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assist staff in managing potential problems identified with the total smoking ban could play an important role in bringing about this change. Staff who are smokers may particularly need support during the implementation of the total smoking ban from July 2008. It would also be interesting to study staff attitudes after implementation of the total smoking ban and the effects of the ban on service users' mental and physical health.

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Declaration of interest

None.

References

- COULTHARD, M., FARRELL, M., SINGLETON, N., et al (2002) *Tobacco, Alcohol and Drug Use and Mental Health*. TSO (The Stationery Office).
- DEPARTMENT OF HEALTH (2004) *Choosing Health: Making Healthier Choices Easier*. Department of Health.
- GUBBAY, J. (1992) *Smoking and the Workplace*. Centre for Health Policy Research, University of East Anglia.
- JOCHELSON, K. & MAJROWSKI, W. (2006) *Clearing the Air: Debating Smoke-Free Policies in Psychiatric Units*. King's Fund.
- KELLY, C. & McCREADIE, R. G. (1999) Smoking habits, current symptoms and pre-morbid characteristics patients in Nithsdale, Scotland. *American Journal of Psychiatry*, **179**, 498–502.
- LAWN, S. & POLS, R. (2005) Smoking bans in psychiatric in-patient settings? A review of the research. *Australian and New Zealand Journal of Psychiatry*, **39**, 866–885.
- McCREADIE, R. G. (2003) Diet, smoking and cardiovascular risk in people with schizophrenia. Descriptive study. *British Journal of Psychiatry*, **183**, 534–539.
- MELTZER, H., GILL, B., HINDS, K., et al (1996) *OPCS Surveys of Psychiatric Morbidity in Great Britain. Report 6: Economic Activity and Social Functioning of Residents with Psychiatric Disorders*. HMSO.
- MESTER., R., TOREN, P., BEN-MOSHE, Y., et al (1993) Survey of smoking habits and attitudes of patients and staff in psychiatric hospitals. *Psychopathology*, **26**, 69–75.
- OFFICE OF PUBLIC SECTOR INFORMATION (2007) *The Smoke-Free (Exemptions and Vehicles) Regulations 2007*. Office of Public Sector Information (http://www.opsi.gov.uk/si/si2007/uksi_20070765_en_1).
- RICKARDS, L., FOX, K., ROBERTS, C., et al (2004) *Living in Britain No. 31 Results from the 2002 General Household Survey*. TSO (The Stationery Office).
- STUBBS, J., HAW, C. & GARNER, L. (2004) Survey of staff attitudes to smoking in a large psychiatric hospital. *Psychiatric Bulletin*, **28**, 204–207.
- TARBUCK, P. (1996) Smoking with patients. Policy vs. therapy. *British Journal of Nursing*, **5**, 224–29.

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MPHO ABEL THULA

Cocaine use and dependence in clients attending a drug treatment centre in Dublin

AIMS AND METHOD

To assess the number of cocaine-dependent clients attending a typical addiction clinic, using urine drug testing for screening and a structured clinical interview for diagnostic assessment.

RESULTS

Of the 419 clients whose urine records were analysed, 38 were regular users of cocaine (9.1%), with

at least half of their urine samples positive for cocaine in a 12-week period; 84.2% of these regular users of cocaine satisfied the criteria for cocaine dependence (7.7% of the total number of those attending the clinic).

CLINICAL IMPLICATIONS

Publicly funded addiction treatment centres in Ireland are mostly designed

for the treatment of opiate addiction. There is, however, a significant problem of concomitant cocaine dependence in these centres. Increased availability of psychological/behavioural treatment programmes with proven efficacy in cocaine addiction may help improve overall treatment outcome.

The Drug Treatment Centre Board in Dublin runs the largest substance misuse treatment centre in Ireland, with over 500 clients from all over Dublin registered with the clinic. The vast majority are on substitution treatment for opiate dependence. However, cocaine use is increasingly becoming a major problem in this group as the use of the drug in the country continues to increase. In January 2008, a report by the National Advisory Committee on Drugs, and the Drug and Alcohol Information and

Research Unit noted a significant increase in lifetime cocaine prevalence rates among all adults (15–64 years of age) in Ireland, from 2.5% in 2002/2003 to 5.1% 2006/2007 (National Advisory Committee on Drugs, 2008). In a national multi-site evaluation in the USA (Hubbard et al, 1997), cocaine misuse was found in 42% of those beginning treatment with methadone and in 22% of the same group at 1-year follow-up. Cocaine misuse during opioid maintenance treatment has been associated with poor



treatment outcome (DeMaria *et al*, 2000); a high risk of HIV infection (Bux *et al*, 1995); higher levels of family, medical, vocational and legal problems; and continued focus on drug-related criminal activity (Kosten *et al*, 1987). Clients with cocaine dependence also have a greater risk of suicidal behaviour (Marzuk *et al*, 1982).

The aim of the study was to quantify the number of regular users of cocaine in the treatment centre, using a cut-off point of half weekly urine samples testing cocaine positive in a 12-week period. The study also sought to find out what proportion of this cohort of regular users fulfil dependence criteria as assessed by the Structured Clinical Interview for DSM–IV Axis I disorders (SCID–I) (First *et al*, 2002).

Method

Participants

Using the database from the clinic laboratory, information was obtained about urine drug test results for all clients attending the drug treatment centre over a 12-week period between 7 August and 30 October 2007 (clients are required to submit a urine sample for drug analysis once a week as part of the treatment programme). The results were then analysed to find the number of clients whose urine samples tested positive for cocaine in more than 50% of cases. Only those who provided more than four samples over the period of analysis and had provided a sample within 3 weeks of the commencement date of the study were selected for further assessment. All eligible candidates provided written voluntary consent for involvement in the study. The study and all its procedures were approved by the drug treatment centre board ethics committee.

Diagnostic measures

Participants fulfilling the study criteria were assessed for cocaine dependence using SCID–I. The assessment was carried out by a psychiatrist.

Results

Participants

The data from the laboratory showed that 419 clients had submitted a minimum of four urine samples for drug testing in the 12-week period, of which 38 (9.1%) met the inclusion criteria of at least half for cocaine positive samples in this period.

Of the 38 candidates who were eligible for assessment for cocaine dependence, 2 did not give their consent to participate in the assessment (5.3%) and 3 (7.9%) could not be assessed for other reasons (1 was in prison, 1 had since stopped attending the clinic and 1 had a very poor attendance record). Therefore, 33 of the eligible candidates were assessed for cocaine dependence. The flow of candidates through the study up to the assessment stage is presented in Fig. 1.

Outcomes

Of the candidates who were assessed using SCID–I, 32 satisfied the criteria for cocaine dependence and 1 did not (Table 1). Therefore, 84.2% of all eligible candidates satisfied the DSM–IV criteria for dependence and 2.6% did not. Of the 32 candidates who satisfied the DSM–IV criteria for dependence, 3 (9%) did not meet the criteria in the last month before the diagnostic assessment; 25 (86%) of those who met the criteria for cocaine

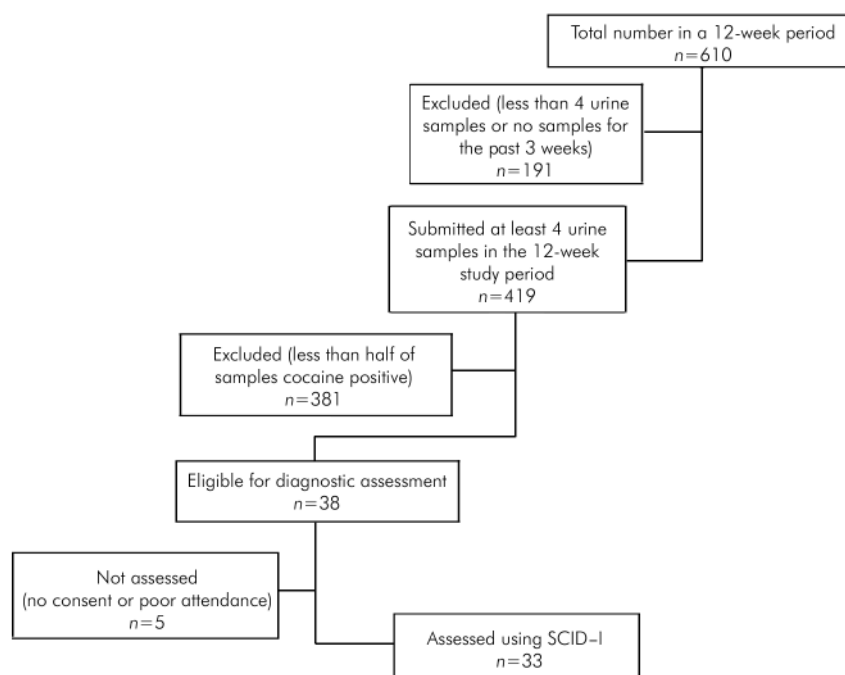


Fig. 1. Study profile.

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Table 1. Results of the SCID-I assessment

Gender	Current cocaine dependence, <i>n</i>	Cocaine dependence, but not in month before assessment, <i>n</i>	No cocaine dependence, <i>n</i>	Total, <i>n</i>
Male	21	3	1	25
Female	8	0	0	8
Total	29	3	1	33

SCID-I, Structured Clinical Interview for DSM-IV Axis I Disorders.

dependence in the previous month had physiological dependence to the drug.

Discussion

The study aimed to assess the extent of cocaine dependence among clients attending treatment for opiate addiction. The results showed that 9.1% of clients attending an opiate dependence treatment clinic were regular users of cocaine and 84.2% of these satisfied the DSM-IV criteria for cocaine dependence as assessed by SCID-I. In total, 7.7% of clients attending the clinic had cocaine dependence. This compares well with previous studies of cocaine dependence in this population group, where 9% of daily cocaine misuse was found in patients 6 months after admission into methadone maintenance treatment, falling to 6% after 12 months (Dobler-Mikola *et al*, 2005). Although most available data tend to quote cocaine use and cocaine misuse, this study set out to find the rates of cocaine dependence in a chosen population group.

The 2007 report from the National Advisory Committee on Drugs in Ireland noted that treatment programmes in Ireland are not designed for stimulant users and that opiate-based treatment services have to deal with increasing numbers of individuals presenting with cocaine-related problems (National Advisory Committee on Drugs, 2007). Cocaine use is higher among individuals with opiate dependence in maintenance treatment than among the general population (Haasen *et al*, 2004). Although effective substitution pharmacological treatment is available for opiate dependence, there is no similarly effective intervention for primary cocaine dependence (de Lima *et al*, 2002). However, psychosocial interventions, mainly contingency management and cognitive-behavioural approaches, have been effective in the management of cocaine addiction (Rawson *et al*, 2002).

Drug treatment programmes focusing mainly on opiate addiction need to adapt so that they can deal with increasing numbers of cocaine users (National Advisory Committee on Drugs, 2007). This will require resources and training in non-pharmacological approaches that have been shown to be effective in treating cocaine addiction.

Limitations

The sample of those who were eligible for assessment was quite small. Of the 38 clients eligible for diagnostic

assessment, 5 (13%) could not be assessed, which could have affected the outcome. At any given time, patients who fail to stabilise on opiate agonist maintenance are placed on a low-dose regime for a defined period of time as part of contingency management and do not have to provide urine samples. Therefore, they would not be included in this study. This group tend to be more likely to be misusing cocaine as well as opiates. Excluding this group could have underestimated the prevalence of cocaine dependence in the clinic.

Diagnostic assessment was carried out by one individual which could have resulted in bias.

Despite the limitations of the study, the results show that there is a significant cocaine dependence problem among clients attending opiate treatment centres. Appropriate services need to be put in place to address this.

Declaration of interest

None.

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References

- BUX, D. A., LAMB, R. J. & IGUCHI, M. Y. (1995) Cocaine use and HIV risk behavior in methadone maintenance patients. *Drug and Alcohol Dependence*, **37**, 29–35.
- DE LIMA, M. S., DE OLIVEIRA SOARES, B. G., REISSER, A. A., *et al* (2002) Pharmacological treatment of cocaine dependence: a systematic review. *Addiction*, **97**, 931–949.
- DEMARIA, P. A. JR., STERLING, R. & WEINSTEIN, S. P. (2000) The effect of stimulant and sedative use on treatment outcome of patients admitted to methadone maintenance treatment. *American Journal of Addictions*, **9**, 145–153.
- DOBLER-MIKOLA, A., HÄTTENSCHWILLER, J., MEILI, D., *et al* (2005) Patterns of heroin, cocaine and alcohol abuse during long-term methadone maintenance treatment. *Journal of Substance Abuse Treatment*, **29**, 259–265.
- FIRST, M. B., SPITZER, R. L., GIBBON, M., *et al* (2002) *Structured Clinical Interview for DSM-IV-TR Axis I Disorders (research version, patient edition)*. Biometric Research, New York Psychiatric Institute.
- HAASEN, C., PRINZLEVE, M., ZURHOLD, H., *et al* (2004) Cocaine use in Europe: a multi-centre study. *European Addiction Research*, **10**, 139–146.
- HUBBARD, R. L., CRADDOCK, S. G., FLYNN, P. M., *et al* (1997) Overview of



1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, **11**, 261–278.

KOSTEN, T. R., ROUNSAVILLE, B. J. & KLEBER, H. D. (1987) A 2.5-year follow-up of cocaine use among treated opioid addicts: have our treatments helped? *Archives of General Psychiatry*, **44**, 281–284.

MARZUK, P. M., TARDIFF, K., LEON, A. C., et al (1982) Prevalence of cocaine use among residents of New York City who committed suicide during a one-year period. *American Journal of Psychiatry*, **149**, 371–375.

NATIONAL ADVISORY COMMITTEE ON DRUGS (2007) *An Overview of Cocaine Use in Ireland II*. The Stationery Office Dublin.

NATIONAL ADVISORY COMMITTEE ON DRUGS & THE DRUG AND ALCOHOL INFORMATION AND RESEARCH UNIT (2008) *Drug Use in Ireland and Northern Ireland: First Results from the 2006/2007 Drug Prevalence Survey*. NACD.

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RAWSON, R. A., HUBER, A., McCANN, M. J., et al (2002) A comparison of contingency management and cognitive-behavioral approaches during methadone maintenance treatment for cocaine dependence. *Archives of General Psychiatry*, **59**, 817–824.

Psychiatric Bulletin (2009), **33**, 91–95. doi: 10.1192/pb.bp.107.017392

WALID K. ABDUL-HAMID, KELLY LEWIS-COLE, FRANK HOLLOWAY AND MARISA SILVERMAN

Older people with enduring mental illness: a needs assessment tool

AIMS AND METHOD

There is a lack of tools to assess the needs of older people with enduring mental illness who have 'graduated' from adult mental health services and little is known about this population. The Elderly Psychiatric Needs Schedule (EPNS) was developed and applied to older people with enduring mental illness in

contact with the old age and general adult components of an inner-city mental health service.

RESULTS

The EPNS proved reliable (mean agreement 96%, mean Kappa $\kappa=0.90$). The mean number of needs identified was 7.6, of which 4.3 were unmet and 3.3 were met.

CLINICAL IMPLICATIONS

The EPNS provided a reliable method of needs assessment in this population. The authors offer the EPNS as a tool to assess service needs of older adults with functional psychiatric disorders having 'graduated' from adult mental health services.

In common with mental healthcare in general the provision of services for elderly people is shifting from in-patient treatment to the community (Gatz & Smyer, 1992; Campbell, 1994). There is evidence that functionally mentally ill, former long-stay elderly patients who are resettled into community provision do well (Holloway et al, 1994; Anderson & Treiman, 1995). However, less is known about the fate of those becoming 'older people with enduring mental illness' in contemporary community-oriented services (Abdul-Hamid et al, 1998). 'Graduate' is a term that describes people with severe psychiatric disorders who have graduated into old age (Arie & Jolly, 1982).

The pragmatic approach to needs for care assessment has informed the development of a series of needs assessment tools (Wykes et al, 1982; 1985, Brewin et al, 1987; 1988; Brugha et al, 1988; Abdul-Hamid, 1991; Marshall et al, 1995). The Camberwell Assessment of Need (CAN) was developed by Phelan et al (1995). It provides comprehensive needs assessment for adults and has been shown to be easy to use, valid and reliable. McWalter et al (1998) described the development and reliability and validity of the Care Needs Assessment Pack for Dementia (CARENAPD). There is, however, a lack of simple and effective tools to assess the needs of elderly people with a functional mental illness (older people with enduring mental illness). In the current study we report the development and application of such an assessment

tool to a population of older people with enduring mental illness.

Method

The aims of this study were to: determine the reliability and validity of a novel needs assessment method, the Elderly Psychiatric Needs Schedule (EPNS); to undertake a point prevalence survey of older people with enduring mental illness in contact with specialist mental health services (both generic and elderly); and to undertake a needs assessment of this population.

The study was carried out in Norwood, which had a total population of 41 740 and is an ethnically diverse and socially deprived part of inner London, of whom 5472 were over 65 years (1991 census). The study population included all people at or over the age of 60 with a functional mental illness who were in contact with the catchment area psychiatric services (both old age and general adult services) and who had an onset of illness before the age of 60.

Along with people who were over 65 years of age, a pre-elderly group of people who were 60–65 years of age were included since these 'pre-elderly group' people are likely to become older people with enduring mental illness within 5 years. Hospital medical notes of more than 300 Norwood patients who were at or over the age of 60 were reviewed and 77 older people with enduring