potential for individuals to access the social, economic and cultural benefits of life. The Council agreed that member administrations will actively encourage the renewed focus on recovery and will work together to evaluate and share successful approaches.

With regard to the eleven workstreams on which the work of the BIC is based, the summit meeting noted the good progress and work of each, including the Misuse of Drugs workstream, which is led by the Irish administration. Since the 16th summit meeting, BIC Misuse of Drugs workstream meetings have included a presentation on the review of

Ireland's opioid treatment protocol. This presentation outlined the history of opiate substitution in Ireland, the development of the first set of national protocols, and how the opiate situation has changed in Ireland since those initial protocols were developed, as well as the key findings of the review and their implementation. A more recent meeting included two presentations from Northern Ireland, the first on findings from a longitudinal research project on adolescents, and the second on the tool developed by Northern Ireland to measure the impact of their national drugs strategy. The workstream also provided the discussion paper 'Recovery from Problem Drug Use' which was discussed at the meeting.

1. The BIC was established under the Agreement reached in Belfast on Good Friday, 1998. The governments of Britain, Scotland, Wales, Northern Ireland, Ireland, Jersey, Guernsey and the Isle of Man are represented on the Council. The BIC facilitates co-operation on east-west issues between each of the member administrations by way of exchanging information, consulting on best practice and discussing matters of mutual interest. For further information, visit www.britishirishcouncil.org

Politicians and the drugs debate – six years on

Recent comments by politicians in the Oireachtas and in the public arena suggest that the political climate in Ireland is becoming more open than it was just six years ago to exploring responses to the illicit drug problem other than strictly prohibitionist options.¹

In September 2011 members of the Joint Committee on Health and Children asked whether it was time to consider the drug policy options preferred by Portugal and the Netherlands, i.e. eliminate criminal sanctions for illicit drug users,² and whether it was time to consider allowing people with a complete physical and chemical dependence on heroin or morphine to get their heroin or morphine in well-supervised, clean, incorruptible circumstances, i.e. establish safe injecting facilities.³ Speaking at the second National Drugs Conference of Ireland in November 2011, Junior Health Minister Róisín Shortall, who is in charge of Ireland's drugs strategy, said she had an 'open mind' in relation to Portugal's model.⁴

How has this change come about? What factors have influenced the shifts in thinking? Answers to such questions would increase our understanding of Ireland's policy process in relation to illicit drugs, including how the increased body of research and information in recent years, and different actors and stakeholder groups, have influenced the policy debate. They would also indicate to what extent the development of Ireland's drug policy is becoming a more transparent and democratic process, less shrouded in ambiguity, than it has been in the past.⁵

To answer such questions would require a dedicated research effort. Instead, the following article outlines how the drugs

policy issue may be debated while avoiding the polarised, and increasingly unproductive, debate between those supporting the prohibition of psychoactive substances under the UN conventions and those arguing for legalisation, or some form of decriminalisation.

(Brigid Pike)

1. A report on an Oireachtas debate in 2006 on Ireland's drug policy noted that the speakers did not take the opportunity to explore the full range of strategic options available. See Pike B (2006) Politicians and the drugs debate. *Drugnet Ireland*, (19): 16–17.
2. Dowds R (2011, 22 September) *Parliamentary Debates Dáil Éireann (Official report: unrevised): Joint Committee on Health and Children debate*. Illegal drug use: discussion (resumed). <http://debates.oireachtas.ie/HEJ/2011/09/22/00004.asp>.
3. Crown J (2011, 15 September) *Parliamentary Debates Dáil Éireann (Official report: unrevised): Joint Committee on Health and Children debate*. Illegal drug use: discussion. <http://debates.oireachtas.ie/HEJ/2011/09/15/00003.asp>.
4. O'Keefe C (2011, 4 November) Minister considers Portuguese drugs strategy. *Irish Examiner*.
5. Butler S and Mayock B (2005) 'An Irish solution to an Irish problem': harm reduction and ambiguity in the drug policy of the Republic of Ireland. *International Journal of Drug Policy*, 16 (6): 415–422; O'Shea M (2007) Introducing safer injecting facilities (SIFs) in the Republic of Ireland: "Chipping away" at policy change. *Drugs: education, prevention and policy*, 14 (1): 75–88.

HSE plans to maximise efficiencies

The HSE's National Service Plan 2012 (NSP) sets out the HSE's plans for 2012.¹ In his introduction to the plan, the CEO of the HSE points out that this is the third consecutive year in which the organisation has taken a cut in its annual budget. Unlike those in previous years, expenditure cuts in 2012 will begin to impact directly on frontline services.²

The CEO outlines how the HSE plans to minimise this impact by 'fast-tracking new, innovative and more efficient ways of using a reducing resource' and by moving to models of care which 'treat patients at the lowest level of complexity and provide services at the least possible unit cost'. Services in the drugs and alcohol area will not be exempt from these new approaches.

The strengthening of 'multidisciplinary complex care', including the development of protocols signposting referral pathways between specialist addiction/homeless/traveller services and primary care services, is listed as a 'key result

area' under Primary Care, Demand-Led Schemes and Other Community Schemes (p. 26).

In the delivery of addiction services (Table 1), which continue to be co-located with homelessness, intercultural health, Travellers' health, and lesbian, gay, bisexual and transgender (LGBT) health services under Social Inclusion Services, it is planned to monitor treatment outcomes and to analyse methadone waiting lists and exits from the Methadone Treatment List on a quarterly basis; these actions are noteworthy when set against the performance activity report for 2011, which shows that the target of 100% substance misusers over the age of 18 years for whom treatment commenced within one month of assessment was not achieved (Table 2). The HSE also intends to review the operation of the national drugs rehabilitation framework and identify hindrances to care planning/case management at the systemic and individual client level.

HSE plans to maximise efficiencies (continued)

Table 1 Addiction services, deliverable outputs 2012

Addiction services	Deliverable outputs 2012	Target completion
<i>National Drugs Strategy (NDS) 2009–2013</i> – implement recommendations from HSE Opioid Treatment Protocol	<ul style="list-style-type: none"> Establish a national data collection, collation and analysis group to maximise the use of current data, identify new data, and develop a brief outcome monitoring process for individuals. 	Q1
	<ul style="list-style-type: none"> Develop joint clinical guidelines on the treatment of opioid addiction across the full range of drug services by the ICGP, ICP, PSI and the HSE. The guidelines will include an implementation plan for the move to less urine testing and a greater clinical focus on the use of the results of drug testing samples. 	Ongoing
	<ul style="list-style-type: none"> Produce a quarterly analysis report on methadone waiting lists. 	Ongoing
	<ul style="list-style-type: none"> Produce a quarterly analysis report on exits from the Methadone Treatment List. 	Q2–Q4
<i>Report of the Working Group on Residential Treatment and Rehabilitation 2007 and HSE National Drugs Rehabilitation Framework 2010</i>	Conduct an analysis of the HSE's <i>National Drug Rehabilitation Framework</i> for usefulness for the following groups: service users, case managers, key workers within other disciplines and service managers	Q4
	Measure client care plan progression over the course of 2012.	Q4
	Identify the barriers that hinder care planning/case management at the systemic and individual client level.	Q4
Prioritise and implement HSE actions in the <i>National Substance Misuse Strategy</i> (following its publication)	Develop an annual training plan which targets emerging trends in addiction and reflects best practice via the HSE National Addiction Training Programme.	Q1
	Implement Quality Standards (Quality in Addiction and Drug Services, QuADS) in both the statutory and voluntary-managed addiction services.	Ongoing
	Conduct an effectiveness review exercise on all current forms of needle exchange provision currently funded by the HSE.	Q4
	Launch an Alcohol Public Education/Awareness Campaign.	Q1
	Further develop web-based information and awareness systems for addiction.	Q4
	Develop a national drug and alcohol service directory to include in-depth information on treatment and rehabilitation and geo-mapping for staff and service (linked with HSE Health Intelligence Unit and Health Atlas).	Q3

Source: NSP 2012, pp. 68–69.

Table 2 Performance activity and indicators 2011 and 2012 (from NSP 2012, p. 70)

	Expected Activity / Target 2011					Projected Outturn 2011					Expected Activity / Target 2012				
	DML	DNE	South	West	Total	DML	DNE	South	West	Total	DML	DNE	South	West	Total
Methadone Treatment															
No. of clients in methadone treatment (outside prisons)	4,900	3,050	275	275	8,500	4,948	3,062	323	289	8,622	4,950	3,050	350	290	8,640
No. of clients in methadone treatment (prisons)					500					564					520
Substance Misuse															
No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment					100%	228	61	604	132	1,025					1,260
						82.9%	91%	99%	89.8%	95.8%					100%
No. and % of substance misusers (under 18 years) for whom treatment has commenced within two weeks following assessment					100%	24	6	46	14	86					105
						100%	100%	94%	100%	100%					100%

Notwithstanding the budget cuts, new initiatives are flagged for 2012. In line with recommendations in the revised *HSE Opioid Treatment Protocol*, implementation of new clinical guidelines on the treatment of opioid addiction will see less urine testing and a greater clinical focus on the

results of drug-test samples. Following publication of the *National Substance Misuse Strategy*, the HSE will adopt a new addiction training plan, implement quality standards across all addiction services, and develop a series of new information and awareness initiatives. Needle exchange is

HSE plans to maximise efficiencies (continued)

another new focus for the HSE in 2012. As well as reviewing the effectiveness of all needle exchange provision which it is currently funding, the HSE is aiming to recruit 90 pharmacists to provide the needle exchange programme.

The target set in last year's service plan, to complete by the end of 2011 an analysis of addiction services for children nationwide based on best practice, was not met and has been moved out to Quarter 3 of 2012 (p. 60). This action was identified in response to Recommendation 3 in the *Report of the Commission to Inquire into Child Abuse* (the Ryan

Report), on the provision of counselling and educational services for children, which called on the HSE and the drugs task forces to establish addiction services for children nationwide based on best practice by June 2011.

(Brigid Pike)

1. Health Service Executive (2012) *National Service Plan 2012*. Available at www.hse.ie
2. For an overview of the 2011 objectives, see Pike B (2011) HSE plan for drug-related services in 2011. *Drugnet Ireland*, (37): 12–13. www.drugsandalcohol.ie/14994

Funding drugs services in a recession

Budget 2012 outlines cuts to directly drug-related funding under two Votes – Education and Health (see table below).¹ Current funding for education-related projects will drop by €132,000 (24%), while funding for pilot projects in drugs

task force areas across the country, funded under the Drugs Initiative, will decrease by just over €2.5 million (7%). Against the trend, capital funding under the Drugs Initiative will increase by 38%.

Vote: Subhead	2011 Estimate (€000)			2012 Estimate (€000)			Change 2012 over 2011
	Current	Capital	Total	Current	Capital	Total	
Education: Funding of Projects in Drugs Task Force Areas	543	-	543	411	-	411	-24%
Health: Drugs Initiative	33,044	623	33,667	30,475	1,000	31,375	-7%

Source: Department of Finance (2011)

In 2010, in anticipation of a decline in its funding, one regional drugs task force commissioned an independent study to evaluate the efficiency and effectiveness of the 30 projects it had funded in 2008 and 2009, to undertake a needs assessment with regard to substance misuse in the region, to score the capacity of the evaluated projects to meet these needs, and to prepare a roadmap to ensure it continued to use its resources in the most effective way possible.² Using the Rapid Assessment Response (RAR) method promoted by the World Health Organization (WHO) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the researchers who undertook the three-month study concluded that it is a useful approach for service planners and policy makers 'who often have difficult funding decisions to make in short time frames and under competing pressures'.³

A mix of quantitative and qualitative methods was used to gather data relevant to both the needs assessment and the performance evaluation:

- analysis of existing data sources on the prevalence and nature of the drug problem, to inform a retrospective needs analysis;
- the administration of a standardised needs assessment questionnaire to each service, to provide the basis for a prospective needs analysis;
- one-to-one qualitative interviews with service providers;
- consultations with regional stakeholders; and
- analysis of data collected relevant to service efficiencies, and of each service's financial and monitoring data for the previous year.

The roadmap was developed in round-table discussions by the three researchers, based on triangulation and constant comparing of all the data gathered in the course of the study. This ensured that any inconsistencies in the data could be identified, and that the most relevant and efficient projects for the region emerged.

The main recommendations of the roadmap were as follows:

Strategic priorities: A short regional drugs strategic plan should be developed, adapting and localising the national drugs strategy by prioritising the national pillars of the strategy in line with the region's needs and by setting clear measurable targets and outcomes for each pillar. The researchers proposed placing the pillars in the following order of local priority: (1) Treatment, (2) Rehabilitation and (3) Prevention.

Treatment: The roadmap proposed three targets – a drug substitution service for opiate users that ensured access to 100% of opiate users, comparability of local service provision to Dublin's range of services, and availability of mental health services to substance misusers within one month of referral.

Rehabilitation: The researchers recommended that the region should engage closely with the National Drug Rehabilitation Implementation Committee (NDRIC) on how to localise its recommendations, and in preparation for shared care planning, it should implement a unique identifier system for clients in the region.

Prevention: Although the region had prioritised prevention among projects funded, the RAR revealed that work methods and approaches to the delivery of preventative education were uneven. The researchers suggested that the task force and regional service providers should examine

Funding drugs services in a recession (*continued*)

the quality standards framework developed by the National Drug Education Workers Forum (DEWF). They also suggested that resources should be focused on those most 'at risk', and to this end, 'targeted' and 'selected' interventions should be prioritised while other 'more generic' approaches could be delivered by organisations working with the regional population as a whole.

Funding: Table 5 in the published report shows how funding allocations could be made in accordance with the local strategic priorities; thus, funding to projects aligned with the top priorities should continue to be funded, funding to other projects should continue but their relevance or efficiency be further reviewed; and funding to other projects should be suspended, because the project is not of sufficient strategic importance or relevance, or the need could be met by some other means.

With regard to research, the roadmap recommended that the task force should form 'a strategic alliance with an educational institute in the region in order to assist the development of the research pillar for the region'. In response to needs identified by services in relation to

processes and support for projects (including the need for enhanced information sharing, the development of common working methods and the provision of training), the roadmap recommended a review of data collection methods and the appointment of a half-time monitoring and evaluation position for the region.

(Brigid Pike)

1. Department of Finance (2011) *Comprehensive Expenditure Report 2012–2014*. Part IV: Estimates for Public Services 2012 and Summary Public Capital Programme. Downloaded on 15 December 2011 from <http://budget.gov.ie/Budgets/2012/2012.aspx>
2. Comiskey C, O'Sullivan K and Milnes J (2011) Regional drug user services in times of scarce financial resources: using a rapid assessment response approach to evaluate, plan and prioritize essential services. *Substance Use & Misuse*, 47 (3): 254–264.
3. The *International Journal of Drug Policy* (2000) Volume 11, Issues 1–2, included a series of articles discussing the advantages and disadvantages of the RAR method.

Make social solidarity a core concern to ensure fairness and unity of purpose

An NESCI Secretariat paper, *Ireland's economic recovery: an analysis and exploration*, published in July 2011, argued that, in order to sustain and deepen the country's economic recovery, Ireland needs to focus on 'working the (EU/IMF) deal' rather than debating whether it can work. It outlined five connected elements necessary for 'working the deal', including making social solidarity a core concern to ensure fairness and unity of purpose, which the authors explained as follows: 'In adjusting public expenditure it is necessary to identify innovative ways of cutting costs and maintaining standards. This requires engagement of local problem-solving to ensure that expenditure is reduced in a way that does not undermine the services provided to citizens.' The full Secretariat paper is available at www.nesci.ie

Thirteenth annual Service of Commemoration and Hope



'Growing Strong Together' – the FSN Service of Commemoration and Hope at Our Lady of Lourdes Church, Sean McDermott Street (Photo: Michael Gallagher)

On Wednesday 1 February, the Family Support Network (FSN) held its thirteenth annual Service of Commemoration and Hope, entitled 'Growing Strong Together', in remembrance of loved ones lost to drugs and related causes and to publicly support families living with the devastation that drug use causes.

The service in Our Lady of Lourdes Church, Sean McDermott Street, was attended by President Michael D Higgins, Ms Róisín Shortall TD, Minister of State, Commander Mick Treacy, aide de camp to the Taoiseach, Garda Commissioner Martin Callinan, Bishop Eamonn Walsh and other religious representatives, as well family members, friends and representatives from family support groups throughout Ireland, and many people working in this area.

In her address to the gathering, Sadie Grace of the FSN emphasised the importance of local family support groups working in partnership with local services to enable these service to support families. She highlighted current issues involving the Network, which include: recommendations to government from the FSN bereavement group, the setting up of a bereavement support group, nationwide training within family support groups, working with gardaí to assist victims of intimidation and working on a regional response to Garda harassment. She welcomed the Minister's response to alcohol marketing and benzodiazepine misuse and her acknowledgement of the important role families play in rehabilitation. She mentioned cuts to the Network's core funding and requested decision makers in the audience to prioritise the FSN. She finished her address with a line taken from a previous speech by Minister Shortall, 'in times of test families are best'.

Thirteen annual Service of Commemoration and Hope *(continued)*

Minister Shortall emphasised the family's critical role in rehabilitation and reinforced the message that drug addiction can be overcome. She stated that a partnership approach is underpinned in the current National Drugs Strategy, which aims to tackle drug use in a comprehensive way. She recognised the importance of the Service of Commemoration and Hope in acknowledging and celebrating the young lives of those who had been lost to drugs, and in looking forward with hope.

The growth of family support groups throughout Ireland was evident at the Service. At the first Service of Commemoration and Hope in 2000, less than 10 family support groups, all located in the Dublin area, were represented. At this year's service over 100 groups from across the island of Ireland were represented.

President Higgins recited the poem 'For Grief' by John O'Donohue. In his address to the gathering, Bishop Walsh stressed the importance of supporting families, especially children from families who have been affected by drug addiction.

For many families, this service is the first time that they can openly grieve for their loved ones lost to drug use and related causes. Personal testimonies were given by members of family support groups, reflecting the vital support received through these groups. Music was provided by the soprano Nickola Hendy and the Gardiner Street Gospel Choir.

(Ena Lynn)

Contact the Family Support Network at 16 Talbot Street, Dublin 1. Tel: 01 836 5168; email: info@fsn.ie ; web: www.fsn.ie

Study findings on opiate substitution programme for adolescents

There is not a lot of Irish or international research to inform or guide service providers on treatment pathways for adolescents receiving opiate substitution treatment (OST). Smyth and colleagues recently conducted a retrospective cohort study looking at the outcomes for heroin-dependent adolescents receiving OST in Dublin, and the incidence of hepatitis C, HIV and mortality among this group.¹

The Young Persons Programme (YPP), a multidisciplinary adolescent treatment service provided by the Drug Treatment Centre Board (DTCB), accepts adults aged 17 years or under (and 18-year-olds occasionally). Based in Dublin, it also provides treatment to young people from surrounding counties. The programme is 'harm reduction orientated' but overall the aim is to assist clients to abstinence through detoxification.

The authors studied the records of heroin-dependent adolescents who were referred to the YPP between May 2000 and July 2008. Adolescents with a dependence on prescription opioids and those who dropped out of the assessment process before starting on medication were excluded from the study. The study cohort comprised the first 100 patients who met the inclusion criteria. Information on participation in the programme was recorded at 3, 6 and 12 months.

Doctors working at the DTCB were permitted to prescribe buprenorphine when it became available as a treatment option in 2005. Nineteen of the cohort were prescribed buprenorphine at the start of treatment, while all others received methadone. The mean peak methadone dose prescribed over the treatment period was 53mg (range 15mg to 90mg).

Three quarters of the 100 adolescents were aged 16 or 17, and 13 were aged 15 or under. There were more girls (54, 54%) than boys (46, 46%). There were statistically significant differences between the boys and the girls.

Boys were more likely than girls:

- to have left school at a younger age (13.8 years versus 14.9 years [mean]);
- to report that a sibling abused opiates (56% versus 32%);

- to have previous criminal convictions (59% versus 29%);
- to have ever been imprisoned (41% versus 14%).

Girls were more likely than boys:

- to have a current partner who used heroin (16% versus 64%).

The final progression route of the adolescents was the primary outcome of interest for the authors. The route of exit was recorded for 92 clients who left or moved on from the treatment programme:

- 22% (20) had a planned discharge following detox;
- 32% (29) dropped out;
- 8% (7) were imprisoned;
- 39% (36) transferred to another service to continue opiate substitution.

Twenty-eight adolescents dropped out during their first year of treatment, 19 of whom left within the first three months. Boys were significantly more likely than girls to leave treatment because of imprisonment (14% versus 2%).

Of the 49 adolescents who remained in treatment for 12 months and for whom urinalysis results in the 12th month were available, 39% (19) were completely abstinent from heroin. There was no statistically significant difference between boys and girls.

The study also looked at the incidence of blood-borne viruses and mortality:

- 20% were hepatitis C positive (17 of the 84 tested);
- 33% of injectors were hepatitis C positive (12 out of 36 tested);
- no clients were HIV positive (0 out of 69 tested);
- no deaths were recorded during treatment.

The authors noted the relatively long assessment process for admission to the treatment programme. They point out that, while only 12 adolescents dropped out during the assessment phase, 'a faster route into treatment may have

Opiate substitution programme (continued)

resulted in more study participants and may have altered the detected outcome profile'. Boys were significantly more likely than girls not to progress from assessment to treatment, which may be linked to the finding that slightly more girls than boys were treated in the programme over the study period. This differs from what is shown in the national data, where the majority (73%) of cases in treatment for problem opiate use are male.²

While the adolescents who remained in treatment showed reductions in heroin use, the authors caution that, 'heroin dependence represents a complex and serious clinical problem and poses major treatment challenges'. These challenges include high drop-out rates, especially in the early months of treatment, along with the proportion who

never complete detoxification or who relapse. The authors conclude that many adolescents with heroin dependence will require opiate substitution treatment for at least a year or more.

(Suzi Lyons)

1. Smyth B, Fagan J and Kernan K (2012) Outcome of heroin-dependent adolescents presenting for opiate substitution treatment. *Journal of Substance Abuse Treatment*, 42(2): 35–44.
2. Carew AM, Bellerose D, Lyons S and Long J (2009) *Trends in treated problem opiate use in Ireland, 2002 to 2007*. HRB Trends Series 7. Dublin: Health Research Board. www.drugsandalcohol.ie/12371

Detoxification: the evidence on setting and intervention

An expansion in the number of residential detoxification beds has been recommended by the Working Group on Drugs Rehabilitation (2007)¹ and endorsed by the *National Drugs Strategy (Interim) 2009–2016*.² While the provision of effective detoxification services is acknowledged as a key component of rehabilitation and recovery from substance addiction, it is important to understand the impact of different settings and interventions for detoxification to improve the evidence base and promote best practice. This article summarises the evidence from one systematic review and one randomised controlled trial (RCT) concerning the most effective setting for detoxification and one systematic review that compared different interventions for detoxification.

Evaluating the setting in which detoxification takes place

Day and colleagues³ looked for RCTs comparing inpatient detoxification programmes with other types of opiate withdrawal programmes (outpatient programmes) to ascertain what was more effective. They found only two trials, only one of which, from 1975 and involving 40 patients receiving methadone substitution treatment, satisfied the inclusion criteria. The results of that trial suggested that inpatient detox might be more effective in the short term: 70% of the inpatient group were opioid free on discharge, compared to 37% in the outpatient group. However, all of the inpatients had relapsed within three months of detoxification. The authors' conclusions and their notes for practitioners state '...there is very little available research to guide the clinician about the longer-term outcomes or cost-effectiveness of inpatient or outpatient approaches'.

Day and Strang⁴ undertook an RCT on the impact of treatment setting on detoxification. In the trial, 68 opioid-dependent patients (most were in receipt of methadone and all but six were also using heroin) were randomised to an inpatient or an outpatient setting. Participants in both settings received the same structured lofexidine detoxification treatment. More inpatients (51%, 18) than outpatients (36.4%, 12) completed the detox but the difference was not statistically significant. This meant that less than half of the 68 patients randomised to the different detoxification settings managed to complete the treatment. Eleven participants in all were abstinent from all opioids at one-month follow-up, and only eight at six-month follow-up, with no superior differences between the groups. The

authors state: 'The results of [this] trial confirm previous research findings that detoxification is an ineffective stand-alone treatment for opioid dependence.'

Evaluating different interventions for detoxification

Amato *et al.*⁵ compared the effectiveness of any psychosocial plus any pharmacological intervention with any pharmacological intervention alone for opioid detoxification. Eleven studies including 1,592 participants met the inclusion criteria for the review; these included both RCTs and non-randomised trials. The authors concluded that 'psychosocial treatments offered in addition to pharmacological detoxification treatments [methadone or buprenorphine] are effective in terms of completion of treatment, use of opiate results at follow-up and clinical attendance'. However, they also state that 'the evidence is limited due to the small numbers of participants in the trials and differences in assessments from the trials'. On the other hand, they do contend that it may be desirable to combine both psychosocial and pharmacological approaches to make detox more effective.

(Martin Keane)

1. Working Group on Drugs Rehabilitation (2007) *National Drugs Strategy 2001–2008: rehabilitation. Report of the Working Group on drugs rehabilitation*. Dublin: Department of Community, Rural and Gaeltacht Affairs. www.drugsandalcohol.ie/6267
2. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009-2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
3. Day E, Ison J and Strang J (2008) Inpatient versus other settings for detoxification for opioid dependence. *Cochrane Database of Systematic Reviews*. Published online 8 October 2008. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004580.pub2/full>
4. Day E and Strang J (2011) Outpatient versus inpatient opioid detoxification: A randomised controlled trial. *Journal of Substance Abuse Treatment*, 40(1): 56–66.
5. Amato L, Minozzi S, Davoli M and Vecchi S (2011) Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. *Cochrane Database of Systematic Reviews*. Published online 7 September 2011. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005031.pub4/full>

CRA, ACRA and CRAFT: a brief review of the evidence

The Community Reinforcement Approach (CRA) is acknowledged in the National Drugs Strategy as an effective evidence-based approach that could be used as an adjunctive to services delivered within the rehabilitation pillar.

Roozen *et al.* (2004) undertook a meta-analysis of 11 randomised controlled trials (RCTs) to review the effectiveness of two approaches to treating substance abuse: (i) Community Reinforcement Approach (CRA) versus usual care, and (ii) CRA versus CRA with contingency management. A qualitative analysis was also performed using a four-level rating system (Table 1).

The authors report that there is strong evidence that CRA is more effective than usual care in reducing the number of days alcohol is consumed, and conflicting evidence on its effectiveness in maintaining continued abstinence. There is moderate evidence that CRA with disulfiram (Antabuse) is more effective than usual care with disulfiram in reducing the number of days alcohol is consumed, and limited evidence for no difference in effect between CRA with disulfiram and usual care with disulfiram on continuing abstinence.

There is strong evidence that CRA with ‘incentives’ is more effective than usual care in achieving abstinence from cocaine use. There is strong evidence that CRA with abstinent-contingent incentives is more effective than CRA without abstinent-contingent incentives in achieving abstinence from cocaine use.

There is limited evidence that CRA with incentives is more effective than usual care in an opioid detox programme and there is limited evidence that CRA on its own is more effective than usual care in achieving abstinence through a methadone maintenance programme.

Table 1 A four-level rating system to assess the strength of scientific evidence

1	Strong evidence	Consistent findings in multiple high-quality RCTs
2	Moderate evidence	Consistent findings in one high-quality RCT and in one or more low-quality RCTs, or consistent findings in multiple low-quality RCTs
3	Limited evidence	Only one RCT (of high or low quality)
4	Conflicting evidence	Inconsistent findings in multiple RCTs

Source: After Van Tulder *et al.* (2000), cited in Roozen *et al.* (2004)

The review by Roozen and colleagues represents the most rigorous analysis of the evidence base on CRA; however, it only covers studies undertaken before 2004. No high-quality analysis has been located since then. The review is useful as it examines the effectiveness of CRA in tackling the use and misuse of different substances, both when used alone and in combination with medications and contingency management incentives. This type of review is a useful

source of information to a diverse body of practitioners working in the substance misuse field. Regarding the strength of the evidence base for CRA (pre-2004), the authors state: ‘In general, there is limited to moderate evidence for the efficacy of CRA with or without medication or contingency management in various substance-related disorders, including alcohol, cocaine and heroin.’

Abbot (2009) reviewed published research on the use of CRA in the treatment of opioid dependence. The review included three randomised and one non-randomised controlled trials. The review is different from that of Roozen *et al.* in that Abbot summarises the findings from the four trials whereas Roozen and colleagues synthesise the findings from 11 trials to compute a new and overall estimate of effectiveness.

Abbott concludes that CRA, when combined with methadone reduces opioid use and use of other drugs and, in one study, improved legal status, reduced psychiatric symptoms and improved social and vocational functioning. When combined with vouchers (contingency management), CRA can retain people in treatment long enough to achieve detoxification from buprenorphine.

In a study undertaken in a less clinical setting than previous studies, Slesnick *et al.* (2007) randomly assigned 96 homeless young people aged 14–22 to a CRA and 84 homeless youth to treatment as usual (TAU) at a homeless drop-in centre in the US. Homeless youth assigned to CRA showed greater improvement in respect of substance use, social stability and depression from baseline to six months compared to those assigned to TAU. However, those receiving TAU also showed improvement in several domains. Acknowledging the design limitations of the trial and the need for caution when drawing conclusions from these outcomes, the authors note that ‘the research design is limited in that youth were only assessed at post-treatment. A longer follow-up is needed to determine stability of treatment effects.’

Smith *et al.* (2008) describes the CRAFT programme as an outgrowth of the CRA. The CRAFT programme works with concerned family members to rearrange contingencies in the alcohol abuser’s environment so that alcohol abuse is discouraged and sobriety is encouraged. The ultimate goal of the CRAFT programme is to equip concerned family members with the skills to influence the alcohol abuser to engage with treatment. Smith and colleagues provide a brief review of a number of both randomised and non-randomised studies that evaluated the effectiveness of CRAFT in comparison with Al-Anon and other interventions. Most of the studies showed that CRAFT was more effective in helping concerned family members to persuade the substance abusers to engage with treatment. However, the data provided are much too brief to enable a rigorous critical appraisal of the studies.

An additional recent outgrowth of the CRA is the Adolescent Community Reinforcement Approach (ACRA), which aims to make an alcohol- and drug-free lifestyle more rewarding than continued substance abuse. In a recent study that compared the outcomes of 151 adolescents (aged under 18) and 152 emerging adults (aged 18–25), who were diagnosed with substance misuse disorders and had received

CRA, ACRA and CRAFT (continued)

the ACRA programme, Douglas *et al.* (2011) found that emerging adults were less likely to be abstinent and had more days of alcohol use compared to adolescents after both received the ACRA programme.

(Martin Keane)

Abbott PJ (2009) A review of the Community Reinforcement Approach in the treatment of opioid dependence. *Journal of Psychoactive Drugs*, 41(4): 379–385.

Meyers RJ, Villanueva M and Smith JE (2005) The Community Reinforcement Approach: history and new directions. *Journal of Cognitive Psychotherapy*, 19(3): 251–264.

Roozen HG, Boulogne JJ, van Tulder MW, van den Brink W, De Jong CA and Kerkhof AJ (2004) A systematic review of the effectiveness of the community reinforcement approach in alcohol, cocaine and opioid addiction. *Drug and Alcohol Dependence*, 74(1): 1–13.

Slesnick N, Prestopnik J, Meyers RJ and Glassman M (2007) Treatment outcomes for street-living, homeless youth. *Addictive Behaviours*, 32(6): 1237–1251.

Smith JE, Meyers RJ and Austin JL (2008) Working with family members to engage treatment-refusing drinkers. *Alcoholism Treatment Quarterly*, 26(1/2): 169–193.

Implementing needle exchange programmes: the evidence base

*The National Drugs Strategy (interim) 2009–2016*¹ prioritises the expansion of needle and syringe programmes (NSPs) throughout the local and regional drugs task force areas. While plans to expand the availability of NSPs are welcome, improving access and effectiveness must also be key to the aims of the drugs strategy, which include the reduction of the prevalence of blood-borne viruses among intravenous drug users (IDUs) and the reduction of drug-related deaths. Key to improving access and effectiveness is understanding how best to organise and deliver NSPs.

This article summarises the only review that has examined the evidence base to determine what works best in the organisation and delivery of NSPs.² The authors reviewed the literature since 1990 to determine:

1. What types of NSP are effective?
2. Which additional harm reduction services offered by NSPs are effective?
3. Are NSPs delivered in parallel with, or alongside, opiate substitution therapy effective?

Of 406 articles screened, 16 studies were judged eligible for inclusion in the review.

Two random controlled trials (RCTs) in the US in 2003 and 2007 were included in the review. The 2003 trial compared pharmacy-only sales with NSP plus pharmacy sales; neither setting produced superior results for reducing injecting risk behaviour. However, IDUs in both groups reduced their injecting drug use over time, but group assignment did not modify this reduction. The 2007 trial examined differences between IDUs attending hospital NSPs and those attending community-based NSPs and found that neither setting had a superior influence on injecting risk behaviours. However, both groups reduced their drug use risk behaviours over time.

Findings from three studies included in the review suggested that mobile van services and vending machines attracted younger IDUs and IDUs with high-risk profiles.

Findings from three studies in the USA suggested that syringe- dispensation dispensing policies had a limited impact on the sharing of needles and syringes but had some impact on the re-use of syringes. Where policies put fewer

limits on the number of syringes exchanged, the re-use of syringes for personal use was less likely.

A study involving a cohort of drug users in Amsterdam³ reported that full participation in a harm reduction programme that combined daily methadone maintenance at a dose of 60mg or more with needle and syringe exchange (with all needles exchanged) was associated with a lower risk of HIV and HCV infection in drug users who had ever injected, compared to no participation. The authors of that study claimed: 'To provide needles and syringes only or methadone only will not be sufficient to curb the rapid spread of these and other blood-borne infections among DU [IDUs]. It is essential to offer a comprehensive programme in which both measures are combined, preferably also with social-medical care and counselling.' (p. 1461)

One RCT compared the effectiveness of case management (intervention group) with passive referral (control group) among NSP attendees who requested referral to drug treatment. Participants who received case management were more likely to enter treatment compared to the control group. Case management was based on the Strengths Based Case Management model which is designed to build upon the clients' strengths. Further analysis suggested that the provision of transportation (a lift) to the treatment programme was an important ingredient in the case of management intervention.

Another RCT evaluated the effectiveness of motivational interviewing (MI) in the treatment interest and treatment enrolment of 302 NSP participants. Participants were randomly assigned to MI, job-seeking readiness or (iii) standard care referral. There was no superior effect of MI on treatment enrolment.

The authors of the systematic review concluded 'it is difficult to draw conclusions on "what works best" within the range of harm reduction services available to IDUs. Further studies are required which have a stated aim of evaluating how different approaches to the organisation and delivery [of] NSPs impact on effectiveness.'

(Martin Keane)

Needle exchange programmes (continued)

1. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
2. Jones L, Pickering L, Sumnall H, McVeigh J and Bellis BA (2010) Optimal provision of needle and syringe programmes for injecting drug users: a systematic review. *International Journal of Drug Policy*, 21(5): 335–342.
3. Van Den Berg C, Smit C, Van Brussel G, Coutinho R and Prins M (2007) Full participation in harm reduction programmes is associated with decreased risk for human immunodeficiency virus and hepatitis C virus: evidence from the Amsterdam Cohort Studies among drug users. *Addiction*, 102(9): 1454–1462.

Evaluating the Strengthening Families Programme

Sixsmith and D’Eath (2011)¹ were commissioned by the Western Region Drugs Task Force to evaluate the roll-out of the Strengthening Families Programme (SFP) in five centres in the region. The SFP was developed in the USA to build resilience and reduce risk factors for poor health and social outcomes, including substance misuse and related behaviours, in at-risk families. This article describes the main findings of the evaluation as they relate to seven specific questions posed by the evaluators.

Was the SFP implemented as planned; what, if any, were the deviations from the plan; and what were the reasons for the deviations?

Steering committees comprising multi-agency representation were convened in all five centres as planned. However, levels of participation varied across committees, with several experiencing non-involvement of individuals and agencies. In one of the centres, plans to implement the SFP were abandoned because of inadequate levels of participation on the committee. For some steering committees, the referral system did not work as planned. Referral processes varied across the centres and some did not receive any referrals from the committees.

The steering committees, for the most part, decided the criteria for referral to the SFP. However, these decisions exhibited a lack of clarity and consensus as to the appropriate target groups. Steering groups reported inconsistencies around understanding which risk factors were relevant to determining eligibility for the SFP. For example, groups differed on whether substance use was a risk factor, and, if it was, how the nature and extent of the risk was to be assessed. These inconsistent views were at variance with the overall aim of the SFP, which, according to the task force, was to reduce substance misuse by both parents and teenagers.

What were the perspectives of participating parents and teenagers on the SFP content and delivery?

The delivery of the SFP by a facilitator was valued by participants and the variety of activities, including role play, games and art, contributed to an unexpected fun experience; it was this experience that appeared to engage and sustain involvement. Teenagers seemed to learn more from specific modules, such as substance misuse, sexuality, communication and resolving conflict. On the other hand, parents tended to speak about their learning in general terms.

Was the mealtime an important element of the SFP for participants?

Parents, teenagers and service providers considered the mealtime an important component of the SFP. The mealtime preceded each of the 14 weekly sessions and was seen to act as an ice-breaker, providing an opportunity for less formal communication between families and providers and within families. Some families expressed the desire to incorporate this experience into family living.

Was the training adequate for facilitators to deliver the SFP, overall and in this setting?

An information seminar and a two-day training session were delivered in each of the four sites. Overall, there were mixed views on the adequacy of training, with several facilitators saying that the training was only adequate because of the range of skills they already possessed and that essential skills were neither provided nor tested during the training provided.

What alterations to the process and programme (implementation and content) are necessary to ensure successful outcomes in future delivery?

Changes to the referral process and greater clarity about the role of the referral agencies were identified as necessary improvements. In addition, improved clarity in identifying relevant target groups and in recruitment processes were perceived as necessary changes that could improve implementation and impact. Service providers suggested that future programmes could focus on families with children who were younger than the 12–16-year age group stipulated by the current SFP. This suggestion was based on the view that younger children were more amenable to behaviour change, and that some teenager participants in the current SFP exhibited challenging behaviours.

Did the SFP impact on participants, and if so what was the impact?

Families were assessed before and after their participation in the SFP, using three domains in the Family Environment Scale (FES): family cohesion, expressiveness and conflict. According to the authors, the small sample size and poor response rate to some questions interfered with the analysis that was planned; the limited data generated meant that no significant differences between pre and post intervention were detected.

Interviews with family members suggested that some benefits from participation in the SFP were achieved, such as improved communication within the family unit and enhanced parenting skills.

Evaluating the Strengthening Families Programme (continued)

Did the SFP reduce drug and alcohol use among participants?

Parents were invited to answer questions drawn from the SLAN questionnaire about their alcohol intake and related behaviours, before and after their participation in the SFP. The authors report that too few participants answered some questions, which interfered with meaningful analysis. From the limited number of questions answered, no measurable impact on alcohol intake or related behaviours was detected.

Teenagers were invited to answer questions drawn from the Health Behaviour in School-aged Children (HBSC) questionnaire about their substance use and related behaviours, before and after their participation in the SFP. The authors report that the amount and consistency of data generated from responses was inadequate to allow a meaningful statistical analysis. From the data generated, no differences in substance use can be credited to participation in the SFP.

Interviews with parents (n=10), teenagers (n=7) and service providers (n=9) revealed that, for most of the families taking part in the SFP, substance use was not perceived to be a major problem.

Conclusion

The lack of consensus on appropriate target groups and on what constitutes an at-risk family could have been overcome by a thorough needs assessment of potential participants. The lack of clarity between participants and service providers regarding the main objectives of the programme could have been resolved by setting short-term objectives, such as the reduction of identified risk factors, rather than focusing on long-term and perhaps unrealistic outcomes such as the reduction or cessation of substance use. The inclusion of alternative outcomes would have necessitated the selection of alternative data collection instruments. Instead of using modified versions of the SLAN and HBSC surveys, alternative instruments could have been used to assess the impact of the SFP on participants.

(Martin Keane)

1. Sixsmith J and D'Eath D (2011) *An independent evaluation of the Strengthening Families Programme in the WRDTF Region*. Galway: Western Region Drugs Task Force. www.drugsandalcohol.ie/16657

The lived experience of those on methadone maintenance in Dublin North East

Van Hout and Bingham¹ were commissioned by the client forum of Dublin North East Drugs Task Force to undertake an exploratory study of the experience of individuals in receipt of methadone maintenance who had engaged with the Special Community Employment scheme. Data were collected through in-depth interviews with 15 men and 11 women. The main issues to emerge from the interviews are described in the report and are summarised in this article.

Experiences of methadone

Getting access to prescribed methadone was reported as being relatively straightforward, with the main criteria for access being the provision of three urine samples that tested positive for heroin use. Some interviewees reported moving to weekly take-home supplies of methadone after providing clean urines for 16 weeks. Although some interviewees agreed with the practice of regular urine testing, the majority, and especially women, perceived this practice as embarrassing and degrading. Most of the people interviewed, particularly the women, gave examples of improved daily functioning when they replaced the use of street drugs with daily doses of methadone.

Interviewees reported a lack of therapeutic dialogue between themselves and the doctors and clinic staff prescribing methadone. Issues mentioned in this context included not being informed of the physical side-effects of methadone, and an absence of clinical advice and support on dosage reduction or detoxification. Arising from the absence of therapeutic dialogue, interviewees expressed ambivalence around detoxification, with some preferring indefinite maintenance instead of potentially painful withdrawal, while others expressed frustration at the prospect of long-term maintenance and signalled intentions to eventually detoxify.

Several interviewees talked about their dependence on methadone and their fear of the withdrawal symptoms

if they tried to detoxify; they perceived a detoxification from methadone as more difficult than coming off heroin and perceived methadone as being more addictive than heroin. Many saw their daily dependence on methadone as restricting their personal freedoms, with some referring to methadone as 'a ball and chain'.

Many of the interviewees felt stigmatised because of their heroin addiction and, although they were receiving prescribed methadone, they also felt ashamed of being seen by neighbours when frequenting the methadone clinics and the pharmacies.

Experiences of recovery, progression and Special Community Employment schemes

The meaning of recovery and rehabilitation differed among participants: for some it meant being on methadone and not using the main problem drug, i.e. heroin, while for others it meant the cessation of all substance use. The improvement in quality of life and the pursuit of mainstream norms such as employment and a settled family life were also cited as meaningful components of recovery.

The majority of participants reported that their engagement with the Special Community Employment schemes was a positive experience. Accounts varied as to the nature of these experiences and included improvements in personal development and addiction management strategies and the development of positive daily structures. For some participants, the value of the schemes lay in interaction they had with other participants who were 'clean' and with staff who a listening ear and support. The effectiveness of the schemes in developing vocational and employment skills was less pronounced; however, some participants reported that they had developed literacy and computer skills. Several participants expressed the aspiration of progressing to third-level education from the schemes.

Methadone maintenance (continued)

The variety of experiences narrated in this report is testament to the diverse needs of this cohort of people – needs which, according to the people themselves, are not being met by the provision of other addiction recovery supports and services in the area. Participants referred to the lack of connectivity between services, having to wait long periods to access a counsellor and not having adequate information on what services were available to promote and support progression and social reintegration. Several participants noted a lack of tangible outcomes for those who attended the employment schemes. For example, there was a feeling that employers would be prejudiced against potential applicants due to their engagement with such schemes, gaps in their curriculum vitae and a lack of formal education and training qualifications. Several noted the lack of aftercare and support for those that exit the schemes.

Conclusion

This report, although exploratory in nature, and confined to the context-specific location of the Dublin North East Drugs Task Force area, provides a welcome insight into the lived experience of people in receipt of prescribed methadone and accessing the Special Community Employment schemes. The reported absence of therapeutic dialogue between prescribers of methadone and clients can lead to confusion and frustration among clients around dosage reduction, detoxification and dependence on long-term maintenance.

The Special Community Employment schemes serve the personal development needs of participants but do not help to develop educational skills and improve employability, the role they were established for. Several participants expressed the aspiration of progressing to third-level education from the schemes but could not envision how this aspiration could be tested and fulfilled.

While both interventions, either separately or combined, contributed to some improvements in the lived experiences of the people interviewed the authors found that they were delivered in a way that prevented meaningful progression for participants. They conclude: 'It appeared that not only was methadone maintenance treatment a "holding pattern" for heroin users, but Special Community Employment schemes also operated in a similar fashion, with little real life employment preparation, assistance in seeking and securing employment or vocational skills development.' (p. 44)

(Martin Keane)

1. Van Hout M C and Bingham T (2011) *Holding pattern: an exploratory study of the lived experiences of those on methadone maintenance in Dublin North East*. Dublin: Dublin North East Drugs Task Force. www.drugsandalcohol.ie/16231

Legal update 2011

This update covers drug-related Acts and Bills of the Oireachtas introduced or progressed since the Government came to office on 9 March 2011.

- The **Road Traffic Act 2011 (No 28 of 2011)** provides for the amendment to existing legislation to permit the early introduction of mandatory alcohol testing of drivers of mechanically propelled vehicles in certain circumstances, including involvement in road traffic collisions. The Act also clarifies the position regarding mandatory preliminary breath testing.
- The **Criminal Justice (Community Service) (Amendment) Act 2011 (No 24 of 2011)** The primary purpose of this Act is to introduce a requirement on a court before which an offender stands convicted of an offence for which a sentence of up to 12 months' imprisonment would be appropriate, to consider imposing the alternative sentence of a community service order. Although the Bill does not mention specific offences, many offenders whose offences are committed as a consequence of drug addiction receive short custodial sentences and could benefit from the terms of this legislation.
- The **Criminal Justice (Public Order) Act 2011 (No 5 of 2011)** prohibits harassment or intimidation of members of the public by persons who engage in begging and confers powers on members of the

Garda Síochána to give directions to persons to desist from begging, in certain circumstances such as where they are begging near cash machines or in front of places of business. It also provides for a series of sanctions including fines and possible imprisonment for breaches of the law.

- The **Communications (Retention of Data) Act 2011 (No 3 of 2011)** requires service providers, those engaged in the provision of a publicly available electronic communication service or a public communication network by means of fixed line or mobiles or the internet, to retain data relating to fixed and mobile telephony for one year, and data relating to internet access, internet email and internet telephony for two years, and provides for disclosure in relation to the investigation of specified offences, including customs offences.

Status of Bills before the Dáil

Current status of relevant Bills is shown in the table below.

The full legislative programme for the forthcoming Dáil session was published by the Government in January 2012 and is available at the following link: www.taoiseach.gov.ie/eng/Taoiseach_and_Government/Government_Legislation_Programme

(Johnny Connolly)

Title and explanatory memorandum	Status
The Spent Convictions Bill 2011 provides that in the case of convicted persons whose sentence is below a specific threshold, they may, under certain circumstances, withhold details of the conviction. This is intended to apply where a prison sentence not exceeding six months or a fine or penalty have been imposed, and then only after a certain number of years have elapsed without a further conviction. The purpose of the Bill is to help rehabilitate convicted persons through facilitating their reintegration into the workforce and allowing them to build new careers.	Referred to Select Committee 08/06/2011

Launch of Ana Liffey Strategic Plan 2012–2014

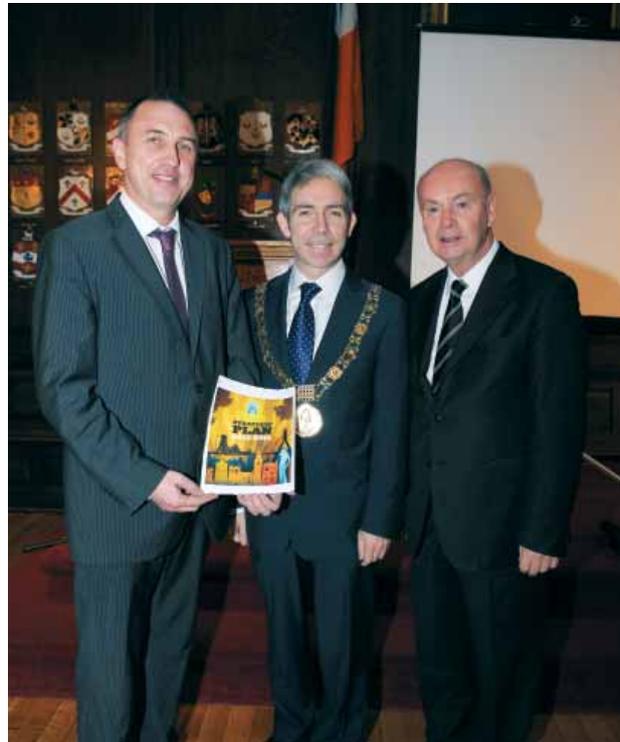
The Ana Liffey Drug Project launched its new strategic plan¹ on 20 January 2012. This document, informed by feedback from many stakeholders, will shape the work and aims of the organisation through the next three years.

Dublin's Lord Mayor, Andrew Montague, who formally launched the strategy, congratulated Ana Liffey staff for their hard work and for the ambitious goals they are setting in this new plan. He spoke of the value of pilot projects, even those that could be controversial. He declared his support for Ana Liffey's plan to pilot a medically supervised drug consumption room in order to find out what effect it might have on the wider community, and whether it could reduce the overall harm of drug use in the Irish context.

Tony Duffin, director of Ana Liffey, briefly highlighted the progress made and the challenges faced by the organisation in the last five years. He said that the project now offered a wider range of services to meet the growing demand from service users. There had been a significant increase in the numbers of staff and of drop-in contacts between 2007 and 2011. However, levels of funding had not kept pace with these developments, and the project was now having 'to do more with less'. He said that the heroin drought in 2010 had had an effect on services, and also on service users, many of whom had turned to benzodiazepines and other substances. The availability of head shop products (prior to the ban in 2010), especially mephedrone, along with an increase in violence and intimidation, were among the major challenges faced by both the staff and the people they worked with.

Ana Liffey's plan for 2012–2014 includes six strategic objectives, as described below.

- 1. To maintain and develop a range of high quality low threshold services which support our service users to access integrated pathways and achieve their goals.**
This objective is internally focused on service delivery. The main goal is to establish and strengthen inter-agency partnerships and to provide easy access to a wide range of services in order to support and meet the changing needs of each individual.
- 2. To create service responses which will address the unmet service user needs.**
This objective is the most controversial part of the plan, and was the focus of most questions and comments at the launch. The goals under this heading are to advocate, plan and work towards the establishment of a pilot medically supervised injecting centre by December 2014, and of a crisis centre for residential detoxification specifically aimed at tackling the issue of multiple substance use by December 2013.
- 3. To promote quality service delivery in the sector through the provision of practical organisational supports and initiatives.**
In relation to the work done through the Progression Routes Initiative, the plan reiterates Ana Liffey's commitment to the QuADS support project. This objective also includes the national roll-out of the Community Detox Initiative, as well as the co-ordination and evaluation of a naloxone pilot targeted at drug users, their peers and families, both by December 2014.
- 4. To develop appropriate partnerships in order to advance our strategic objectives.** The goals set by the organisation cannot be achieved without the support of



At the launch of Ana Liffey's Strategic Plan: Mr Tony Duffin, director of Ana Liffey, Cllr Andrew Montague, Lord Mayor of Dublin, and Mr Pat Carey TD

all stakeholders. In this objective, Ana Liffey emphasises the importance of monitoring opportunities to progress those objectives on an ongoing basis.

- 5. To communicate the vision, mission and values of the organisation so that individuals with problem substance use issues are treated with dignity and respect.**
A communication strategy will be developed that includes annual reviews of services so that stakeholders can effectively support service delivery.
- 6. To develop the capacity of the organisation at all levels to enable delivery of the strategy.**
In the current difficult economic context, it is vital that the organisation finds ways to optimise resources, using tools such as a client management system and a learning and development plan for staff.

In his director's report, Tony Duffin acknowledged that Ana Liffey anticipates 'continuing challenges over the next three years. Not least because of the significant challenges to delivering on some of our goals...'

Ana Liffey's mission remains to work with people affected by problem substance use and the organisations that assist them in order to reduce harm to individuals and society, and to provide opportunities for development of those individuals and organisations.

(Delphine Bellerose)

1. Ana Liffey Drug Project (2012) *Strategic plan 2012–2014*. Dublin: Ana Liffey Drug Project. Available at www.aldp.ie

Changing patterns of drug use impact on services and communities

How have changing patterns of drug use impacted on individuals, communities and treatment services in recent years? In a seminar hosted by the Dales centre in co-operation with CityWide Drugs Crisis Campaign in December 2011, several speakers addressed this question. Declan Andrews, chairperson of the Dales centre, stated that the shift in Dublin from what had been essentially a heroin problem to what was now an increasingly complex problem of multiple substance use had put a lot of pressure on services. He said that this was a serious challenge for all addiction treatment providers, especially in a context where funding cuts were having a dramatic impact on the delivery of such services.

Presenting the results of a survey done in Darndale, Samantha Parkes of the Dales centre described a change in the drug of choice among users in that small community. In the years 2004–2007, a huge increase in cocaine use had led to the implementation of a specific cocaine support service at the centre. Interviews conducted in 2011 with drug users in that area revealed an increase in the use of cocaine and crack cocaine, particularly in cocaine used with other substances such as alcohol, benzodiazepines and head shop drugs. Heroin, now often ranked as a fourth or fifth drug of choice, had not come back to the level of popularity it had prior to the heroin drought in 2010. Many drug users had replaced heroin with crack cocaine or benzodiazepines, the latter more common among women.

The wide availability of, and easy access to, substances contributed to some degree of acceptance within the community, facilitated by the legal status of some of those substances (alcohol, benzodiazepines, and head shop substances prior to the 2010 ban). In the last four years, cannabis had become so widely available and relatively cheap that its use, sometimes in conjunction with mephedrone, had increased dramatically. The cannabis strains currently available were far more potent than those in recent years; it was noted that the reduced availability of hash, the resin form of cannabis, had led to the promotion of stronger herbal forms of cannabis on the market, with 'skunk' now commonplace. In 2011, methylamphetamine, known as 'crystal meth', appeared to be increasingly present on the drug scene and was now being used instead of crack cocaine in some areas.

The Darndale survey also showed that substances such as cocaine, head shop products and benzodiazepines did not carry the same stigma as that associated with heroin, and that drug users, and indeed the wider community, did not view the use of such substances as a serious problem that required intervention. Addiction treatment was still often viewed by service users as a response to heroin use. Dermot King, director of Ballymun Youth Action Project, outlined the difficulty faced by services in addressing the normalisation and the social acceptance of benzodiazepine use in the Ballymun area. The increased use of benzodiazepines among young people who had never used opiates reflected a perception that benzodiazepines were safer and better to use than stimulants or opiates. Mr King described an initiative in Ballymun involving a close partnership between addiction counsellors and general practitioners in order to illustrate the positive outcome that some community responses have had in the area.

Johnny Connolly of the Health Research Board spoke of the value of local surveys and small-scale research projects in revealing what can be hidden in national data or surveys. He said that, while levels of crack cocaine use in Ireland remained low, increased use in the last few years had tended to be hidden behind an overall decrease in the reporting of cocaine powder use in national figures. He said that because the drug problem differs from one area to another, and within local areas, the community approach was complementary to policies, monitoring and interventions implemented at national level, and was a key element of any adequate and efficient response to the drug problem.

Drugs are changing, they are more toxic, there is easy access to a wider range of substances and therefore more opportunities for potentially lethal combinations. Gary Broderick, director of the Saol project, said that there was a growing population of stable ex-opiate users who were returning to treatment for misuse of cocaine or other substances. Multiple substance use, now the norm, increases the complexity of drug interventions and is associated with poorer treatment outcome and the need for repeated episodes of treatment. This is a huge challenge for services in a context where already stretched resources are being further reduced.

(Delphine Bellerose)

Social exclusion and crime

A position paper by the Irish Penal Reform Trust highlights the causative connection between social exclusion, deprivation and crime.¹ The paper argues that marginalised communities are more heavily policed and that those from such communities receive more severe punishment than those from more affluent communities. It also argues that cuts to community-based services will exacerbate crime rates. Speaking at the launch of the paper, Liam Herrick, director of the IPRT, stated:²

Austerity measures which see cuts to health, education and other key services impact disproportionately on marginalized communities... increasing levels of social exclusion which will have a negative impact on crime.

Other speakers who addressed the launch, which was jointly organised by the IPRT and Community Platform (www.communityplatform.ie), included John Lonergan, former governor of Mountjoy Prison and a patron of the IPRT, Kathleen Lynch, professor of equality studies at University College Dublin, Tony Geoghegan, chief executive of Merchants Quay Ireland, Orla O'Connor, head of policy at the National Women's Council of Ireland and Brid O'Brien of the Irish National Organisation of the Unemployed.

The paper explores the social profile of prisoners and the 'specific ways in which the criminal law is unduly focused on marginalised groups' (p.9). The IPRT calls for the cessation of the practice of imprisonment for non-payment of fines, citing research which found that 'fine defaulters had an 85% likelihood of returning to prison after release' (p.9). The paper is also critical of the Criminal Justice (Public Order) Act 2011, which prohibits some forms of begging, describing it as 'a regressive legislative measure, which unduly penalises the most vulnerable members of society' (p.11). The paper highlights the links between substance misuse and crime and is critical of the recent budgetary cuts for projects in drugs task force areas (p.17). With regard to the reintegration of offenders upon release from prison, the paper calls for

adequate resources to be applied to Integrated Sentence Management so that prisoners are adequately prepared for their release, 'receiving assistance with accommodation, mental health and/or addiction supports' (p.18).

Highlighting the fact that 'Ireland is the only EU state without spent convictions legislation',² the IPRT calls for the speedy enactment of the proposed Spent Convictions Bill so that individuals convicted of minor criminal offences can be aided in their attempt to reintegrate back into society (p.20). The IPRT also highlights the disproportionate way in which offenders of different socio-economic backgrounds are treated by the Irish criminal justice system. According to Herrick, 'That we continue to imprison thousands of people every year for not paying fines, while those involved in "white collar" crime remain largely unpunished, further underscores Ireland's disproportionate punishment of some sections of society.'²

The paper forms part of the IPRT's Shifting Focus campaign (www.iprt.ie/shifting-focus), which uses evidence and research to support its call for a movement away from traditional criminal justice responses to issues of social exclusion and associated crime and to demonstrate to policy makers that such a shift, '- with emphasis on prevention and early intervention - makes social and economic sense'.²

(*Johanny Connolly*)

1. Irish Penal Reform Trust (2012) *The vicious circle of social exclusion and crime: Ireland's disproportionate punishment of the poor*. IPRT Position Paper 9. Dublin: IPRT. www.iprt.ie/position-papers
2. Irish Prison Reform Trust (2012) *Punishing cuts to prevention services will exacerbate unfairness of criminal justice system*. Press release issued by the Irish Penal Reform Trust, 2 February 2012. www.iprt.ie/contents/2279

Mandatory minimum sentencing

The Law Reform Commission (LRC) has highlighted in a consultation paper a number of serious deficiencies in the operation of the presumptive 10-year sentence for certain drug offences and has recommended that the provision be reviewed.¹

The consultation paper begins with a consideration of the overall aims of criminal sanctions and the principles by which these are regulated. The broad aims of criminal sanctions as identified by the LRC include punishment, deterrence, reform and rehabilitation, and reparation. These form the basis of its analysis of presumptive sentencing in drug offences. The Criminal Justice Act 1999 created a new offence of possessing controlled drugs having a value of £10,000 (€13,000) or more for sale or supply, which attracted a presumptive sentence of 10 years' imprisonment, except where there were 'exceptional and specific circumstances' relating to the offence, or to the person convicted of the offence (p.101). According to the LRC, the changes introduced in this legislation 'marked an important turning point in the Irish sentencing regime which had until 1999 - with the exception of the sentences for

murder and capital murder - accorded primacy to judicial discretion in the determination of sentences' (p.102). This occurred 'against a backdrop of an escalating drug problem and a growing realisation that Ireland had become a portal not only to the Irish drugs market but also to the British and European drugs markets' (p.102).

In the years immediately following these provisions however, the courts appeared resistant to allowing their discretion to be eroded in this way. The LRC paper cites a Department of Justice report on judicial sentencing practices for drug offences under section 15A,² which concluded that 'the courts showed a marked reluctance to impose the mandatory minimum sentence ... for fear that it would result in a disproportionate sentence in individual cases' (p.105). That research found that, out of 55 cases between November 1999 and May 2001, a sentence of 10 years or more had been imposed in only three cases.

The LRC also suggests that further legislation was introduced to address this 'apparent rift which had developed between legislative intent and judicial execution' (p.102). Introducing

Mandatory minimum sentencing (*continued*)

the Criminal Justice Bill 2004, the Government announced that it would be making a series of legislative amendments in order to strengthen the presumptive sentencing provisions for drug offences. In its final form, the Criminal Justice Act 2006 created a new offence of importing drugs having a value of €13,000, which would attract a minimum sentence of 10 years. In addition, it introduced provisions to oblige the court to consider evidence of previous drug trafficking provisions. It also clarified that the *mens rea*³ regarding the value of the drugs was not an element of the offence. Consequently, 'the prosecution needed only to establish that the accused knew that he or she was in possession of drugs with intent to supply and not that he or she knew the value of the drugs involved.' During the committee stages of the Criminal Justice Bill, the then Minister for Justice, Michael McDowell TD, alluded to the apparent rift between the intentions of the Oireachtas and the practice in the courts at that time:

By enacting the 1999 Act, the Oireachtas gave a clear statement to the Judiciary that convictions for drug offences involving the sale or supply of substantial quantities of drugs should attract significant custodial sentences. ...[T]he wishes of the Oireachtas have not been reflected in practice. For the first five years of its operation, the mandatory minimum sentence was applied in only 6% of convictions. (p.107).

The Minister concluded by noting that for the year 2004, 'after public controversy grew, the figure was approximately 21%' (p.107). Clearly, the changes made had the desired effect for the Government.

The LRC however, following a lengthy consideration of the way in which the various components of the sentence have been adjudicated in practice in the courts, highlights a number of criticisms of the presumptive sentencing regime.⁴ As a consequence of the constraints it places on the exercise of judicial discretion, the LRC suggests that the regime has created 'a discriminatory system of sentencing where all cases are treated alike regardless of differences in the individual circumstances of the offenders' (p.189). The LRC also refers to an assertion that the sentence is akin to a 'one-strike rule' (p.131). In this regard the LRC refers to the observation of one sentencing expert⁵ that 'by contrast to the "three strikes" laws enacted in some US states', the Irish regime 'does not require the accused to have a previous conviction for drug dealing or anything else before the presumptive minimum may apply' (p.131).

The LRC also states, 'it has been observed that the majority of those being caught for offences under section 15A are drug couriers rather than drug "barons"'. Those at the higher levels of the drugs trade have simply adapted to the sentencing regime by using expendable couriers or 'victims of circumstance', such as 'impoverished individuals from African countries or underprivileged Irish citizens' to hold and transport drugs thus avoiding detection themselves (p.132). The regime has also, the LRC concludes, subverted the normal criminal process by leading accused people to plead guilty simply to avoid the sentence, rather than testing the prosecution case.⁶

In recommending a review of the sentencing regime, the LRC states that the legislation has merely led to a 'bulge in the prison system comprising low-level drugs offenders' serving lengthy prison sentences, and that it has not contributed to any reduction in levels of criminality (p.189).

(Johnny Connolly)

1. Law Reform Commission (2011) *Consultation paper: mandatory sentences*. Dublin: Law Reform Commission. www.lawreform.ie. The LRC uses the term presumptive as distinct from mandatory sentence in that there is a presumption that the sentence would apply unless the court deems otherwise in a specific case. The LRC distinguishes such sentences from mandatory life sentences for murder treason or capital murder, for example. See discussion on p.3 of the LRC paper.
2. McEvoy P (2005) *Research for the Department of Justice on the criteria applied by the courts in sentencing under section 15A of the Misuse of Drugs Act 1977 (as amended)*. Dublin: Department of Justice, Equality and Law Reform. www.inis.gov.ie/en/JELR/Research.pdf/Files/Research.pdf
3. A fundamental principle of criminal law is that a crime consists of both a mental and a physical element. *Mens rea*, a person's awareness of the fact that his or her conduct is criminal, is the mental element, and *actus reus*, the act itself, is the physical element.
4. A recent Supreme Court decision, in the case of DPP v. Connolly (2011) IESC 6, overturned a 10-year sentence because of concerns about the way in which the market value of a drug seizure was determined. See Connolly J (2011) Supreme Court overturns mandatory drug sentence. *Drugnet Ireland*, (38): 15.
5. O'Malley T (2006) *Sentencing law and practice*. 2nd edition. Dublin: Round Hall. p. 340.
6. See discussion on p.119 of the LRC paper. The McEvoy study referred to above found that the accused pleaded guilty in all but one of the 55 cases studied. McEvoy suggests that the 'the consequences of unsuccessfully testing the prosecution case...are so severe, it would seem that one of the practical effects of the section has been to discourage the vast majority of accused persons from proceeding to trial...'

In brief

In April 2011 the **National Review Panel** set up to undertake reviews in accordance with *Guidance for the HSE on for the review of serious deaths including deaths of children in care* completed its first annual report, for March to December 2010. During this period, 22 cases of death were notified and eight serious incidents. Of the 22 deaths reported, four were drug overdoses. www.hse.ie/eng/services/Publications/services/Children/natreviewpanelannualreport2010.pdf

On 6 September 2011 the **European Parliament** adopted a resolution on an **EU homelessness strategy (B7-0475/2011)** in which, among other things, it urged member states to make progress towards the goal of ending street homelessness by 2015; called for the development of an ambitious, integrated EU strategy, underpinned by national and regional strategies, with the long-term aim of ending homelessness within the broader social inclusion framework; called for a framework, agreed by the European Commission and member states, for monitoring the development of national and regional homelessness strategies, as a central element of the EU homelessness strategy and for this monitoring framework to address the progress of the member states towards ending street homelessness and ending long-term homelessness. www.europarl.europa.eu/sides/getDoc.do?type=MOTION&reference=B7-2011-0475&language=EN
www.feantsa.org/code/en/hp.asp

On 20 September 2011 places on the **Community Employment scheme** that are ring-fenced for people being rehabilitated from drugs were the subject of a written Parliamentary Question, to which the Minister for Social Protection, Joan Burton TD, responded: 'These 1,000 community employment places are ring-fenced for persons undergoing rehabilitation from drug addiction. Specific criteria exist for these places and the eligibility for participation. These were revised and agreed with the sector in 2010/2011. Further work is under way in the context of the National Drug Rehabilitation Implementation Committee to review the allocation of these places and ensure that appropriate referral protocols are in place. Participants can be in specific drug response projects or may be in 'mainstream' community employment projects. It is my intention to ensure the continuation of such projects subject to the overall budgetary constraints for the community employment programme.'
debates.oireachtas.ie/dail/2011/09/20/00177.asp

Between 10 and 12 October 2011 the **Civil Society Forum on Drugs**, organised by the European Commission, met for the 6th year in succession in Brussels. The main objective of the meeting was to make recommendations to feed into the debate around the new EU Drugs Strategy. The European Commission has accorded the Civil Society Forum on Drugs the status of a European Commission 'expert group', i.e. a consultative entity that provides advice and expertise to the Commission and its services. ec.europa.eu/justice/anti-drugs/civil-society/index_en.htm

On 12 October 2011 the **European Centre for Disease Prevention and Control (ECDC)** and the **European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)** co-published *Prevention and control of infectious diseases among people who inject drugs*. It outlines seven interventions to reduce and prevent infectious diseases among people who inject drugs, ranging from the supply

of injection equipment, testing and vaccination to the treatment of infections and drug dependence. The ECDC–EMCDDA joint publication is published together with a 'Guidance in brief' summary and with two technical reports providing a full assessment of the evidence. www.ecdc.europa.eu
www.emcdda.europa.eu

On 16 November 2011 the **National Drugs Strategy 2009–2016** was the subject of a 'topical issue debate' in Dáil Éireann, in the course of which Minister for Health, Dr James Reilly TD, stated: 'The Government is committed to dealing with the scourge of drugs in our community. ... Of course, the war on drugs will continue, with the involvement of law-enforcement and customs officers. We will endeavour to have more effective treatments. I am not happy with the numbers of people who come off methadone and I am reviewing that situation. I certainly want it reflected in any new contracts given to doctors who are treating people currently on methadone.'
debates.oireachtas.ie/dail/2011/11/16/00031.asp

On 17 November 2011 the **Global Initiative for Drug Policy Reform** was launched at the House of Lords in London. It brings together countries interested in reform, countries who have successfully implemented alternative drug control strategies, and the Global Commission on Drug Policy, in order to discuss new evidence and reports commissioned by the Beckley Foundation, towards the goal of reforming global drug policy, including amendments to the UN Conventions. www.reformdrugpolicy.com

On 22 November 2011 *Growing up in Northern Ireland* by Sheena McGrellis was published. It examines the lives of 18 young people growing up in (and sometimes leaving) Northern Ireland between 1990 and 2010. The stories of two young women, Cynthia and Adele, among others, show how they experienced and negotiated various types and levels of risk. Living in areas where paramilitaries continued to exercise a level of control even after the ceasefires, and where sectarian attitudes were openly displayed, affected the life journeys of both young women. A growing drugs culture and a culture of binge drinking, fuelled by the energy of an expanding night-time economy, compounded the perception, and reality, of risk for many in this generation of young people. www.jrf.org.uk/publications/growing-up-northern-ireland

On 15 December 2011, **local and regional drugs task forces** were the subject of a written Parliamentary Question from Catherine Byrne TD, to which the Minister of State at the Department of Health, Róisín Shortall TD, replied: 'With a view to strengthening their effectiveness, I have initiated a review of Drugs Task Forces and the National Drugs Strategy structures under which they operate. In this regard, I have consulted with the key stakeholders on the future direction and role of Drugs Task Forces and this will inform the development of reforms in this area. The recommendations of a Steering Group on a National Substance Misuse Strategy will be published in the New Year. Proposals in regard to a Strategy are likely to be considered by Government in the Spring and any consequences for Drugs Task Forces arising from these will be considered at that stage.'
debates.oireachtas.ie/dail/2011/12/15/00259.asp

(Compiled by Brigid Pike)

From Drugnet Europe

Best practice portal: bridging the gap

Article by Marina Davili and Marica Ferri in *Drugnet Europe*, No. 77, January–March 2012

One of the added values of the EMCDDA's Best practice portal (www.emcdda.europa.eu/best-practice) is the synthesis of available evidence on the effects of drug demand reduction interventions. Having developed a systematic process for updating and grading the quality of evidence in the portal, the EMCDDA will take another step forward in 2012, with a new project to identify knowledge gaps and highlight topics for further investigation in this area.

This 'gap-analysis project' will proactively garner unanswered questions arising from the day-to-day experiences of decision-makers, practitioners and clients. It will also identify topics for the development of guidelines. The project, which is now in its protocol phase, encompasses a literature review and exploratory interviews with individual practitioners and clients from across Europe. The project will result in a structured overview of available information and recommendations for bridging the identified gaps. Preliminary results will be presented to the EMCDDA Scientific Committee in May.

Enhancing EMCDDA–ESPAD cooperation

Cited from article by Deborah Olszewski in *Drugnet Europe*, No. 77, January–March 2012

The EMCDDA and the European School Survey Project on Alcohol and Other Drugs (ESPAD) are scaling up their cooperation in monitoring substance use among 15- to 16-year-old school students. Their commitment was underlined in a joint statement adopted at the 2011 ESPAD project meeting, hosted by the EMCDDA in Lisbon (www.emcdda.europa.eu/about/partners/espad)

ESPAD data provide crucial information on substance use among school students of this age and are routinely included in the EMCDDA's annual reporting on the drug situation in Europe. In the statement, the partners agreed to boost technical cooperation to enhance understanding of long-term drug use trends in Europe. ... Among others, they agreed to: develop an enhanced dissemination strategy for ESPAD findings and work together to ensure harmonisation of methods and support methodological developments. In 2012, the partners will be collaborating, for the second time, in a joint multilingual publishing project to disseminate the key results of the latest ESPAD survey (2011). This summary, in 23 languages, is scheduled to be released before summer.

First European quality standards to improve drug prevention in the EU

Cited from article by Gregor Burkhart in *Drugnet Europe*, No. 77, January–March 2012

Developing and implementing best practice in drug prevention in Europe are goals set by the current EU drug strategy and action plan. In line with these goals, ... [a new EMCDDA] manual is the culmination of a two-year project to assess existing guidance in this area and to meet the need for a commonly agreed European framework to improve drug prevention in the EU. ... Bridging science, policy and practice, over 400 international, European and national experts and stakeholders contributed to developing the standards via a dynamic process involving focus groups, consultations and studies. www.emcdda.europa.eu/publications/manuals/prevention-standards

EMCDDA launches new multicity project

Cited from article by Liesbeth Vandam and Ana Gallegos in *Drugnet Europe*, No. 77, January–March 2012

The EMCDDA has recently launched a multicity 'demonstration project' to investigate the potential of wastewater analysis as an indicator for estimating community drug use levels (www.emcdda.europa.eu/wastewater-analysis). By the end of 2012, the project will have generated comparable data from at least 15 European cities, thanks to an agreed common sampling approach designed to ensure maximum comparability. ... By sampling a known source of wastewater – for example, a sewage influent to a wastewater treatment plant – scientists can now obtain estimates of the total quantity of drugs consumed by a community by measuring the levels of illicit drug metabolites excreted in urine. This demonstration project will provide comparable information in real time on weekly patterns of use, trends and changing consumption habits in the participating cities.

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.

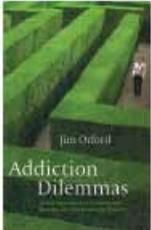
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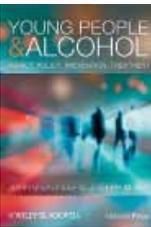
On our shelves

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



Addiction dilemmas: family experiences in literature and research and their lessons for practice

by Jim Orford
Wiley-Blackwell (2012)
ISBN: 978-0-470-97701-9



Young people and alcohol: impact, policy, prevention, treatment

by John Saunders and Joseph Rey (eds)
Wiley-Blackwell (2011)
ISBN: 978-1-444-33598-9

Journal articles

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

[Regional drug user services in times of scarce financial resources: using a rapid assessment response approach to evaluate, plan, and prioritize essential services](#)

Comiskey C, O'Sullivan K and Milnes J
Substance Use and Misuse, 2012, 47(3): 254–264.
www.drugsandalcohol.ie/16502

The objective was to assess need, evaluate projects, and devise a roadmap for future provision given budget cuts. The analysis of 30 substance misuse services in towns and rural areas of Ireland was conducted in 2010. Analysis revealed that 24,315 (95% CI 12,928–40,629) individuals were using illegal drugs in 2006, 893 individuals were using opiates, opiate and cocaine use was increasing as was drug use amongst females. Evaluations demonstrated that not all services were meeting emerging needs, services lacked administrative support, and funding needed to be redirected. The RAR approach was useful for policy decisions and budget cuts in times of economic restraint.

[Prevalence of substance misuse comorbidity in an Irish university training hospital](#)

Dixit A and Payne A
Irish Journal of Psychological Medicine, 2011, 28(4): 201–204.
www.drugsandalcohol.ie/16477

Objective: Substance misuse complicates an individual's management in adult mental health services. This study aimed to examine both the overall prevalence of substance misuse in those admitted to the psychiatric unit and additionally those admitted with a primary diagnosis and comorbid substance misuse. The study focuses on the associated diagnoses and demographics in 100 consecutive admissions to an acute psychiatric unit in an Irish university hospital.

Results: The combined prevalence of mental illness and

substance misuse was 47%. Twenty-two out of 100 (22%) were admitted primarily for the management of substance misuse and dependence (plus psychosocial reasons). Twenty-five of the patients admitted with a primary psychiatric illness (25%) were discovered to have comorbid substance misuse. At risk groups were found to be males and aged under 45 years.

Conclusion: Our study demonstrates the importance of screening and identification for substance misuse in psychiatric inpatient units; and consequently, the need for individual case management, additional development of dual diagnosis services and accurate patient data reporting to facilitate forward service-planning.

[‘A costly turn on’: patterns of use and perceived consequences of mephedrone based head shop products amongst Irish injectors](#)

Van Hout MC and Bingham T
International Journal of Drug Policy, 2012, 16 Feb; Early online.
www.drugsandalcohol.ie/17066

Mephedrone injecting has recently been reported in Romania, Slovenia, Guernsey and Ireland. This research aimed to describe the experiences of a group of Irish injecting drug users who were injecting mephedrone-based head shop products prior to the introduction of legislative controls in Ireland, with particular focus on pre- and post-legislation use, effects, settings and contexts for injecting, polydrug use and serial drug injecting, risk perceptions and harm-reduction practices.

Conclusion: Continued monitoring of drug displacement patterns in post legislative time frames is advised, alongside longitudinal ethnographic research to track the diffusion of mephedrone and other cathinone derivatives within injecting networks. Further investigation of the adverse health consequences of these drugs on injection is warranted.

[Cannabis use: What's law got to do with it? Perceptions and knowledge of cannabis policy from the user perspective in Northern Ireland](#)

Stevenson C
Drugs: education, prevention and policy, 19(2): 129–136.
www.drugsandalcohol.ie/17069

The aim of this article was to examine attitudes to cannabis policy among adults who use the drug in Northern Ireland, and to consider these opinions in the context of the UK generally and draw parallels with other regions. Data were collected through semi-structured interviews with 38 adults aged 18–59 with a range of levels of cannabis experience. The results showed that people who used cannabis were generally unaware of and unconcerned about legal penalties.

Conclusion: Cannabis users tend to consume the drug irrespective of policy. The reclassification of cannabis resulted in confusion as to what the penalties were, users continued to use cannabis irrespective of the law prior to and following reclassification and they felt that policy was irrelevant to use.

[Reducing the harm from adolescent alcohol consumption: results from an adapted version of SHAHRP in Northern Ireland](#)

McKay MT, McBride N and Sumnall H
Journal of Substance Use, 2012, 8 Feb; Early online.
www.drugsandalcohol.ie/17020

The study aimed to trial an adapted version of the School Health and Alcohol Harm Reduction Project (SHAHRP) in Northern Ireland. The intervention aims to enhance alcohol related knowledge, create more healthy alcohol-related attitudes and reduce alcohol-related harms in 14–16-year-olds.

Method: A non-randomised control longitudinal design with intervention and control groups assessed post-primary students at baseline and at 12, 24 and 32 months after baseline. A total of 2,349 participants was recruited at baseline (mean age 13.84) with an attrition rate of 12.8% at 32-month follow-up. The intervention was an adapted, culturally competent version of SHAHRP, a curriculum programme delivered in two consecutive academic years, with an explicit harm reduction goal. Knowledge, attitudes, alcohol consumption, context of use, harm associated with own alcohol use and the alcohol use of other people were assessed at all time points.

Results: There were significant intervention effects on all measures (intervention vs. controls) with differential effects observed for teacher-delivered and outside facilitator delivered SHAHRP.

Conclusion: The study provides evidence of the cultural applicability of SHAHRP for risky drinking in adolescents in a UK context.

Increased incidence of QT interval prolongation in a population receiving lower doses of methadone maintenance therapy

Roy AK, McCarthy C, Kiernan G *et al.*
Addiction, 2011, December 11, Early online.
www.drugsandalcohol.ie/16656

The aim of the study was to investigate the frequency of corrected QT interval (QTc) prolongation in a methadone maintenance therapy (MMT) population, and to examine potential associations between this QTc interval and methadone dose as well as concurrent use of opiates, cocaine, and benzodiazepines.

Conclusions: Drug-induced QTc interval prolongation is evident (ranging from 8.8-11.1%, depending on definition applied) in patients receiving relatively low daily doses of methadone therapy, with no evidence of a dose-response relationships. The presence of cocaine metabolites in urine does not appear to be associated with increased QTc-interval. Increased awareness of cardiac safety guidelines, including relevant clinical and family history, baseline, and trough dose ECG monitoring, should be incorporated into methadone maintenance therapy protocols.

Upcoming events

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

May

25–27 May 2012

Europad 10th International Conference – Heroin addiction and related clinical problems

Venue: Barcelona, Spain

Organised by / Contact: Europad

Email: giusi@tigicongress.com

Web: www.europad.org

Information: The mission of Europad has always been to promote information exchange and updating within the scientific community, but also to spread an illness-centred conception of addictive disorders, with heroin addiction as a long-dating prototype. Separate symposia at this conference will be dedicated to a bunch of ‘hot’ topics: drug-related morbidity and mortality, treatment of special populations, cost-benefit issue. This year, a whole session will concern the issue of long-term discontinuation of successful treatment: speakers will deal with the issue of ‘leaving’ treatment and of the viability of patient-suggested discontinuation in the long-term.

30–31 May 2012

Sixth Annual Conference of the International Society for the Study of Drug Policy

Venue: Cathedral Lodge, Canterbury

Organised by / Contact: ISSDP

Web: www.issdp.org/conferences.php

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Information: This event will be hosted by the University of Kent (School of Social Policy, Sociology and Social Research). The call for abstracts is now open. For details, please see ISSDP website. The invited keynote speakers are:

Professor Thomas McLellan, University of Pennsylvania (formerly Deputy Director of the US Office for National Drug Control Policy)

Dr Michel Kazatchkine, Executive Director of the Global Fund and member of the Global Commission on Drug Policy.

Dr Fiona Measham, University of Lancaster and member of the UK Advisory Council on the Misuse of Drugs

Martin Jelsma, Transnational Institute

The conference will discuss a wide range of drug policy issues, with a particular focus on ‘how can and do empirical studies influence drug policy?’

June

8 June 2012

**Poppy Love: Opioid use and abuse
11th CARES Conference**

Venue: Dundee, Scotland

Organised by/ Contact: Dundee Medical School

Email: s.a.marr@dunde.ac.uk

Web: www.dundee.ac.uk/medschool/medsci/neuroscience/cares/conferences

Information: Methadone substitution represents the dominant, albeit controversial, treatment intervention for a substantial number of people who use illicit heroin. Presently, this programme serves a clearly articulated public health and criminal justice-driven agenda. There is, however, an implicit assumption that chronic exposure to opioids is ‘safe’ or at least ‘safer’ than any other alternatives. This international conference will allow leading experts in the field to articulate the evidence from recent research findings, bridge these findings to clinical settings and provide alternative modes of treatment.