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New National Drug and Alcohol Strategy launched

PART 1

Reducing harm, supporting recovery: a health-led approach to drug and alcohol use in Ireland 2017–2025 was launched on 17 July 2017 by An Taoiseach Leo Varadkar, alongside the Minister for Health Simon Harris TD, and the Minister for Health Promotion and the National Drugs Strategy, Catherine Byrne TD.

A health-led approach

The strategy follows through on the commitment made by Government in May 2016 'to pursue a health-led rather than a criminal justice approach to drug use'.² At the launch of the strategy, all of the speakers emphasised the importance of this shift in approach.^{3,4,5} The Taoiseach said that 'treating substance abuse and drug addiction as a public health issue, rather than a criminal justice issue, helps individuals, helps families, and helps communities. It reduces crime because it rebuilds lives'.³ Compassion has been identified internationally as an 'essential ingredient'⁶ of a health-led approach to drug policy and is a recurring theme both in the strategy document and in what was said at the launch. In her speech, Minister Byrne said 'there is one word that runs like a thread throughout the strategy, and that word is "compassion" – compassion is the basis for a health-led approach to addiction'.⁴



Minister for Health Simon Harris TD, Minister of State for Health Promotion and the National Drugs Strategy Catherine Byrne TD and An Taoiseach, Leo Varadkar TD, at the launch of *Reducing harm, supporting recovery* in July

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In brief

The Government launched Ireland's third national drugs strategy in July. While there are a number of consistent themes linking all three strategies, the shift towards a health-led approach, already apparent in previous strategies, is explicitly made in *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*.

The values that the new strategy espouses, and particular actions that give these values expression in very concrete ways, moves Ireland towards the more progressive end of the spectrum internationally.¹ Another important development in terms of international comparisons is the description of *Reducing harm, supporting recovery* as the first integrated drug and alcohol strategy in Ireland. Policy coherence is an indicator used for international comparison and the new strategy would be seen in a different light from previous strategies in this context.²

These changes, in particular the willingness to examine the legislation relating to the criminal status of certain possession offences, reflect developments and debate in drug policy internationally. While human rights is only mentioned specifically once in the strategy document, the overall vision of the strategy, the values underpinning it and some specific actions would suggest that there is greater emphasis on human rights than in previous strategies.

The strategy's humanist values promote inclusion, fairness and participation, and also the use of evidence in policy development and implementation. The growth in the knowledge base since the beginning of the last strategy, and the increasing emphasis on evidence-informed decision-making internationally, makes an increasing and more consistent use of evidence more likely. Evidence-informed policy also implies that success will be measured by appropriate indicators. A recent EMCDDA report stated that 'evaluation is essential for effective policymaking, helping ensure that policies and programmes have the desired effect, provide value for money and do not have negative unintended consequences'.³ The strategy will use a number of key performance indicators, each of which will be supported by information systems providing the data, to give an accurate determination of performance.

It is probably in this respect that the *Reducing harm, supporting recovery* is most innovative. The performance measurement system developed to assess the response to problem substance use at a population level is both an evaluation instrument and a mechanism to enable funding to be allocated on a more equitable and rational basis. The successful implementation of this system during the lifetime of this strategy will be the clearest expression of its commitment to fairness, efficient use of resources and the use of evidence.

- 1 Pike B (2015) How does Ireland's drugs policy compare with others? *Drugnet Ireland*, 53: 4–5. <http://www.drugsandalcohol.ie/23687/>
- 2 Pompidou Group (2012) *Policy paper providing guidance to policy makers for developing coherent policies for licit and illicit drugs*. Strasbourg: Council of Europe. <http://www.drugsandalcohol.ie/17318/>
- 3 European Monitoring Centre for Drugs and Drug Addiction (2017) *Evaluating drug policy: a seven-step guide to support the commissioning and managing of evaluations*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/27536/>

New National Drug and Alcohol Strategy launched continued

Integrated drug and alcohol strategy

Reducing harm, supporting recovery is the first 'integrated' drug and alcohol strategy in Ireland. In his foreword to the strategy, the Taoiseach notes that 'many Irish people engage in harmful drinking patterns and alcohol has become a major drugs issue' (p. 3). While a Government commitment was made in 2009 to produce 'a combined National Substance Misuse Strategy to cover both alcohol and drugs' (p. 5),⁷ this did not happen. The new strategy takes account of what the Expert Review Group for the 2009–2016 strategy described as this 'elephant in the room' (p. 4)⁸ for Irish drug policy, i.e. alcohol. The strategy defines substance misuse as 'the harmful or hazardous use of psychoactive substances, including alcohol, illegal drugs and the abuse of prescription medicines' (p. 7).¹ There is an explicit commitment to ensuring 'an integrated public health approach to drugs and alcohol is delivered as a key priority' (p. 22). The strategy complements the Public Health (Alcohol) Bill and reinforces some of the key elements of the alcohol-focused National Substance Misuse Strategy from 2012.⁹ However, illicit drug use continues to be the primary focus of many of the actions of the new strategy from 2017 to 2020. It is not clear from the strategy and its accompanying action plan how the challenges of implementing such an integrated approach will be overcome.

Additional funding for 2017

At the launch, Minister for Health Simon Harris TD expressed the Government's commitment to 'making progress on the delivery of the actions in the strategy in the current year'.⁵ An additional €3 million was allocated to drug initiatives in Budget 2017 to:

- Commission 105 new treatment episodes from residential and rehabilitation services.
- Implement a pilot supervised injecting facility in Dublin City centre (expected to be open by the end of 2017).
- Support the phased increase from Q3 2017 in the availability of buprenorphine/naloxone treatment as an alternative treatment for the identified cohorts of patients for whom methadone treatment is not suitable.
- Fill gaps in addiction service provision for under 18-year-olds.
- Provide more detoxification places in community and residential settings in 2018.

Lucy Dillon

- 1 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 2 Government of Ireland (2016) *Programme for partnership government*. Dublin: Department of the Taoiseach. <http://www.drugsandalcohol.ie/25508/>
- 3 Varadkar L (2017) Speech by An Taoiseach Mr Leo Varadkar TD to launch *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. <http://www.drugsandalcohol.ie/27650/>
- 4 Byrne C (2017) Speech by Catherine Byrne TD, Minister of State for Health Promotion and the National Drugs Strategy at the launch of *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. <http://www.drugsandalcohol.ie/27651/>

- 5 Harris S (2017) Speech by Simon Harris TD, Minister for Health at the launch of *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. <http://www.drugsandalcohol.ie/27611/>
- 6 Pike B (2016) What's in a drugs strategy? *Drugnet Ireland*, 57: 10–11. <http://www.drugsandalcohol.ie/25490/>
- 7 Department of Community, Rural and Gaeltacht Affairs (2009) *National drugs strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. <http://www.drugsandalcohol.ie/12388/>
- 8 Griffiths P, Strang J and Singleton N (2016) *Rapid expert review of the national drugs strategy 2009–2016*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27289/>
- 9 Department of Health (2012) *Steering group report on a national substance misuse strategy*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/16908/>

PART 2

Structure of the new drugs strategy

The new strategy¹ indicates a departure from the pillar structure of the two previous drug strategies.² It is underpinned by a set of core values and is structured around a vision and five goals — each goal has a set of objectives, accompanying actions and performance indicators. While the structure has changed, its overall direction is very similar to previous strategies.

Vision and values of the new drugs strategy

Vision

The strategy's vision is for:

A healthier and safer Ireland, where public health and safety is protected and the harms caused to individual, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life.

Values

To deliver on this vision, the strategy is underpinned by six values:

- **Compassion:** A humane, compassionate approach focused on harm reduction which recognises that substance misuse is a healthcare issue.
- **Respect:** Respect for the right of each individual to receive person-centred care based on his or her specific needs and to be involved in the development of their care plan.
- **Equity:** A commitment to ensuring that people have access to high-quality services and support, regardless of where they live or who they are.
- **Inclusion:** Diversity is valued, the needs of particular groups are accommodated and wide-ranging participation is promoted.
- **Partnership:** Support for maintaining a partnership approach between statutory, community and voluntary bodies and wider society to address drug and alcohol issues.
- **Evidence-informed:** Support for the use of high-quality evidence to inform effective policies and actions to address drug and alcohol problems (p. 16).

New National Drug and Alcohol Strategy launched continued

Action plan

The strategy covers an eight-year period (2017–2025), and is accompanied by a shorter-term action plan (2017–2020). The previous seven-year strategy had actions set out for its duration from the start. A review of that strategy found that the actions could not be reactive to change in the drug situation over time, which contributed to an overall perception of a decline in the strategy's 'relevance and momentum' (p. 6)³ over its timeframe. At the launch of the strategy, the Taoiseach noted that having a new action plan from 2021 to 2025 'will ensure the continued relevance of the strategy until the end of its term'.⁴

Synergy with other strategies

A noticeable feature of the new strategy and its action plan is a synergy with other Government strategies and policies. To minimise duplication, the waste of scarce resources and to maximise the impact of strategies, the Expert Review Group on the 2009–2016 national drugs strategy emphasised the importance of having clear 'synergy and complementarity'³ (p. 31) between the new strategy and other related strategies. These include broad strategies such as Healthy Ireland and the Action Plan for Education 2016–2020, as well those that target the needs of specific groups, such as the National Traveller and Roma Inclusion Strategy 2016–2020. The enactment of the Public Health (Alcohol) Bill would be critical to delivering on a number of the alcohol elements of the strategy. In her foreword to the document, Minister Catherine Byrne TD described the Bill as 'a key step forward' (p. 4), and in the main body of the document it is described as containing 'the proposed legislative provisions to provide a public health response to issues associated with alcohol consumption in Ireland' (p. 20). However, it is not mentioned in the action plan.

Lucy Dillon

- 1 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 2 Department of Community, Rural and Gaeltacht Affairs (2009) *National drugs strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. <http://www.drugsandalcohol.ie/12388/>
- 3 Griffiths P, Strang J and Singleton N (2016) *Report of the rapid expert review of the national drugs strategy 2009–2016*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27289/>
- 4 Varadkar L (2017) Speech by An Taoiseach Mr Leo Varadkar TD to launch *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. <http://www.drugsandalcohol.ie/27650/>

PART 3

Goals of the drugs strategy

Five goals form the core of *Reducing harm, supporting recovery: a health-led approach to drug and alcohol use in Ireland 2017–2025*.¹ Broadly speaking, they cover similar themes to those in the previous strategy's pillars: prevention, treatment, rehabilitation, recovery, supply reduction, research and evidence. Goal 4 reflects an increased focus on supporting

the participation of individuals, families and communities in responding to the drug situation. Below are brief descriptions of each goal, its objectives, and elements of the 50 accompanying actions.

Goal 1: To promote and protect health and wellbeing

This goal focuses on prevention. It aims to:

Protect the public from threats to health and wellbeing related to substance misuse by preventing early use of alcohol and other drugs among young people, influencing behaviour and challenging social norms and attitudes and providing targeted interventions aimed at minimising harm for those who have already started to use substances. (p. 17)

There are three objectives to this goal:

1.1 To promote healthier lifestyles within society

Actions include:

- To ensure that the commitment to an integrated public health approach to drugs and alcohol is delivered as a key priority by developing a relevant initiative and promoting the use of evidence-based approaches to mobilising community action on alcohol (1.1.1).
- To improve the delivery of substance use education across all sectors (1.1.2).

1.2 To prevent use of drugs and alcohol at a young age

Actions include:

- To support the Social, Personal and Health Education (SPHE) by promoting effective communications between schools and Drug and Alcohol Task Forces (1.2.3).
- To improve supports for young people at risk of early substance use by prioritising initiatives under the new DEIS [Delivering Equality of Opportunity in Schools] programme to address early school leaving; and providing a continuum of support for young people encountering difficulty in mainstream education (1.2.5).
- To facilitate increased use of school buildings, where feasible, for afterschool care and out-of-hours use to support local communities (1.2.7).
- To improve services for young people at risk of substance misuse in socially and economically disadvantaged communities by developing a new scheme to provide targeted, appropriate and effective services (1.2.8).

1.3 To develop harm reduction interventions targeting at risk groups

Actions include:

- To mitigate the risk and reduce the impact of parental substance misuse on babies and young children by developing protocols between addiction services, maternity services and children's health and social care services (1.3.9c).
- To strengthen early harm reduction responses to current and emerging trends and patterns of drug use by establishing a working group to examine the evidence on responses such as drug testing and amnesty bins (1.3.11).

Goal 2: To minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery

This goal focuses on the range of treatment, rehabilitation and recovery services available to users. It recognises that 'timely access to appropriate services relevant to the needs and circumstances of the person concerned is of fundamental importance' (p. 33). There are two objectives to the goal:

New National Drug and Alcohol Strategy launched continued

2.1 To attain better health and social outcomes for people who experience harm from substance misuse and meet their recovery and rehabilitation needs

This objective focuses on improving access to a range of services, for users generally and for some groups in particular. These include women, children and young people, groups with 'more complex needs' (p. 44), and prisoners.

Associated actions include:

- To strengthen the implementation of the National Drugs Rehabilitation Framework (2.1.12).
- To enhance the quality and safety of care in the delivery of opiate substitution therapy (OST) by implementing the HSE National Clinical Guidelines on OST (2.1.15).
- To further strengthen services to support families affected by substance misuse (2.1.17).
- To help individuals affected by substance misuse to build their recovery capital by monitoring and supporting the Framework for Community Employment Drug Rehabilitation Schemes (2.1.18a); and utilising the Social Inclusion and Community Activation Programme (SICAP) (2.1.18b).
- To increase the range of progression options for recovering drug users and develop a new programme of supported care and employment (2.1.19).
- To improve outcomes for people with comorbid severe mental illness and substance misuse problems by supporting the Mental Health Clinical Programme to address dual diagnosis (2.1.24a); and develop joint protocols between mental health services and drug and alcohol services (2.1.24b).

2.2 To reduce harm among high-risk users

This objective focuses specifically on people who inject drugs and the issues of overdose and drug-related deaths.

Among the associated actions are:

- To provide enhanced clinical support to people who inject and mitigate the issue of public injecting by establishing a pilot supervised injecting facility (2.2.29).
- To continue to target a reduction in drug-related deaths and non-fatal overdoses by expanding the availability of naloxone to people who use drugs, their peers and family members (2.2.30b).

Goal 3: To address the harms of drug markets and reduce access to drugs for harmful use

This goal focuses on the range of activities that aim to reduce the supply of illicit drugs and deal with those involved in supply activities. It also considers the ways in which users are dealt with in the criminal justice system. There are three associated objectives:

3.1 To provide a comprehensive and responsive misuse of drugs control framework which ensures the proper control, management and regulation of the supply of drugs

Associated actions are:

- To map the future direction and objectives of the Drug Treatment Court by carrying out an independent evaluation of it (3.1.34a).
- To consider the approaches taken in other jurisdictions to the possession of small quantities of drugs for personal use with a view to making recommendations on policy options to the relevant Minister within 12 months (3.1.35).

3.2 To implement effective law enforcement and supply reduction strategies and actions to prevent, disrupt or otherwise reduce the availability of illicit drugs

Actions include:

- To support the role of law enforcement authorities in monitoring drug markets, in particular new drug markets, surface web and darknet drug markets (3.2.36).
- To consider the case for the use of Community Impact Statements within the criminal justice system in Ireland (3.2.37).

3.3 To develop effective monitoring and responses to evolving trends, public health threats and the emergence of new drug markets

Actions include:

- To strengthen the response to the illegal drugs market by developing systems to monitor changing drug trends in line with the EU Early Warning System (3.3.38a); and to complete the development of the HSE public alert system for adverse events due to drugs (3.3.38b).

Goal 4: To support participation of individuals, families and communities

This goal recognises the need to support communities by building on their capacity to respond to the drugs situation. It also emphasises the need for meaningful involvement of service users and their families in the planning, design and delivery of effective services. There are two objectives:

4.1 To strengthen the resilience of communities and build their capacity to respond

Actions include:

- To support and promote community participation in all local, regional and national structures (4.1.39).
- To measure the impact of drug-related crime and wider public nuisance issues on communities by piloting a Community Impact Assessment Tool (4.1.40).
- To strengthen the effectiveness of the Drug-Related Intimidation Reporting Programme (4.1.42).

4.2 To enable participation of both users of services and their families

Actions include:

- To build capacity within the problem substance use sector to develop a patient safety approach requiring services within a Quality Assurance Framework (4.2.43).
- To promote the involvement of service users and their families in decision-making structures and networks at all levels (4.2.44).

Goal 5: To develop sound and comprehensive evidence-informed policies and actions

There are no objectives under this goal but its actions include:

- To strengthen Ireland's drug monitoring system (5.1.45).
- To strengthen the National Drug Treatment Reporting System by requiring all publicly funded drug and alcohol services to complete the NDTRS (5.1.47).
- To improve knowledge of rehabilitation outcomes by undertaking a study on outcomes that takes into account the experiences of service users and their families (5.1.49).

Lucy Dillon

1 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>

New National Drug and Alcohol Strategy launched continued

PART 4

Implementing the drugs strategy

The final substantive chapter of the national drugs strategy (NDS) focuses on what is termed 'strengthening the performance of the strategy'.¹ There are two elements to this: measuring performance and the structures that will support the implementation of the strategy.

Measuring performance

The strategy sets out a number of ways in which progress on the delivery of the strategy will be monitored and assessed:

- A number of performance indicators appear at the end of each goal. However, the detail of which objective they relate to, how they will be used, and timelines for delivery are not included.
- Bodies charged with delivering the different actions of the strategy will be required to report to the Minister with responsibility for the NDS on an annual basis.
- The strategy aims to operationalise a new Performance Measurement System by 2020. The system that was developed by consultants will 'support *Reducing Harm, Supporting Recovery*, improve accountability across the statutory, community and voluntary sectors and strengthen the Drug and Alcohol Task Force model' (p. 74). It focuses on 'the net effects of the strategy at the population level, in particular, the effects on the health wellbeing and quality of life of people living in local and regional DATF areas' (p. 73). Essentially, it makes predictions about what it would expect the level of problem drug use to be in a small area, based on a selection of social indicators linked to deprivation, urbanity and social class. It then compares these with the predicted level of problem substance use. If the model finds significant changes over time, or differences are found between DATF areas, then analysis will be carried out to explore why this has happened.

Implementation structures

The new strategy makes some changes to the existing organisational structure for the implementation and delivery of the drugs strategy. Among the aims of the restructure are that the structure of the previous drugs strategy would be streamlined to better deliver on the key functions of the strategy; and that participation in the strategy would be optimised in a way that avoids 'duplication and overlap' (p. 76). The *Report of the rapid expert review of the National Drugs Strategy 2009–2016*² identified the 'strong role of community organisations' in both strategy development and delivery as one of the 'key features of the Irish context' (p. 9). However, they noted that in some areas of the strategy, the coordination between local, regional and the national level became less effective over time.

The new structures represent what is termed a 'more streamlined structure'¹ (p. 76). As with the previous strategy, the challenge will remain for the structures to be able

to sustain the active membership of those who are in a position to take action, and to ensure that community voices are heard at all levels. In her response to such concerns expressed at the launch of the new strategy, Minister Byrne gave assurances that the structures would deliver on this for the duration of the strategy.

Ministerial responsibility: The Minister for Health continues to have overall responsibility for the NDS. There also continues to be a Minister of State in the same department with responsibility for Health Promotion and the National Drugs Strategy.

National Oversight Committee: This will be a senior official level committee 'sponsored' (p. 76) by the Minister of State for the NDS. Membership will include representatives from the statutory, community and voluntary sectors and expertise from both a clinical and academic representative. Membership from the statutory sector will be at the level of Assistant Secretary. The committee is to meet on a quarterly basis and has five main functions, as outlined in its terms of reference:

- To give leadership, direction, prioritisation and mobilisation of resources to support the implementation of the strategy.
- To measure performance in order to strengthen the delivery of drug initiatives and to improve the impact on the drug problem.
- To monitor the drugs situation and oversee the implementation of a prioritised programme of research to address gaps in knowledge.
- To ensure that the lessons drawn from evidence and good practice inform the development of policy and initiatives to address the drug problem.
- To convene subcommittees, as required, to support implementation of the strategy (p. 77).

Standing subcommittee: A standing subcommittee will be set up to support the implementation of the NDS and promote coordination between national, local and regional levels. It will meet on a monthly basis and will be chaired by a senior official of the Department of Health. Membership will include representatives from the statutory, community and voluntary sectors. Its terms of reference are:

- To drive implementation of the NDS at national, local and regional level.
- To develop, implement and monitor responses to drug-related intimidation as a matter of priority.
- To support and monitor the role of Drug and Alcohol Task Forces in coordinating local and regional implementation of the NDS with a view to strengthening the task force interagency model.
- To improve performance, promote good practice and build capacity to respond to the drug problem in line with the evidence base.
- To ensure good governance and accountability by all partners involved in the delivery of the strategy.
- To report to the National Oversight Committee on progress in the implementation of its work programme.

New National Drug and Alcohol Strategy launched continued

The strategy specifically requires drug-related intimidation to be on the agenda for the committee's first meeting. Members are expected to develop what is called a 'liaison relationship' (p. 78) with task forces to support effective coordination and communication between delivery bodies and stakeholders at all levels.

Subcommittees: The national committee will be able to establish subcommittees to address specific issues and draw on any expertise necessary to support it on delivering its functions.

Drugs Policy Unit, Department of Health: This unit will be responsible for:

- Analysing the implications of research findings for policy and design of initiatives to tackle the drug problem.
- Providing the national committee with advice on the commissioning of new research and development of new data sources, having regard to current information and research deficits and advice and changing patterns of drug use and emerging trends.
- Providing a secretariat to the committee and the standing subcommittee.

Health Research Board (HRB): The HRB will continue to be the EMCDDA's national focal point. It will manage the commissioning of any research that the national committee decides should be undertaken to address gaps in their knowledge.

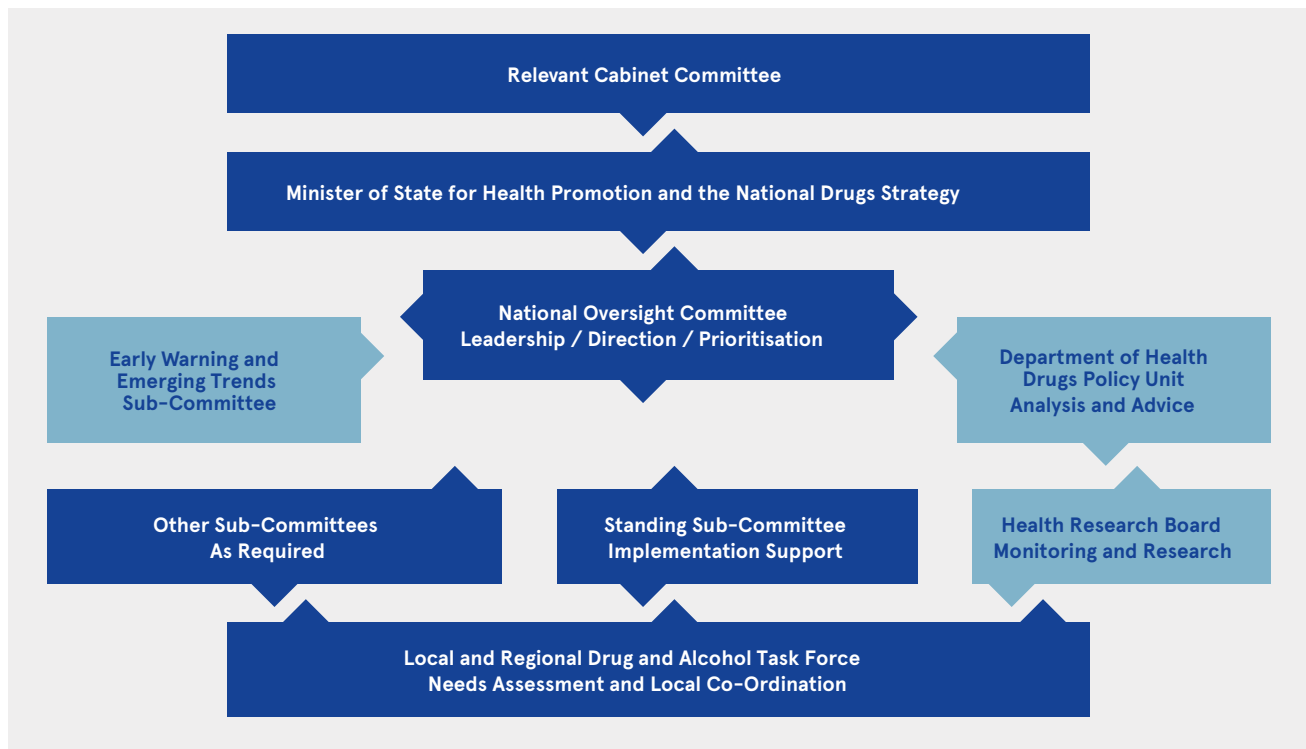
Early Warning and Emerging Trends Committee: This committee will receive, share and monitor information from national and EU sources on new psychoactive substances of concern and any emerging trends and patterns in drug use and the associated risks. Membership of this committee is to be extended to include representatives of the network of coordinators of the Local and Regional Drug and Alcohol Task Forces.

Drug and Alcohol Task Forces (DATFs): The current terms of reference of the DATFs are referred to in the strategy. Based on these, their role will continue to focus on assessing the extent and nature of the drug and alcohol problem in their areas and in coordinating action at local level so that there is a targeted response to the drug problem in local communities. They will continue to implement the NDS in the context of the needs of their region or local area through action plans. They will also provide an annual report on their activities to the Minister of State with responsibility for the NDS. It is envisaged that the new performance measurement framework will provide the DATFs with information that will support them in the delivery of their role.

Lucy Dillon

- 1 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 2 Griffiths P, Strang J and Singleton N (2016) *Report of the rapid expert review of the national drugs strategy 2009–2016*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27289/>

Figure 1: Structures supporting implementation of the new drugs strategy



Source: NSRF, 2016

POLICY AND LEGISLATION

Responses to the new drugs strategy

A number of stakeholder agencies have published statements on the new national drug and alcohol strategy. These include: CityWide,¹ Gay Health Network,² Simon Communities³ and UISCE (Union for Improved Services, Communication and Education).⁴ The more health-led approach and the inclusion of alcohol in the strategy were widely welcomed. There were concerns, however, about how the strategy would be implemented in practice and the need for additional funding to do so. The statements are summarised below.

CityWide¹

CityWide Drugs Crisis Campaign welcomed two elements of the strategy in particular: the establishment of a working group to look at alternative approaches to the possession of drugs for personal use; and the commitment to an integrated drug and alcohol policy. However, it has a number of concerns relating to the implementation of the strategy.

Integrated drug and alcohol strategy: It expresses concern that while there have been Government commitments to a joint policy in the past, this has often been 'over-stated' and has not been delivered in practice. It notes the ongoing opposition of the alcohol industry.

Funding: CityWide is concerned there will not be enough investment in services to be able to deliver on the range of actions laid out in the three-year action plan embedded in the strategy. It highlights that many of the strategy's actions involve the 'expansion and/or development' of existing services, but that services are already operating on budgets that have been subject to numerous cuts over the last six years. Significant investment would therefore be required if actions are to be delivered.

Interagency partnership: CityWide notes that interagency partnership has always been crucial to the implementation of Ireland's drug strategies. While the new strategy says that it will remain a cornerstone of its implementation, CityWide argues that interagency partnership on drug issues 'is no longer working effectively at either national, regional or local level'. It argues that Government departments and their agencies are where key policy decisions are now made, rather than within the interagency structures where communities are represented. For interagency partnership to work in practice, the new structures established by the strategy will need, from the very start, a 'strong and proactive' National Committee that ensures all stakeholders are held to account for their responsibilities in delivering on the strategy, and that the Drug and Alcohol Task Forces are adequately supported.

Causes of problem drug use: CityWide identifies one of the most significant barriers to delivering on the new strategy as a failure to address the underlying causes of 'serious community drug problems'. It reiterates the fact that problem drug use continues to be concentrated in areas characterised by high levels of social and economic deprivation. Over time, the drug problem has become 'chronic, deep rooted and embedded

in these communities, impacting negatively on all aspects of community life'. Addressing the underlying issues causing drug use is essential 'if we are serious about tackling the impact of problem drug use'.

Gay Health Network²

The Gay Health Network (GHN) welcomed the specific mention, for the first time in the national strategy, of the need for targeted harm-reduction, education and prevention measures that are tailored towards the lesbian, gay, bisexual, transgender and intersex (LGBTI) community. It highlights actions dealing with the issue of chemsex (the use of drugs for or during sex). First, the need to provide addiction supports in non-traditional settings with particular reference to chemsex, and that it hopes this 'signals a widening of resource provision for services attempting to bridge the gap between sexual, mental and addiction health'. Second, the inclusion of chemsex as a topic to be considered by the working group examining the evidence base for early harm reduction responses to current and emerging trends.

Simon Communities³

Housing and homeless organisation, the Simon Communities, welcomed the new strategy, saying that the move to a more health-led approach will 'save lives and reduce harm', and that the inclusion of alcohol is 'positive'. It notes in particular the introduction of the supervised injecting facilities. It welcomes the recognition in the strategy that people who are homeless are at a 'far higher risk' of problem drug use than those in secure housing and notes the complex relationship between homelessness and problematic drug and alcohol use. Both a harm reduction and recovery focus were identified by the Simon Communities as 'at the heart of drug and homeless service provision'. It also notes the synergy with other Government strategies dealing with homelessness and that their successful delivery 'depends not just on housing but also, crucially, on drug and alcohol, mental health, and community integration services being available'. While it welcomes the strategy and accompanying action plan, it calls for a more detailed implementation plan that would include targets and timelines 'to enhance the Strategy'.

UISCE⁴

UISCE welcomed the new strategy. Its statement focuses on how 'excited' it is that 'for the first time the voice of people who use drugs in Ireland has been captured and included in the development of the National Drug Strategy', as well as now being represented in the implementation structures of the strategy for the first time. As with CityWide, it welcomes in particular the action to explore the alternative approaches to the possession of drugs for personal use. It also welcomes the establishment of a safe injecting facility, and the values of the strategy that see addiction as 'a condition that requires compassion, understanding and seeing people as human beings'.

Lucy Dillon

- 1 CityWide Drugs Crisis Campaign (2017) Press release on the launch of the new national drugs strategy (NDS). <http://www.drugsandalcohol.ie/27700/>
- 2 Gay Health Network (2017) Gay Health Network statement on national drug strategy 2017–2025. <http://www.drugsandalcohol.ie/27701/>
- 3 Simon Communities of Ireland (2017) Simon Communities welcome national drugs strategy publication. <http://www.drugsandalcohol.ie/27702/>
- 4 Drugs.ie (2017) UISCE reacts to the launch of the national drug strategy 2017–2025. <http://www.drugsandalcohol.ie/27703/>

Public consultation for the new drugs strategy

The new national drug and alcohol strategy (NDS), *Reducing harm, supporting recovery: a health-led approach to drug and alcohol use in Ireland 2017–2025*,¹ was informed by a number of inputs, including a public consultation process. The public were invited to provide feedback on what they thought of the 2009–2016 strategy and what issues should be considered in the development of the new strategy. They could provide this by making a written or oral submission to the Department of Health, completing a questionnaire, or attending one of six regional events. Submissions and questionnaires could be made or submitted over the phone, by email, by post, or through the Department of Health's website. Furthermore, there was an event and questionnaire that specifically targeted young people. *Report on public consultation undertaken to inform the new national drugs strategy* was subsequently published in May 2017.²

The process

The consultation was held over a six-week period between September and October 2016. Those who took part included the general public, Drug and Alcohol Task Forces, service providers, service users, voluntary organisations, members of political parties, and elected representatives. The number of consultation questionnaires received was 2,115; youth questionnaires was 265; other feedback or submissions was 211; and attendees at the regional events was 363. The views expressed through these are summarised in the report. It is structured around the five pillars of the 2009–2016 strategy – prevention, supply reduction, treatment, rehabilitation, research – with additional chapters to cover feedback on the structure and content of the NDS 2009–2016, and 'youth feedback'.

Key findings

The summary of the lengthy report (i.e. 227 pages) focuses on recurring themes from the process. These include:

- **Coverage:** The importance of alcohol as a major drug of misuse was identified and some participants thought it should be included in the new strategy.
- **Geographical coverage:** Drug misuse was seen as a national problem, with a call for greater access to information, treatment and rehabilitation services for people irrespective of where they live. In addition, it was argued that the supply and widespread availability of drugs throughout the country needed to be addressed.
- **Drug education and awareness:** There was an appeal for more education programmes that were evidence based and could be delivered to children of primary school age. More public awareness campaigns were also called for.
- **Medicinal cannabis:** A recurring theme was that cannabis should be made available by prescription for medicinal purposes.

- **Drug use as a health issue:** Participants argued that people who use drugs should not be treated like criminals and that use should be treated as a health rather than a criminal issue.
- **Stigma of being a user:** Service users described the shame and stigma that goes with their addiction. They wanted to feel 'the values of respect, compassion, and a sense of choice at the heart of services provided to them' (p. 2).
- **Debt intimidation and violence:** These were identified as problems facing users and their families that needed to be addressed.
- **Treatment availability:** A need to increase and improve the availability of treatment and rehabilitation services across the country and to all groups was recognised.
- **Terminology:** There was some suggestion that using language that is led by the substance's legal status is unhelpful (i.e. illicit) and that instead they should be defined as 'harmful'.
- **Dual diagnosis:** Participants identified the problem of gaining access to services for those who have dual diagnosis as an important issue for the new strategy to address.
- **Alternatives to methadone:** There was a call for alternatives to methadone to be made available.
- **Prescription medication:** The misuse of prescription medication was described as widespread and problematic.
- **Coordination of delivery:** A need was identified for improved communication and coordination between statutory, community and voluntary sectors, as well as increased funding for those delivering services on the ground.
- **Quality standards:** These were identified as in need of improvement across the sector.
- **Hidden harm:** The needs of children and young people whose families/caregivers were affected by addiction were identified.
- **Research:** The need for good-quality evidence to inform the strategy and service delivery was identified.
- **Family and community:** The central role of families and communities in addressing local drug issues was discussed.
- **Family support:** There was a call for more support for families living with a family member's addiction.

Lucy Dillon

1 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>

2 RPS Group plc (2017) *Report on public consultation undertaken to inform the new national drugs strategy*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27489/>

Performance measurement and resource allocation

In preparing *Reducing harm, supporting recovery*,¹ the Department of Health commissioned a performance measurement system to help determine the impact of the strategy on problem substance use at a population level. *A performance measurement framework for Drug and Alcohol Task Forces*² (DAFT) aims to capture how successful task forces are at reducing problem substance use within their own areas. This will help to identify both good practice and weaknesses in local responses and help to guide the allocation of resources to bring about better local services and systemic improvements.

The approach taken in developing this system is consistent with the understanding of wellbeing in the Healthy Ireland³ strategy. This approach goes beyond reporting outputs or reporting on progress in particular strategic actions and seeks to measure changes in the behaviours that lead to ill-health and threaten wellbeing. The drugs strategy has a number of population-based objectives and it is only by measuring the population effects of interventions that these objectives can be fully evaluated. This is what the authors of *A performance measurement framework for Drug and Alcohol Task Forces* set out to do. They developed a longitudinal framework to measure the impact of interventions on the level of problem substance use in task force areas. When effects at the local level are aggregated, the success of the strategy as a whole can be assessed.

Measuring problem drug use in a Small Areas

The model at the core of the framework makes predictions regarding the level of problem drug use in a Small Area⁴ based on a number of social indicators describing levels of deprivation, urbanity and social class. It then compares the predicted level with the actual prevalence of problem drug use as indicated in routine monitoring systems, such as treatment data. If differences are observed between the predicted level of problem substance use in an area and the actual levels over a period of time, we must then ask how has this change come about.

By analysing the nature and level of provision of services in an area, we can begin to see what the impact of prevention, harm reduction or treatment programmes have had on the prevalence of problem substance use in that period of time. The difference may have been due to social or economic changes and these too can be identified. So, the framework takes into account the complex range of factors contributing to the problem substance use situation and the difficulty in relating changes in this situation over time to specific causes.

We can also compare the levels of disparity between predicted and actual levels in different areas. When these levels of disparity differ between areas, comparisons between variables, such as service provision, in these areas provide further opportunity to identify causal factors. By identifying the reasons for differences in outcomes, we can get valuable information regarding the implementation of the strategy. This can also help DATFs improve their actions and interventions over time. The performance measurement framework includes a mechanism to enable funding to be allocated on a more equitable and rational basis, taking into consideration the underlying need in DATF areas. It is envisaged that, as the framework develops, it will be able to incorporate other problem substance use data sources and increase the precision of the system evaluating responses to this problem.

Brian Galvin

- 1 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 2 Haase T and Pratschke J (2017) *A performance measurement framework for Drug and Alcohol Task Forces*. Dublin: Trutz Haase – Social & Economic Consultants. Available online at <http://www.drugsandalcohol.ie/27488/>
- 3 Department of Health (2013) *Healthy Ireland: a framework for improved health and wellbeing 2013–2025*. Dublin: Department of Health. Available at www.drugsandalcohol.ie/19628
- 4 Small Areas are areas of population comprising between 50 and 200 dwellings created by the National Institute for Regional and Spatial Analysis (NIRSA) on behalf of Ordnance Survey Ireland (OSi) in consultation with the Central Statistics Office (CSO). Small Areas were designed as the lowest level of geography for the compilation of statistics in line with data protection and generally comprise either complete or part of townlands or neighbourhoods. Available online at <http://www.cso.ie/en/census/census2011boundaryfiles/>

CityWide's evidence base for decriminalisation

In May 2017, CityWide Drugs Crisis Campaign launched a new area on its website dedicated to the evidence base for the decriminalisation of possession of drugs for personal use.¹ Decriminalisation in Ireland would involve changing the current law that defines possession of drugs for personal use as a criminal offence. This does **not** mean that possession for personal use would be legal, as non-criminal penalties may still

be applied. Furthermore, it would **not** affect the law that makes the possession of drugs for sale or supply a criminal offence.

CityWide believes that drug use is a social and health issue not a criminal justice one and it therefore supports decriminalisation.² While it does not believe that decriminalisation is a 'panacea for problem drug use', it argues that the negative consequences of drug use are exacerbated by dealing with it through the criminal justice system. Current Government policy is also to 'support a health-led rather than criminal justice approach to drugs use' (p. 56).³ Furthermore, the new national drug and alcohol strategy includes an action 'to consider the approaches taken in other jurisdictions to the possession of small quantities of drugs for personal use with a view to making recommendations on policy options to the relevant Minister within 12 months' (p. 58).⁴

Decriminalisation evidence continued

Evidence base

A range of national data and policy sources are used to describe the situation in Ireland.⁵ The international elements of the website primarily draw on evidence from three overviews of the international situation and the impact of decriminalisation in countries where it has been introduced.⁶

Core themes

There are a number of areas within the decriminalisation element of the website, each of which presents evidence on a core theme of the debate.

How criminalisation impacts globally

Four key findings on the effects of criminalising drug possession for personal use were identified:

- The level of drug use in a country is not directly related to the toughness of a country's enforcement against drug possession, i.e. a tough enforcement regime does not reduce drug use.
- Criminalising drug use increases the health risks to which people who use drugs are exposed.
- Criminalising drug use creates social risk because society tends to see people convicted of drug offences as unproductive criminals. This stigmatisation can lead to discrimination, including reduced support for health-led responses.
- Punitive drug policies have a disproportionate impact on already vulnerable communities, and increase the health risks for entire populations.⁷

Current situation in Ireland

This section of the website provides information on four key areas related to drug use in Ireland: the legislation governing the use of controlled drugs in Ireland; what happens in terms of law enforcement in relation to drug possession offences; an overview of the policy debate on decriminalisation in Ireland and how it has evolved since the 1990s; and the evidence on drug use in Ireland and its associated problems.

Impacts of decriminalisation

Following on from the findings related to how criminalisation impacts globally, this area explores the effects of decriminalising drug possession for personal use. Three key findings were identified:

- The level of drug use in a country is not directly affected by decriminalising drug possession and use. The available evidence shows neither an increase nor a decrease in the level of drug use.
- Decriminalisation is associated with improved health outcomes, as more people who use drugs feel able to access treatment. However, the evidence also indicates that other factors, such as improved harm reduction and treatment services, contribute significantly to the improved health outcomes.
- Decriminalisation leads to improved social outcomes as criminal justice system costs come down and as the prospects of those detected with drugs look up, e.g. in terms of employment and their relationships with significant others. Positive results have also been reported with regard to recovery and recidivism.⁸

UN and decriminalisation

The situation with decriminalisation and the United Nations (UN) is complex. On the one hand, member states need to comply with the UN drug conventions that are often cited as being prohibitive of decriminalisation. However, on the other hand, criminalising the possession of drugs for personal use 'breaches public health and human rights standards, which are also supported by the UN'. This section of the website explores this situation, noting that a number of key UN agencies have called for decriminalisation.

Which countries have decriminalised and how?

This section of the website explores the different models of decriminalisation that have been implemented internationally. It draws on a report by Release, a UK centre of expertise on drugs and drug law, that found 'a surge toward this drug policy model in the past 15 years'.⁹ There is also a link to the e-tool developed by the International Drug Policy Consortium, which allows the user to compare models of decriminalisation globally (see also related article in this issue of *Drugnet*).

There is also a frequently asked questions section that includes definitions of key terms in the debate. The site can be accessed at: <https://www.citywide.ie/decriminalisation/>

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- 1 The CityWide Drugs Crisis Campaign site on decriminalisation can be accessed at <https://www.citywide.ie/decriminalisation/>.
- 2 The term 'decriminalisation' will be used for the remainder of this article to refer to the decriminalisation of possession of drugs for personal use.
- 3 Department of the Taoiseach (2016) *A programme for a partnership government*. Dublin: Government Publications Office. <http://www.drugsandalcohol.ie/25508/>
- 4 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 5 Examples of the sources used include: the Irish Statute Book; Garda Recorded Crime Statistics from the Central Statistics Office; the Courts Service Annual Report; and the National Drug Treatment Reporting System.
- 6 The three overviews used are: (a) Home Office (2014) *Drugs: international comparators*. London: Home Office, United Kingdom. <http://www.drugsandalcohol.ie/22874/>; (b) Office of the High Commissioner for Human Rights, United Nations (2010) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Geneva: Office of the High Commissioner for Human Rights, United Nations. Available online at <http://www.ohchr.org/EN/Issues/Health/Pages/SRRrightHealthIndex.aspx>; (c) Hughes C, Ritter A, Chalmers J, Lancaster K, Barratt M and Moxham-Hall V (2016) *Decriminalisation of drug use and possession in Australia – a briefing note*. Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia. <http://www.drugsandalcohol.ie/25238/>
- 7 CityWide Drugs Crisis Campaign (2017) What are the effects of criminalisation? Available online at <https://www.citywide.ie/decriminalisation/global.html>
- 8 CityWide Drugs Crisis Campaign (2017) Impacts of decriminalisation. Available online at <https://www.citywide.ie/decriminalisation/impacts.html>
- 9 Rosmarin A and Eastwood N (2012) *A quiet revolution: drug decriminalisation policies in practice across the globe*. London: Release. <http://www.drugsandalcohol.ie/18327/>

Human rights and the new drugs strategy

Internationally, there has been a growing focus on adopting a human-rights-based approach to drug policy. This topic has been covered in previous editions of *Drugnet Ireland* both in the national and international context.^{1,2,3,4} With these articles in mind, there are a number of features of the new strategy that would suggest a more human-rights-based approach than in previous strategies:

- It takes a health-led approach to drug use.
- It is underpinned by the values of compassion, respect, equity, inclusion, partnership and evidence-informed.
- It incorporates human rights in some elements, for example introducing supervised injecting facilities and exploring approaches to the possession of small quantities of drugs.

However, human rights are only specifically mentioned once in the document. This is in relation to developing a Quality Assurance Framework for the delivery of services (see action 4.2.43⁵).

Since the introduction of the Irish Human Rights and Equality Commission Act 2014, public bodies are required to take proactive steps to promote equality, protect human rights, and

fight discrimination in relation to their functions and powers.⁴ Therefore, 'in preparing strategic plans, public sector bodies must assess and identify the human rights and equality issues that are relevant to their functions. These issues must relate to all of its functions as policy maker, employer and service provider' (p. 4).⁶ Despite this, a human rights and equality assessment is not reported to have been carried out as part of the methodology used to develop the new strategy.

Lucy Dillon

- 1 Pike B (2016) Drug users' human rights. *Drugnet Ireland*, 58: 6–7. <http://www.drugsandalcohol.ie/25958/>
- 2 Pike B (2016) Human rights and drug policy – international perspectives. *Drugnet Ireland*, 58: 8–9. <http://www.drugsandalcohol.ie/25959/>
- 3 Pike B (2016) Service users' rights. *Drugnet Ireland*, 58: 29. <http://www.drugsandalcohol.ie/25990/>
- 4 Dillon L (2016) Human rights, equality and the National Drugs Strategy. *Drugnet Ireland*, 58: 9. <http://www.drugsandalcohol.ie/25960/>
- 5 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 6 Irish Human Rights and Equality Commission (2016) *The public sector duty: eliminating discrimination, promoting equality and protecting human rights*. Dublin: Irish Human Rights and Equality Commission. <http://www.drugsandalcohol.ie/27649/>

HRB publishes review of reviews

In 2015, the Health Research Board (HRB) commissioned the Public Health Institute at Liverpool John Moores University to prepare a report on the most recent international evidence on responses to problem drug use. This was to support the steering committee working on a new drugs strategy. Incorporating evidence into policy has been a concern of several countries developing drugs strategies in recent years. Part of this process is identifying responses that have been shown to work but, just as importantly, identifying what evidence is relevant to the national situation, where the gaps in evidence are, and what interventions are shown not to be effective or produce harmful results.

Ensuring that a strategy is evidence based requires an acknowledgement that evidence is constantly improving and knowledge on effective responses will develop during the term of the strategy. A dynamic strategy supports this development and recognises the value of the evidence produced by the evaluative process built into responses.

In July 2017, the HRB published *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A 'review of reviews'*.¹ The 'review of reviews' approach provides an overview of the most recent high-quality evidence. The primary research questions for the review were:

- Which interventions are effective in reducing the initiation, or continued use, of illicit drugs and related harmful behaviours among children and young people aged up to 25 years?
- Which interventions are effective in reducing harmful behaviours related to illicit drug use?
- Which interventions are effective in treating drug misuse among people who misuse or who are dependent upon illicit drugs?
- Which interventions are effective in supporting people who misuse illicit drugs to fully recover from their illicit drug misuse and become better reintegrated into the community following/alongside treatment?

Using the reviews to answer questions on responses in the drugs area

It is helpful to separate the findings of the reviews into what is known to work or not work and interventions of unproven efficacy thus far. This makes the findings quickly apparent. But demonstrating the scientific value of the work somewhat hides the value of the 'review of reviews' approach and its role in the development of an evidence baseline relevant to the Irish situation.

Below are some examples of how the review might be used to answer questions that are of interest to stakeholders.

Review of reviews continued

Question 1: *How can young people be enabled to make sensible decisions about substance use or provide help to members at risk of abusing drugs or affected by drug use?*

Family-based programmes are one of the most commonly used approaches internationally to prevent substance misuse in young people. These interventions can be aimed at all individuals (parents and young people) or just parents in a range of settings. Information on the harms of drug use and sessions on effective parenting, communication and discipline typically feature on these programmes. Currently, in Europe, those interventions involving the whole family are more likely to be recommended than those that train parents only.

Findings from high-quality and medium-quality studies in the prevention review suggest that a combined parent-and-child-intervention approach may be more effective at reducing cannabis initiation and use than interventions that target parents alone. Moderate-quality review level evidence from the treatment review suggests that multidimensional family therapy is effective for reducing drug use frequency and severity in comparison to other interventions among adolescents, including cognitive behavioural therapy (CBT), but is generally no more nor less effective for treatment retention.

Question 2: *How do you reduce the risk of harm from drugs in a recreational setting, such as a nightclub?*

High-quality evidence in the harm reduction review suggests that effective harm reduction activities in a recreational setting include staff training, law enforcement, user/patron prevention and harm reduction interventions. No evidence was identified on pill-testing kits or similar interventions for inclusion in this review, reflecting the lack of evidence available (at primary or review level) on this approach.

Question 3: *How can treatment programmes increase the likelihood of reintegration and recovery?*

The researchers were asked to pay particular attention to this topic, as it was anticipated that this would be of interest in the development of the strategy. With this in mind, they looked at reviews prior to 2010 and lower-quality reviews.

Medium-quality and low-quality evidence on recovery and reintegration interventions in the treatment reviews section of the report indicates that peer coaching, recovery housing, and mutual aid approaches may have benefits for substance use outcomes. Moderate-quality evidence indicates that residency in recovery homes was associated with improved employment, reduced criminal behaviour and substance use in comparison to 'usual care' treatments, but evidence on these outcomes was limited. Evidence indicated that peer-recovery coaching interventions were associated with reduced substance use in comparison to individuals receiving usual aftercare, but this evidence was limited by the quality of review and primary study evidence. There was moderate-quality evidence to suggest that continuing care may have a positive effect on substance use in comparison to control treatments.

Question 4: *How can evaluation be integrated into comprehensive community-based programmes aimed at preventing both licit and illicit substance use?*

Measuring the effectiveness of a prevention intervention is difficult. As Germany's *National strategy on drug and addiction policy (2012)*² states:

The goal of prevention is to avoid the occurrence of an event, whether this means the initial consumption of a substance, the emergence of abusive behaviour or addiction. Monitoring success therefore involves measuring the non-occurrence of an event. This is the main reason why the evaluation of prevention measures is one of the most difficult areas to evaluate in terms of methodology.² (p. 16)

The review identified a number of reviews of well-defined and rigorous programmes. Adapting programmes of this type locally presents challenges. However, the reviews included in the study also identify the outcomes used to measure the effectiveness of a prevention programme.

A review from 2006 indicated that comprehensive community-based programmes are more effective than school or community-only-based interventions at preventing both licit and illicit substance use. This review listed a number of primary and secondary outcomes that were measured by the evaluations, including in this systematic review. This is useful in identifying outcomes which could be included in an evaluation of programmes of this type being implemented locally.

Primary outcomes:

- Numbers of people who stop using substances
- Frequency of substance use
- Numbers of people who start using substances
- Time before initiation of substance use

Secondary outcomes:

- Changes in pattern of substance, range of substances, or type of substance
- Changes in risk or protective factors:
 - Knowledge
 - Attitudes towards drug use
 - School attendance
 - Family cohesion
 - Access to services
- Outcomes identified in various health programmes
- Engagement of community of vulnerable young people in the programme
- Drug-related illnesses
- Outcomes related to criminal justice system:
 - Prosecutions
 - Changes in antisocial or offending behaviour
 - Outcomes identified in criminal justice programmes aimed at children

Review of reviews continued

Using the reviews to identify gaps in the evidence

The review identifies gaps in the evidence and areas where further exploration is needed. We can only determine which evidence gaps are relevant when it is decided what questions need to be answered. There are several areas covered by the review where the evidence is inconclusive. This may be because of the low number of studies in this area, the lack of quality evaluations, or the quality of the reviews that have looked at these evaluations. A decision on whether to support a particular intervention should not be based solely on the evidence available in a high-level review. There will always be responses for which we do not have strong evidence to support them. That is the nature of this type of work. This presents an opportunity to contribute to the knowledge base on an intervention using carefully constructed evaluations. Many of the studies included in reviews, while not presenting conclusive evidence, can support this process, as they will have identified appropriate outcomes which can be used to measure the effectiveness of the response.

Psychosocial treatments

It is good practice to provide access to evidence-based and well-designed psychosocial interventions (based on behavioural, cognitive, motivational and social theories) in addition to standard care or in conjunction with existing pharmacological drug treatments. The review provides evidence of effectiveness on many types of psychosocial treatments, including the following interventions:

- **Brief interventions** (*Prevention review*): While evidence on the effectiveness in drug prevention is scarce, there is substantial evidence to suggest that brief interventions may be effective in alcohol prevention. Brief interventions are applied to recreational users or individuals at risk of misusing drugs; however, for individuals, who are already misusing substances, a brief intervention may not be appropriate or sufficient to change an established behaviour.
- **Cognitive behavioural therapy** (*Treatment review*): Moderate-quality evidence suggested that CBT is generally more effective for outcomes relating to cannabis use and dependency in comparison to individuals receiving no treatment, but no more nor less effective than other interventions. When combined with contingency management, low-quality evidence on the effectiveness of CBT was mixed and inconclusive in comparison to other interventions.

- **Couples-based therapy** (*Treatment review*): Moderate-quality review evidence indicates that couples-based interventions are more effective than relapse-prevention CBT for achieving abstinence.
- **Multisession psychosocial interventions** (*Harm reduction review*): Moderate-quality evidence suggests that multisession psychosocial interventions aimed at people who inject drugs may have beneficial impacts on sexual risk behaviours, but not on injection risk behaviours. Evidence regarding behavioural interventions was limited and based on small numbers of primary studies.

Interventions for people who come in contact with the criminal justice system

There is good evidence for only a limited number of interventions in this setting. However, contact with the criminal justice system through arrest, probation or incarceration presents opportunities for preventative and harm reduction interventions. These can complement existing treatments:

- **HIV risk reduction** (*Harm reduction review*): Moderate-quality evidence indicates that improving accessibility to HIV testing through onsite testing in probation and immediate next day testing in prison is associated with an increased uptake of HIV testing.
- **Psychosocial interventions in prison** (*Treatment review*): There is some evidence to suggest that treatment through prison-based therapeutic communities reduces drug relapse and criminal activity among prisoners. There is no consistent evidence to support other treatment types for this population, including drug courts, boot camps and psychosocial interventions, although there was limited and low-quality review level evidence supporting meditation-based treatment.

Brian Galvin

1 Bates G, Jones L, Maden M, Cochrane M, Pendlebury M, Sumnall H (2017) *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A 'review of reviews'*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/27253/>

2 Drug Commissioner of the Federal Government (2012) *National strategy on drug and addiction policy*. Berlin: Drug Commissioner of the Federal Government [Die Drogenbeauftragte der Bundesregierung]. Available online at <http://www.drogenbeauftragte.de/>

Trends analysis of drugs situation in Ireland

The Health Research Board commissioned the Public Health Institute at Liverpool John Moores University to prepare a trends analysis on the drugs situation in Ireland. *The drugs situation in Ireland: an overview of trends from 2005 to 2015*¹ reviews the current drug situation in Ireland, analysing 10 years of data up to the most recent data available, with respect

to the five European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) key indicators (prevalence of drug use, high risk drug use, treatment demand, drug-related deaths, and mortality and drug-related infectious diseases) as well as drug-related crime and supply. In addition to presentation of national trends, this report includes additional evidence looking at trends in data relating to specific subpopulations, including people who inject drugs, prisoners, homeless individuals, sex workers and the Traveller community.

Brian Galvin

1 Bates G (2017) *The drugs situation in Ireland: an overview of trends from 2005 to 2015*. Liverpool: Public Health Institute, Liverpool John Moores University. <http://www.drugsandalcohol.ie/27254>

Club Health Dublin 2017: conference overview and highlights

The 10th Club Health International Conference on Nightlife, Substance Use and Related Health Issues took place in the Printworks in Dublin Castle on 24–26 May 2017.¹ It marked 20 years of Club Health conferences and was the first time the conference was held in Ireland. Club Health conferences enable researchers, practitioners and experts from a wide range of fields to meet, present and exchange on current and emerging evidence, policy and practice relating to protecting and promoting health in urban night-time settings as well as music festivals and holiday destinations with a clubbing or nightlife emphasis.

Club Health began in 1997 in Liverpool, a city that twinned with Dublin also in 1997. It has been hosted in partnership with organisations, government departments and agencies in many countries ever since, including the Netherlands, Italy, Australia, Slovenia, Spain, the Czech Republic, Switzerland, the USA, and in 2015 in Lisbon, Portugal. A critical focus of all Club Health conferences is the interdisciplinary nature of the presentations and attendees, with the 2017 conference attracting 151 international participants from 20 countries in addition to attendees from Ireland. Conference attendees were from a very broad range of occupations and sectors, including city councils, police forces, forensics, pharmacy, medicine, health promotion, drug and alcohol treatment settings, and the night-time economy sector. There were 12 keynote presentations, over 90 parallel session presentations, and 15 poster presentations at the conference in Dublin.

Partnership with key agencies

An important aspect of Club Health Dublin 2017 was the partnership with key agencies in hosting and supporting the conference. The conference organising hub was based within the Community Drugs Programme in the School of Social Policy, Social Work and Social Justice in University

College Dublin (UCD). Conference host committee members included representatives from the Health Research Board; Trinity College Dublin; Dublin City Council; National Advisory Committee on Drugs and Alcohol; Dublin Town; Irish Family Planning Association; SpunOut; Ballymun Local Drug and Alcohol Task Force; Health Service Executive; Institute of Public Health in Ireland; CityWide Drugs Crisis Campaign; An Garda Síochána; and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Key to the success of the conference was the support from the Department of Health, particularly in the provision of the first-class Printworks Conference Centre at Dublin Castle. International conference partners included the Public Health Institute at Liverpool John Moores University; Public Health Wales; and the European Institute of Studies on Prevention (IREFREA), Portugal. Support from these agencies contributed to the strong multidisciplinary aspect to the conference, with keynote speeches and parallel sessions covering a wide range of substance use-related and harm reduction topics. These included pill testing, new psychoactive substances (NPS), prescription drug use, and substance use-related prevention and education. With 12 keynote speakers, conference attendees also had access to a significant range of expertise over the duration of the conference.

Conference themes

Club Health Dublin 2017 covered a range of themes related to healthy nightlife. Although substance use was a core focus, related and intersecting issues such as policing, violence, terrorism, sexual health, and sexual violence were also covered. A new theme for Club Health Dublin 2017 was that of social exclusion, with abstracts sought on nightlife issues in the context of social disadvantage and the crossover between such contexts and more mainstream night-time settings. A dedicated conference parallel session considered discrimination, marginalisation and mobilisation, with a range of papers presented that examined harm reduction in private party spaces, alcohol use by young people, community alcohol mobilisation, young people and cannabis use, and community drug checking in response to the fentanyl crisis. It is hoped this theme will continue on in Club Health 2019, as a converging of club, festival and socially related drug issues and those traditionally connected to problematic substance use emerges in many countries.



Members of the organising committee for Club Health 2017: (L to R) Siobhán O'Brien Green, Chris Luke, Hilda Loughran, Sarah Morton, Karl O'Brien and Andrew Bennett

Club Health 2017 continued

An Irish focus

A number of excellent abstracts was submitted by Irish researchers, practitioners and those involved in policy. In total, 15 Irish papers were accepted for the conference programme, with a further three Irish speakers delivering keynote addresses: Dr Chris Luke, Mercy University Hospital; Dr Fiona Lyons, Health Service Executive; and Dr Sarah Morton, UCD. The topics of the papers delivered within parallel sessions were divided into those that arise regularly in relation to harm reduction in the night-time environment – such as policing, public health, pill testing, harm reduction campaigns, and NPS testing and responses – and those that are emerging and relate to night-time contexts – such as chemsex and responses within and to certain communities, e.g. lesbian, gay, bisexual and transgender (LGBT) – as well as social exclusion. As with the broader conference trend, papers were presented by a range of researchers, practitioners and those working at the practice and/or policy interface.

Conference highlights

The three-day conference concluded with a final reflection on conference highlights and learning points, with a discussion panel selected from the delegates. Key points made during this session included:

- The value of having such an interdisciplinary approach to considering harm reduction in the night-time environment, particularly the value of pharmaceutical and toxicology expertise.
- The focus on alcohol harms, education, prevention and harm reduction, and the level of expertise, research and practice knowledge available to delegates.
- The importance of the social exclusion theme, which was named as a welcome addition to the Club Health programme.
- The combination of research and practice, particularly the sharing of examples of developing and enacting interventions based on research evidence.
- The presence of international expertise in relation to pill testing and pill-testing festival interventions.

Notably, there was a very high attendance rate of delegates each day, with lively discussions and networking during breaks and between sessions, indicating the value of the range of speakers. Feedback and comments from delegates included:

'It was another great Club Health conference. I came away very re-inspired.'

'Many thanks for your work towards the conference; I found it very useful. Look forward to next year!'

'It was a pleasure to see you all in Dublin – really nice conference, well done.'

'Many thanks again for an amazing Club Health Conference in Dublin this year. It was great to see how all the efforts you took with regard to this project were paying off – the organization was incredibly good!'

'Thank you again for the opportunity to speak at the conference; it has given me confidence to expand on my Club Health ideas! I look forward to hopefully attending the next conference.'

'Congratulations on a fantastic conference, it was very well organised and very enjoyable.'

'Thank you for hosting this – [it] was such an interesting conference and [I] went away newly enthused and encouraged about my practice ... so thank you.'

'Thank you and congratulations to you and your team for the well-organized Club Health conference in Dublin.'

Legacy actions

It is hoped that lessons, highlights and emerging topics will inform the programme for the next Club Health Conference in 2019. Organising committee members Andrew Bennett and Sarah Morton will present on a panel session proposed and chaired by the EMCDDA at the Lisbon Addictions Conference 2017 on the topic of 'Nightlife: no risk no fun? Challenges for drug prevention and trendspotting'. Andrew Bennett will present on 'Protecting and promoting health in nightlife environments during the last three decades' and Sarah Morton will present on 'Emerging trends within nightlife settings: Responses and innovation', based on outcomes from Club Health Dublin 2017. Looking to the future, we plan to continue to build alliances and share knowledge and experiences with the Club Health Dublin 2017 partners, presenters and delegates.

Sarah Morton and Siobán O'Brien Green

¹ For further information, visit <http://theclubhealthconference.com/>

Inaugural international conference marks Recovery Month

The first international conference in Ireland on recovery from drug addiction, *Mainstreaming Recovery in Irish Drug Policy and Practice: the Challenge of Change*, took place in Trinity College Dublin (TCD) on 8 September 2017. Organised by the Recovery Academy of Ireland, it was one of a number of events held during International Recovery Month to recognise, promote and celebrate recovery from addiction.

The conference heard international perspectives based on academic research; evidence that recovery works; insights into the recovery response in Scotland where addiction services have embraced a recovery model; lessons from the mental health recovery movement in Ireland that could be applied to addiction recovery; and personal stories of recovery journeys.

Professor David Best of Sheffield Hallam University gave the keynote address. Best is a leading figure in international research around recovery from drug and alcohol addiction and related policy issues. He believes that recovery is fundamentally an issue of social justice. It is about changing behaviour, building positive and supportive social networks and creating an open door to reintegrate the person in recovery. International studies that show what works are the following: dedicated recovery housing; mutual aid; peer-delivered interventions; support networks of sober friends; spending time with other people in recovery; and, spending time actually doing things such as childcare, engaging in community groups, volunteering, education, training, and employment.

Professor Agnes Higgins, a specialist in mental health nursing in the School of Nursing and Midwifery in TCD, said that traditionally recovery in mental health was understood as symptom management (cure, care and containment).

Increasingly, however, it is being seen as a personal process of learning, discovery and growth, often described by the acronym CHIME: connection, hope, identity, meaning and empowerment.

She shared a number of lessons from the mental health recovery movement which could also apply to addiction recovery. The most important was to understand that recovery is a way of being and relating. It was also important to note that changing the services culture takes time and involves challenging values, beliefs, prejudices and fears. She recommended bringing services together to share ideas and bringing staff, service users and families together to build a shared understanding of what recovery means and how it can be achieved.

The conference heard an important contribution from Brian Galvin, senior information specialist at the Health Research Board. He outlined an initiative to create a shared framework which drug and alcohol services could use to measure recovery outcomes. The framework is still in development stage. Some of the outcomes to be measured will include attitude and feelings, employment and skills, relationships, personal circumstances and needs, and drug use behaviour. A pilot project will now occur in selected task forces using appropriate IT systems, agreed measurements and tools, staff training and results analysis. In particular, the service user will be encouraged to have a sense of ownership of the process.

Dharmacarini Kuladharini, chief executive of the Scottish Recovery Consortium, spoke about the Road to Recovery, the Scottish government's drug strategy, published in 2008, which took as a fundamental principle that people in addiction services could lead a purposeful and meaningful life. The strategy transformed drug and alcohol services in Scotland, created new responses and built shared alliances.

Part of the response by the Scottish Recovery Consortium was to make lived experience visible at every level both within addiction services and the wider society. We changed the language, Kuladharini said. People were no longer service users or addicts but recovery activists.

The response also included employing people in recovery, organising a vibrant annual recovery walk and using recovery centres, pop-up cafés and colleges to mobilise people in



Fergus McCabe and Professor Joe Barry of TCD in discussion at the recovery conference

Recovery conference 2017 continued

recovery. In addition, there are workbooks and literature to support people in recovery and over 1,200 mutual aid meetings each week, more than the number of GP surgeries in Scotland.

As a result of the strategy, the response from treatment services and the efforts of people in recovery themselves, Scotland now has a thriving recovery movement with a multitude of vibrant recovery communities across the country.

Recovery as an issue of social justice was raised by several speakers at the conference, including Best. Roisín Shortall, TD, a long-time social justice advocate who chaired the conference, noted that there were about 9,600 people on methadone maintenance, some for more than 10 years, but that there had been little or no thought at policy level as to what should happen to them next. She said that Ireland as a society needed to be much more ambitious about people with addiction, recognise that they have huge potential and provide the supports so they can move out of addiction to recovery.

As with any social issue, it is the personal story that brings it alive. Pearse described the gains of 20 years on methadone:

When I was 16, I had a Junior Cert and an opiate addiction. Nothing changed for me since I went on methadone. Twenty years later, when I came off methadone I had a Junior Cert and an opiate addiction... People don't realise the effect of methadone. It puts the light inside you out. You're just dead.

Now six years clean and sober, Pearse has trained as a recovery coach and is completing a university degree.

Claire, another recovery coach who is now employed and works with women in recovery, also shared her recovery journey.

What has recovery given me? It's given me back a life with a whole new purpose and opportunities that I never could have dreamed of...Most importantly, it has given me a sense of feeling part of something. For years in active addiction, I was disconnected and had no sense of belonging to anything. Today I am a member of a recovery community.

A full conference report and slides of presentations can be found on the Recovery Academy of Ireland website at www.recoveryacademyireland.ie. The Academy can be contacted at recoveryacademyire@gmail.com

Gerry McAleenan

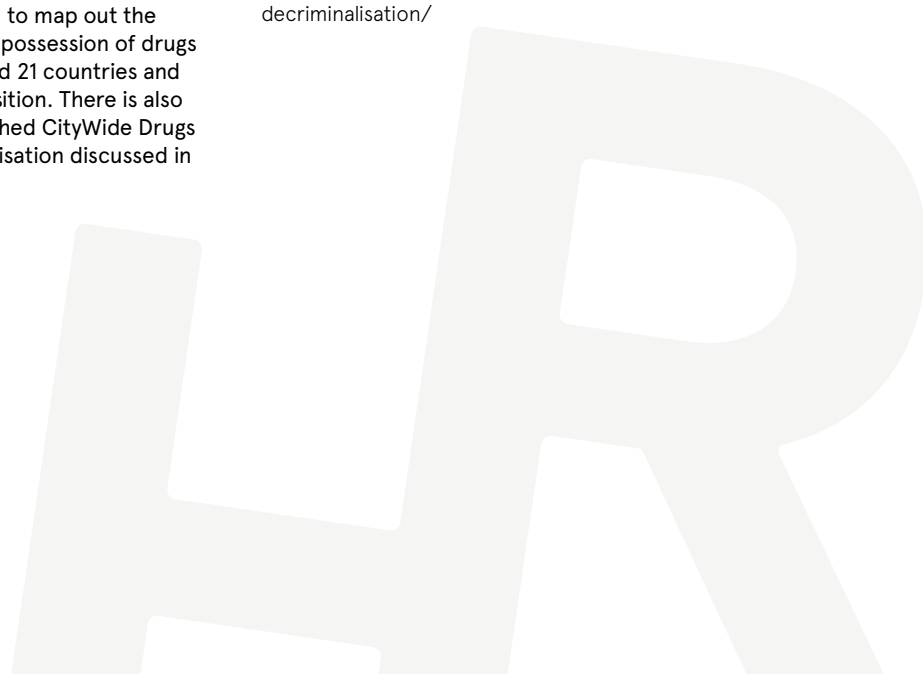
An e-tool to map models of decriminalisation

The International Drug Policy Consortium (IDPC) is a global network of 163 non-governmental organisations (NGOs).¹ It focuses on issues related to drug production, trafficking and use, promoting objective and open debate on the effectiveness, direction and content of drug policies at national and international levels. The network supports evidence-based policies that are effective at reducing drug-related harm. In collaboration with their NGO partners, in July 2015, the IDPC launched an e-tool designed to map out the models of decriminalisation for drug use or possession of drugs for personal use globally. The IDPC identified 21 countries and jurisdictions that had adopted this legal position. There is also a link to the tool through the recently launched CityWide Drugs Crisis Campaign website area on decriminalisation discussed in another article in this issue of *Drugnet*.²

The e-tool aims to map out how these models work in practice and allows the user to explore the differences between each policy. For each model, it does this by describing their legal framework, the role of the police (if any), the judicial or administrative process, the applicable sanction (if any), and providing examples of countries illustrating each model. It makes a distinction between decriminalisation that is *de jure* (i.e. decriminalisation enshrined in law) and that which is *de facto* (i.e. drug use remains a criminal offence by law, but no prosecutions take place in practice). The e-tool is available at <http://decrim.idpc.net/>

Lucy Dillon

- 1 For more information on the IDPC, visit <http://idpc.net>
- 2 CityWide Drugs Crisis Campaign website area on decriminalisation can be accessed at <https://www.citywide.ie/decriminalisation/>



Report from Blanchardstown's drugs and alcohol trends monitoring system

On 18 May 2017, Blanchardstown Local Drug and Alcohol Task Force (BLDATF) launched its report *Drug and alcohol trends monitoring system (DATMS) 2017: Year 2*.¹ BLDATF started the DATMS in 2015 to ensure they had a 'thorough, comprehensive and deep knowledge of the problems of the [Dublin 15] area' (p. 3) upon which to base decisions about service provision. This is the second annual report from the system.^{2,3} The system was designed to identify trends in patterns of drug use, and the authors caution that this requires three years of data. Therefore, any changes identified in the current report will require further investigation in the next rounds of data collection.

Methodology

The DATMS uses a mixed-method design, drawing on both primary and secondary data sources. Primary data sources included drug treatment data and data on at-risk under 18-year-olds. Data collection included interviews with treatment service users and outreach workers administered questionnaires in the local community. The team also collected extensive data on drug litter in the area, focusing on its visibility, locations for drug use, and types of drugs used and methods of administration. The data have been visually represented on a map of Dublin 15 that accompanies the published report.

Key findings

Below are the key findings from the report as they appear in its Executive Summary.

Treated drug use

- Treated drug use in Dublin 15 is increasing.
- The number of drug users aged under 18 years and aged 35 years and over in treatment is increasing.
- The number of Irish and non-Irish drug users in treatment is increasing.
- The number of Irish Traveller drug users in treatment is decreasing.
- Cannabis, alcohol, cocaine powder, and benzodiazepines/Z-drugs are the biggest problem for drug users aged under 18 years; the use of these drugs is increasing among this age group.
- Heroin, cannabis, alcohol, cocaine powder, benzodiazepines/Z-drugs, and methadone are the biggest problem for adult drug users.

- Heroin users are getting older, with few young people treated for this drug.
- The use of the following drugs is increasing among adult drug users: alcohol, cannabis, benzodiazepines/Z-drugs, powder and crack cocaine, Lyrica, and oxycodone.
- Polydrug use is the norm for the majority of treated drug users.
- Steroids and skin-tanning drugs are creating new hazards in Dublin 15.

Untreated drug use

- Alcohol, cannabis, MDMA, cocaine powder, and ketamine are the main drugs of use for untreated under 18-year-olds and adult drug users.
- Cocaine powder use is increasing among untreated under 18-year-olds and adult drug users.
- Cannabis resin use is increasing among Irish Traveller untreated drug users.
- Polydrug use is the norm for untreated under 18-year-olds and adult drug users; alcohol is an integral part of polydrug use.
- Drugs are mostly used at the weekend and the frequency of use is age dependent, with adults reporting more regular use.

Factors contributing to drug use

- Drugs and alcohol are easily accessed in Dublin 15.
- Alcohol, benzodiazepines/Z-drugs, cannabis resin, Lyrica, and oxycodone are increasing in availability.
- The internet continues to facilitate drug distribution and the darknet is a factor in availability.
- Drug use is normalised among some peer, family and work groups.
- A common perception is that drugs are widely used and risk free.
- The family context:
 - Children's education is being compromised by parental drug use.
 - Some drug use in Dublin 15 is intergenerational.

Consequences of drug and alcohol use

- Mental health:
 - Mental health disorders among treated adult drug users are increasing.
 - Mental health disorders among under 18-year-olds in Dublin 15 are increasing.
- Drug-related crime:
 - Drug dealers are getting younger and dealing occurs in schools.
 - Drug debt intimidation continues to be an issue for young people and adults.
- Social consequences:
 - Homelessness and poverty are increasing among drug users.
 - Drug use in schools is increasing and causing greater damage to education and leading to more exclusion.
 - Due to these social consequences rehabilitation is getting harder.

Blanchardstown monitoring continued

Drug litter

- Drug litter is widespread throughout Dublin 15.
- The largest concentrations of drug litter are outside areas traditionally associated with drug use, indicating many more drug users than are using services.
- Most drug litter relates to untreated drug use.
- Drugs are being used in hidden and inaccessible sites, increasing the hazards associated with drug use; many hidden sites are well developed and regularly used.

Gaps in service provision identified by research participants

- Access to mental health services is not improving, especially for young people.
- The prescribing of addictive medication requires regulation.
- Ex-service users working in the area are struggling without adequate supervision.

- There is limited access to buprenorphine treatment for opiate dependence in Dublin 15.
- There is a lack of access to educational psychological assessments for children from preschool age to secondary school age. This issue particularly affects people from disadvantaged backgrounds with no resources to fund private assessments.
- A number of service providers reported a lack of awareness about addiction services in Dublin 15.

Lucy Dillon

- 1 Blanchardstown Local Drug and Alcohol Task Force (2017) *Drug and alcohol trends monitoring system (DATMS) 2017: Year 2*. Dublin: Blanchardstown Local Drug and Alcohol Task Force. <http://www.drugsandalcohol.ie/27339/>
- 2 Blanchardstown Local Drug and Alcohol Task Force (2016) *Drug and alcohol trends monitoring system (DATMS) 2016*. Dublin: Blanchardstown Local Drug and Alcohol Task Force. <http://www.drugsandalcohol.ie/25281/>
- 3 McGuire V (2016) Drug and alcohol trends in Blanchardstown. *Drugnet Ireland*, 58: 14. <http://www.drugsandalcohol.ie/25963/>

Cannabis use in Ireland within the European context

Cannabis is the most widely used illicit drug in Europe and worldwide.¹ While increased mortality rates are not associated with cannabis use, a number of very serious and long-term negative health problems are correlated with regular and long-term cannabis use. These include dependence, mental illness, cognitive impairment, cardiovascular disease and pulmonary disorders, including lung cancer and chronic obstructive pulmonary disease.²

Cannabis use in Ireland

The National Advisory Committee on Drugs and Alcohol (NACDA) published data on drug use in Ireland in 2016.³ The survey found that cannabis is the most commonly used illicit drug in Ireland in both genders and across all age groups, regardless of lifetime, last year or last month use. The results of the survey, completed in 2014/2015, are representative of the general population. Of note, 28% of all adults (15–64 years) had used cannabis in their life, with 4.4% of these having used in the month prior to completing the survey.^{3,4} This is higher than the European average lifetime cannabis use, which stands at 26.3%.⁵

*The 22 European countries included in the study are Bulgaria, Cyprus, Czech Republic, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Portugal, Romania, Slovakia, Slovenia, Spain, the Netherlands, United Kingdom and Turkey.

In the last decade, an increasing trend in cannabis use is evident among Irish 15–34-year-olds, with 23.8% reporting cannabis use in their life in the 2002/2003 survey compared to 33.5% in this survey. A similar trend is seen in a number of other Northern European countries (Finland, Denmark, France, Germany and Sweden).⁷

Cannabis in first-time drug treatment entrants

As cannabis use has risen in the population so too has the number of people seeking specialised treatment for cannabis-related problems. Data on first-time entry into drug treatment services by cannabis users was published by EMCDDA-based Montanari and colleagues at Maastricht University in 2017.⁶ Information about people entering specialised drug treatment in 22 European countries, including Ireland, was included in the paper.* Specialised drug treatment was defined as people attending outpatient or inpatient centres, low threshold agencies, general practitioners (GPs) or treatment centres in prison in all participating countries. Irish data relevant to this paper were collected by the National Drug Treatment Reporting System (NDRTS) at the Health Research Board and routinely sent to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

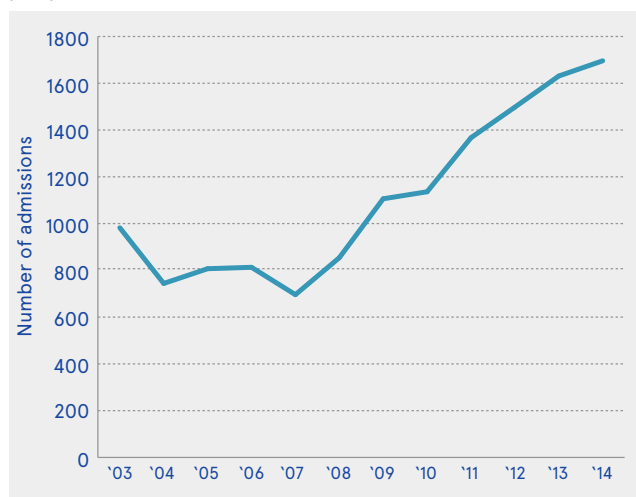
Cannabis was the problem drug used by approximately 30% of clients entering specialised drug treatment in 2014 across the 22 European countries (116,673 out of 400,125 admissions). Focusing on first-time treatment entrants alone, cannabis users accounted for 46% of all new entrants in 2014, with the highest numbers recorded in the UK, Germany, Spain and France. It is also important to note that the number of first-time cannabis treatment entrants has risen from 29% in 2003. In 2014, Ireland ranked eighth highest for the number of first-time cannabis treatment admissions (1,696).

Cannabis use continued

In Europe, the annual number of first-time cannabis treatment entrants has increased each year, with an average annual percentage change (AAPC) of 6.1% between 2003 (32,178) and 2014 (67,444). While Ireland experienced fluctuations in the numbers of first-time cannabis treatment entrants between 2003 and 2006, there has been an increase in the number of admissions since 2006 (Figure 1). From 2003 to 2006, there was an annual percentage change (APC) of -6.23%, and from 2006 to 2015 there was an increase of 11.70% per year. Taken together, Ireland is above the European average with a 6.55% AAPC, between 2003 (982) and 2014 (1,696).

In terms of general admission to specialised drug treatment centres in Ireland (first-time and repeat entrants), cannabis accounted for 28% of overall admissions in Ireland in 2015, following heroin (41%).⁷

Figure 1: The number of first-time cannabis treatment admissions per year in Ireland, 2003–2014



Source: National Drug Treatment Reporting System

Importantly, the paper states that the increases in first-time cannabis admissions do not appear to be due to an overall rise in admission numbers for primary illicit drug problems. The authors also identify a number of potential reasons for the European-wide increase in first-time treatment entrants for cannabis use, including an increase in population awareness of the risk of cannabis use, an increase in the offer and availability of drug treatment across Europe, and an increase in the prevalence and potency of cannabis and synthetic cannabinoids, resulting in more people presenting with negative health outcomes. In addition, changes to drug policies towards more permissive or punitive approaches and an improvement in the level of reporting and monitoring are cited as potential reasons for the rise in the number of first-time cannabis treatment entrants.

Limitations of the study

These include population-related bias; potentially low reporting rates of GPs and other service providers; lack of a 'synthetic cannabinoid' option at the treatment level, which means that all cases are classed as cannabis; and the fact that this paper looks at cannabis alone, as opposed to entrants seeking treatment for polydrug use including cannabis in the list of problem drugs. A lack of quality control of the data is also cited as a limitation, as the data are collected in each country independently and then reported centrally to the EMCDDA.

Conclusions

This data highlight the growing trend of cannabis use in Ireland and Europe, as well as the increasing demand for treatment of cannabis-related problems. In terms of service provision, the needs of cannabis users are very different to those of opioid users, which have typically been the focus of public health interventions across Europe. This data should be used to inform policy-makers and service providers to help address this ever-growing problem.

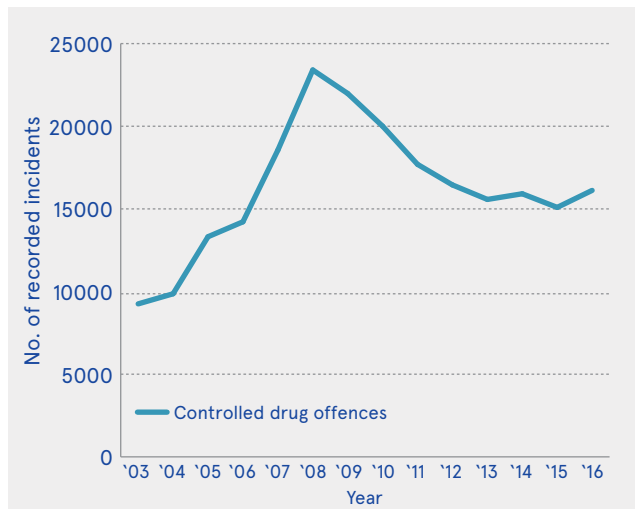
Thérèse Lynn

- 1 United Nations Office on Drugs and Crime (2017) *World drug report 2017*. Vienna: United Nations. <http://www.drugsandalcohol.ie/27436/>
- 2 Hall W, Renstrom M and Poznyak V (eds) (2016) *The health and social effects of nonmedical cannabis use*. Geneva: World Health Organization. <http://www.drugsandalcohol.ie/25267/>
- 3 National Advisory Committee on Drugs and Alcohol (NACDA) and Department of Health (UK) (2016) *Prevalence of drug use and gambling in Ireland and drug use in Northern Ireland*. Bulletin 1. Dublin: NACDA and Department of Health (UK). <http://www.drugsandalcohol.ie/26364>
- 4 Millar S (2017) Results from fourth general population survey on illicit drug use in Ireland. *Drugnet Ireland*, 60: 1–5. <http://www.drugsandalcohol.ie/26697/>
- 5 European Monitoring Centre for Drugs and Drug Addiction (2017) *European drug report 2017: trends and developments*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/27401/>
- 6 Montanari L, Guarita B, Mounteney J, Zipfel N and Simon R (2017) Cannabis use among people entering drug treatment in Europe: a growing phenomenon? *European Addiction Research*, 23(3): 113–121. <http://www.drugsandalcohol.ie/27310/>
- 7 European Monitoring Centre for Drugs and Drug Addiction (2017) *Country drug report 2017: Ireland*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/27404/>

Trends in recorded drug law offences 2003–2016

This article examines trends in drug law offences between 2003 and 2016. Crime data, which are collated on the PULSE system by An Garda Síochána, are provided to the Central Statistics Office (CSO) for analysis. An incident may consist of more than one criminal offence. A primary offence or detection may refer to one offence within an incident. Sometimes, a charged offence may be different from the offence originally identified in the incident. Nevertheless, incidents are a useful indicator of the level of particular types of criminal activities.¹ Figure 1 shows the available statistics for recorded incidents of drug offences between 2003 and 2016, as entered on the PULSE system by Gardaí.

Figure 1: Recorded total number of controlled drug offences between 2003 and 2016



Source: Central Statistics Office website (www.cso.ie)

Recorded incidents of drug offences

Figure 1 provides a summary of the total number of controlled drug offences recorded by Gardaí. Following a decline between 2008 and 2013, the total number of controlled drug offences recorded in Ireland increased in 2014 (4%). Although a decline of 5% (15,915 to 15,090) was recorded between 2014 and 2015, the number of offences recorded increased by 7% between 2015 and 2016.² Further insight can be obtained by examining recorded incidents for supply (importation and cultivation/manufacture of drugs) and possession (sale or supply or personal use) offences separately.

Supply

Figure 2 shows a breakdown of the number of controlled drug offences by importation or by cultivation or manufacture of drugs recorded between 2003 and 2016.

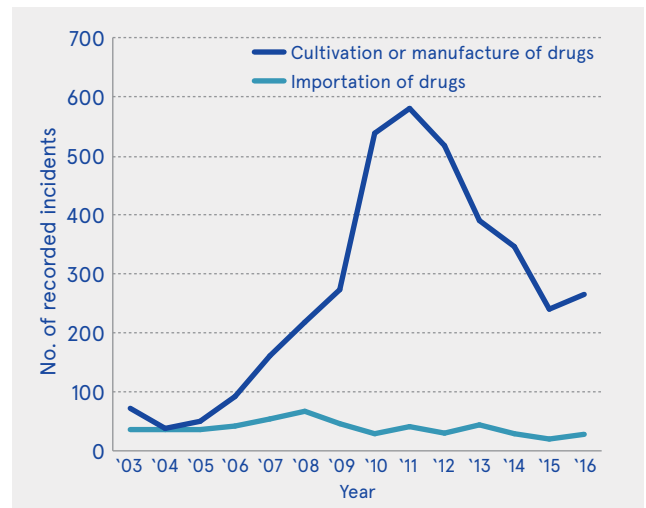
Importation of drugs

Essentially, between 2003 and 2016 an increase/decrease trend has been evident for recorded importation of drugs incidents. Increases were seen between 2005 and 2008 (86%), 2010 and 2011 (41%), 2012 and 2013 (47%), and 2015 and 2016 (40%). Decreases were seen from 2008 to 2010 (-57%), 2011 to 2012 (-27%), and 2013 to 2015 (-55%).

Cultivation or manufacture of drugs

Recorded incidents for the cultivation or manufacture of drugs increased between 2003 and 2011. The increase each year between 2006 and 2010 was substantial. Between 2011 and 2015, there was a steady decline in the number of such incidents reported; 2015 figures were nearly 60% lower than 2011. Between 2015 and 2016, recorded incidents increased by 10% (see Figure 2).

Figure 2: Recorded incidents of controlled drug offences categorised by importation of drugs and by cultivation or manufacture of drugs, 2003–2016



Source: Central Statistics Office website (www.cso.ie)

Possession of drugs

Figure 3 shows the number of recorded incidents for possession of drugs for sale or supply and for personal use.

Sale or supply

Although the number of recorded offences for possession of drugs for sale or supply increased between 2004 and 2008, a steady decline was seen between 2008 and 2013. Since 2013, the number of incidents recorded increased by 10% in 2014, decreased in 2015 (6%), and increased again in 2016 (9%).

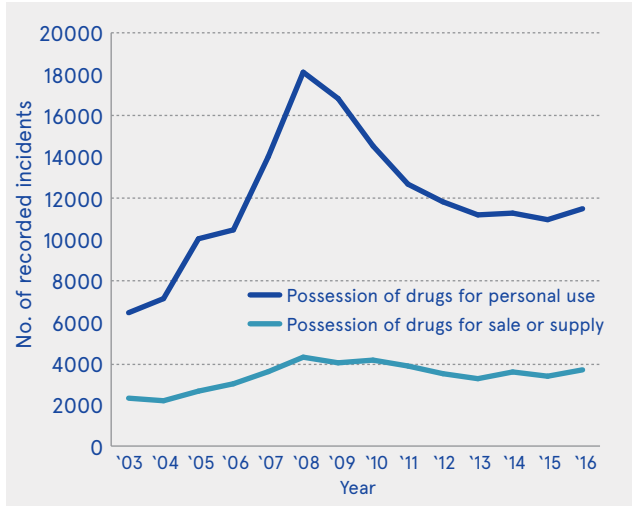
Personal use

The number of incidents recorded for possession of drugs for personal use increased between 2003 and 2008. A decreasing trend was seen between 2008 and 2013. Since 2013, incidents recorded for possession of drugs increased in 2014 (<1%, 85), decreased in 2015 (3%, 317) and increased again by 5% (530) in 2016 (see Figure 3).

Drug law offences 2003–2016

continued

Figure 3: Recorded incidents of controlled drug offences categorised by possession for sale or supply or for personal use



Source: Central Statistics Office website (www.cso.ie)

Other drug offences

The category 'possession/supply drug offences, drug-related crime' also has a classification for other drug offences, which includes forged or altered prescription/obstruction offences.

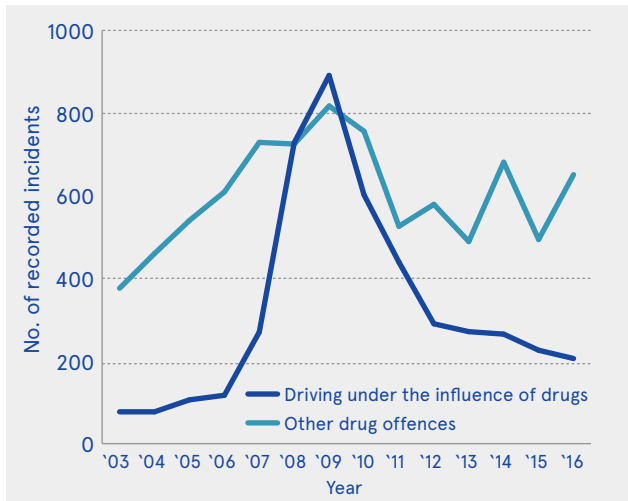
Forged or altered prescription/obstruction under the Misuse of Drugs Acts 1977–2016

Although a substantial decrease (28%) was shown in this category between 2014 (681) and 2015 (494), crimes recorded increased by 24% (157) to 651 in 2016 (see Figure 4).

Driving under the influence of drugs

Driving under the influence of drugs has been a statutory offence in Ireland since the enactment of the Road Traffic Act 1961.³ A decreasing trend for this offence has been evident since 2009, and continued in 2016 (see Figure 4).²

Figure 4: Recorded incidents of other drug offences* and driving under the influence of drugs, 2003–2016



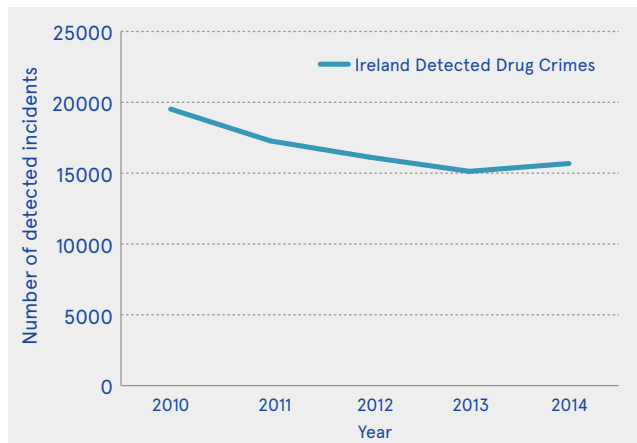
Source: Central Statistics Office website (www.cso.ie)

*Other drug offences include forged or altered prescription offences and obstruction under the Misuse of Drugs Acts 1977–2016

Detected drug offences 2010 and 2014

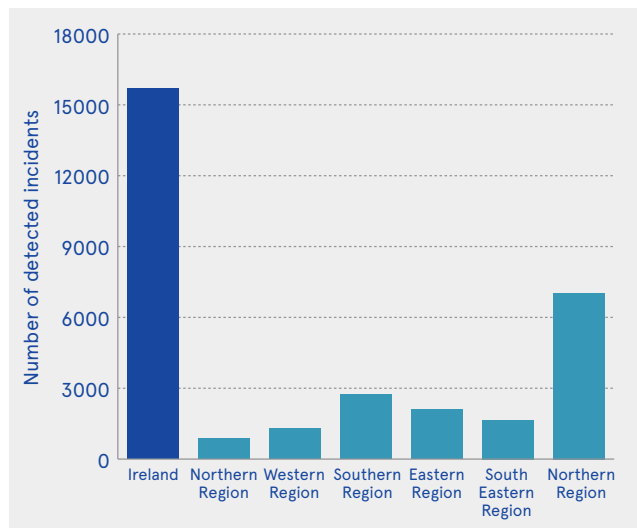
Court proceedings statistics shed light on the level of recorded incidents that become *detected crimes*, i.e. a crime that has been solved by An Garda Síochána. The most recent available data are for 2010 to 2014 (see Figure 5). The number of offences detected decreased between 2010 and 2013 by 23%. Between 2013 and 2014, detections increased slightly by just over 3%. Notably, an examination by region indicates that, although detected offences are dispersed throughout the island of Ireland, the majority of detections (45%) occur in the Dublin Metropolitan Region followed by the Southern Region (17%) representing Cork City, Cork North, Cork West, Kerry, Limerick (see Figure 6).

Figure 5: Detected drug offences for Ireland, 2010–2014



Source: Central Statistics Office (2017), unpublished data

Figure 6: Detected drug offences for Ireland and by region, 2014



Source: Central Statistics Office (2017)

Ciarra H Guiney

- 1 Central Statistics Office (2014) *Interpreting crime statistics: a background briefing note*. <http://www.drugsandalcohol.ie/24806/>
- 2 Central Statistics Office (2017) Crime and justice statistics. Available online at <http://cso.ie/en/statistics/crimeandjustice/>
- 3 Road Traffic Act 1961. Available online at <http://www.irishstatutebook.ie/eli/1961/act/24/enacted/en/html>

Cross-border organised crime: threat assessment 2016

In September 2016, An Garda Síochána (AGS) and the Police Service of Northern Ireland (PSNI) published their biannual cross-border organised crime threat assessment.¹ The aim of the report was to provide insight into how criminal activity orchestrated by organised crime groups (OCGs), North and South of the border, is disrupted by the work of the Cross Border Joint Agency Task Force (CBJATF). The CBJATF involves interagency engagement between the PSNI, AGS, Revenue, HM Revenue & Customs and other agencies, such as the National Crime Agency and the Criminal Assets Bureau.

Abuse of common travel area

A common travel area (CTA), which has existed between the Republic of Ireland (ROI) and the United Kingdom (UK) since the 1920s, allows for the free movement of goods, money, people and information. Despite the many positive aspects of a CTA, the land border (approx. 224 miles) that occurs between the ROI and Northern Ireland (NI) can leave the CTA exposed to abuse from criminals, such as OCGs, who view the setting as a way to undertake a wide range of criminal behaviour, for example, the smuggling of various illicit commodities including drugs, fuel, firearms, counterfeit and contraband cigarettes and alcohol (p. 6).

Organised crime groups

Investigations into OCGs on both sides of the border have demonstrated that links and communication between groups are strong. Indeed, intel on mobile OCGs, which focuses on cross-border activity, suggests that OCGs from the South travel into the North to carry out crimes and vice versa. Notably, these offenders willingly resort to violence; in consequence, victims and police personnel are at risk. The majority of cross-border links are for drug-related activities, for example, trafficking and the cultivation and importation of heroin, cocaine and cannabis. To ensure criminality succeeds, OCGs have established 'mutually beneficial business relationships' throughout each area (p. 7).

Foreign national OCGs, originating from South East Asia, Africa, Portugal, Spain, Italy, Russia, Lithuania, Albania, Romania and elsewhere in Europe, have become more prominent in NI. These groups also undertake criminal behaviour in the South. It is alleged that key members are located in the ROI and repeatedly obtain money from criminal activities undertaken in NI. In addition, paramilitary groups involved in organised crime also operate North and South of the border.

Cross-border organised crime: drugs

The report highlights that drugs and drug-related criminality is a 'common concern' in NI and the ROI. During the last number of years, the drug market has become more varied. 'Traditional' drugs remain prominent (p. 8); however, new psychoactive substances (NPS) are on the rise. The main source of income for OCGs throughout the island is from 'traditional' drugs, and how these products are imported and dispersed remains unchanged. For example:

- Cannabis is the most widespread drug in the ROI and NI. Data from drug treatment centres, in both regions, indicate that treatment referrals for cannabis are higher than for other drug types.

- Prevalence rates suggest that there are 18,000 to 23,000 heroin users in the ROI; the vast majority are thought to reside in Dublin. Although heroin seizures increased between 2014 and 2015 and between 2015 and 2016 in NI, the amounts were small. However, due to concerns within the community and with the aim of protecting the public at large, PSNI investigations are ongoing.
- Cocaine markets in the ROI have been declining since 2007, mainly because of the poor economic climate. However, the value of cocaine seizures nearly doubled between 2013 (€3.6 million) and 2014 (€7.5 million). In NI, seizures in 2015/2016 were lower than the previous year mainly as a result of a large 50 kg seizure, which occurred in late 2014.
- Crack cocaine is the drug of choice for individuals whose primary addiction is heroin. As a result, its use is not widespread. No cases have been reported in NI.
- More recently, NPS have emerged as being seriously problematic North and South. A survey carried out by the European Commission indicated that 16% of young people in the ROI have tried NPS.² Some 443 NPS are currently being monitored by the EMCDDA.
- Although methamphetamine has been low in the ROI for the last decade, in the last two years, four 'box labs' that produce methamphetamine (p. 11) were found in Cork (1), Kerry (1) and Dublin (2).
- Producing tablets from pharmaceutical drugs, for example, zopiclone, zolpidem or benzodiazepine powders, involves ROI OCGs. Prescription drugs, such as alprazolam, diazepam and flurazepam, were available illegally and were widespread throughout the ROI. Similarly in NI, prescription drugs, in particular diazepam, are three times more likely to be identified as cause of death than heroin, cocaine, amphetamines and mephedrone altogether.

Cross-border activity

The PSNI and AGS are aware of the cross-border links between OCGs North and South of the border, in particular for drug-related crimes. For example:

- Cannabis, cocaine and heroin are imported from the ROI to NI by OCGs.
- OCGs on both sides of the border collaborate to import drugs from Europe.
- OCGs in NI have links with OCGs in cities in the ROI.
- Drugs are brought to NI via cars, motorcycles, vans, lorries, taxis, trains and buses.
- The ROI is used as a transit route by OCGs based in NI, where drugs are imported via ports and then transported to NI to be distributed or sold.

With the aim of targeting drug-related crime, joint collaborations are carried out between the PSNI and AGS. For example, in January 2016, the PSNI detained two men in Belfast during the handover of herbal cannabis valued at £1 million. In a subsequent home search in Drogheda, cannabis and cocaine were recovered (estimated value £63,000).

In another joint operation between the AGS and PSNI, codenamed Operation Solaro, cannabis plants were recovered from five locations in NI (estimated value £3m) and in County Meath (estimated value €750). Arrests were made by the PSNI in NI and the AGS in County Meath, numbering 10 and three, respectively. Most of the suspects were detained on drug trafficking offences.

Ciara H Guiney

1 Police Service of Northern Ireland and An Garda Síochána (2014) *Cross border organised crime: threat assessment 2016*. Belfast and Dublin: Department of Justice (UK) and Department of Justice and Equality (ROI). Available online at [http://www.octf.gov.uk/Publications/SARS-information-\(1\)/Cross-Border-Organised-Crime-Assessment-2016](http://www.octf.gov.uk/Publications/SARS-information-(1)/Cross-Border-Organised-Crime-Assessment-2016)

2 Gallup Organization and European Commission (2011) *Youth attitudes on drugs: analytical report – Flash Eurobarometer 330*. Brussels: European Commission. Available online at http://ec.europa.eu/commfrontoffice/publicopinion/flash/fl_330_en.pdf

Injecting drug use and hepatitis C treatment

People who inject drugs (PWID) represent the majority of the hepatitis C virus (HCV) epidemic in the developed world.¹ The majority of new infections develop in active PWID, with this group accounting for more than 80% of new infections in high-income countries.² Furthermore, an additional large reservoir of infection exists among former PWID who remain undiagnosed.

Historically, HCV treatment guidelines have excluded PWID from consideration for treatment. Drug injectors are viewed as having 'difficult to treat' HCV disease, with perceived inferior treatment adherence and outcomes, and concerns regarding reinfection risk. Important factors that have limited treatment uptake in PWID are the contraindications and adverse effects of interferon (IFN) based therapy. The development and availability of IFN-free direct acting antiviral (DAA) regimes with high efficacy, improved tolerability and a limited side-effect profile will significantly increase the proportion of patients who can be offered HCV therapy. However, adherence to therapy in 'real world' population groups will remain paramount in the DAA era.

A recent study conducted in Ireland investigated differences in HCV treatment adherence and outcomes between former PWID, recent PWID, and non-drug users treated with IFN and ribavirin therapy.³ In this study, published in the journal *PLOS ONE*, differences between PWID and non-drug users were analysed for adherence to treatment and outcomes in all patients treated for chronic HCV infection in a university teaching hospital from 2002 to 2012. The PWID group also included former and recent drug users who were treated in a community-based drug treatment centre.

Results

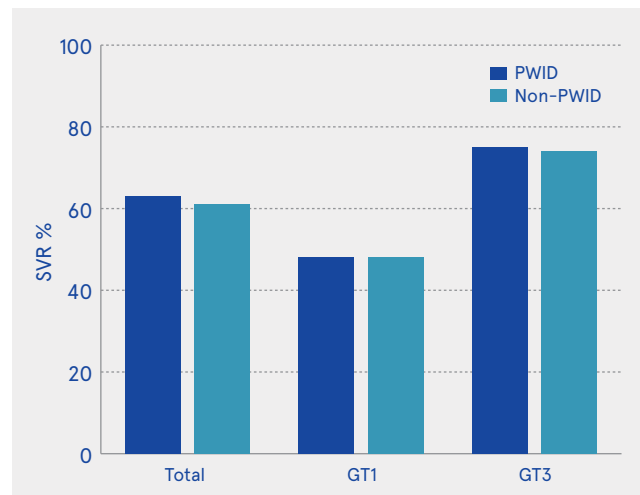
Treatment completion/compliance

There were 608 former PWID, 85 recent PWID, and 307 non-PWIDs who commenced HCV therapy. There was no significant difference in treatment non-completion (for reasons other than virologic non-response) between PWID and non-PWIDs (8.4% vs 6.8%, relative risk: 1.23, 95% CI: 0.76–1.99). Additionally, there was no significant difference in treatment non-completion between former and recent PWID (8.7% vs 5.9%, relative risk: 0.84, 95% CI: 0.33–2.10). Fifteen patients (17.6%) in the recent PWID group tested positive for opiates at least once during treatment, 11 (12.9%) tested positive for benzodiazepines, and 5 (5.8%) tested positive for cocaine. Seven patients tested positive for two of the drug classes, while 5 tested positive for all three classes. No patients reported injecting illicit drugs during treatment or in the 6-month post-treatment follow-up period.

Response to treatment

As shown in Figure 1, the overall sustained virologic response (SVR) rate in PWID (64.1%) was not different from non-PWIDs

Figure 1: Treatment response. Rates of sustained virologic response (95% CI bars) with dual therapy in PWID and non-PWID (a) for all genotypes: 64.1% vs 60.9% (b) genotype 1: 48.6% vs 48.6% and (c) genotype 3: 74.7% vs 73.3%



Source: *PLOS ONE*, 2017

(60.9%) (relative risk: 1.05, 95% CI: 0.95–1.17). In addition, there was no significant difference in SVR rates between the groups when comparing genotype (GT) 1 and genotype 3 infections. Follow-up data on 219 former PWID who achieved SVR between 2002 and 2007 for a median of 57 months (range 6–168 months) indicated that 13 patients were reinfected with HCV, a reinfection rate of 10.5/1000 person years of follow-up. All 13 patients had a relapse in injecting drug use. There was no significant difference in reinfection rate between former PWID with and without HIV co-infection.

Conclusions

The results from this large retrospective study of a decade of HCV treatment outcomes indicate that PWID have similar treatment adherence to IFN and DAA HCV therapy as non-PWID patients with chronic HCV infection. In addition, PWID patients have a comparable response to treatment. The authors concluded that prioritising PWID for HCV treatment may be a more cost-effective initiative for reducing long-term health costs and that HCV elimination is an ambitious target that cannot be achieved by excluding PWID from treatment.

Seán Millar

- 1 Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D and Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet*, 378: 571–83.
- 2 Cornberg M, Razavi HA, Alberti A, Bernasconi E, Buti M, *et al.* (2011) A systematic review of hepatitis C virus epidemiology in Europe, Canada and Israel. *Liver International*, 31: 30–60.
- 3 Elsherif O, Bannan C, Keating S, McKiernan S, Bergin C and Norris S (2017) Outcomes from a large 10 year hepatitis C treatment programme in people who inject drugs: no effect of recent or former injecting drug use on treatment adherence or therapeutic response. *PLOS ONE*, 12(6): e0178398.

Trends in alcohol, tobacco and cannabis use among school-aged children in Ireland, 1998–2014

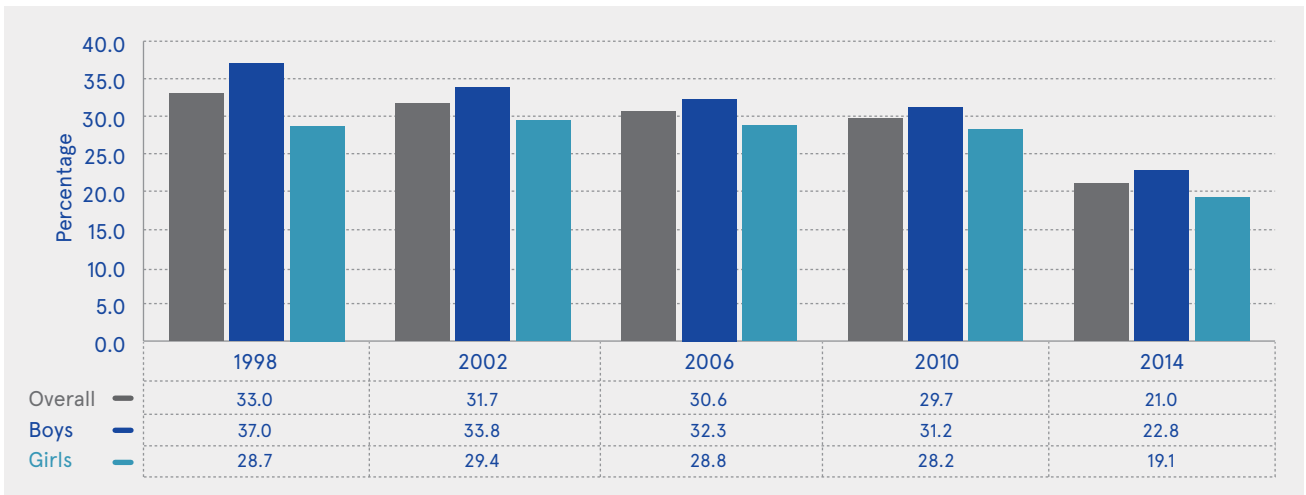
The first Health Behaviour in School-Aged Children (HBSC) survey was conducted in Ireland in 1998 and has been repeated every four years since then. In 2014, the study was conducted in Ireland for the fifth time. This survey included 13,611 children drawn from 3rd class in primary school through to 5th year in post-primary school; 230 primary and post-primary schools across Ireland participated. Data were collected on general health, social class, smoking, use of

alcohol and other substances, food and dietary behaviour, exercise and physical activity, self-care, injuries, bullying and sexual health behaviours. This article presents findings from a 2017 report which examined trends in alcohol, tobacco and cannabis use among 10–17-year-old children between 1998 and 2014.¹

Alcohol use

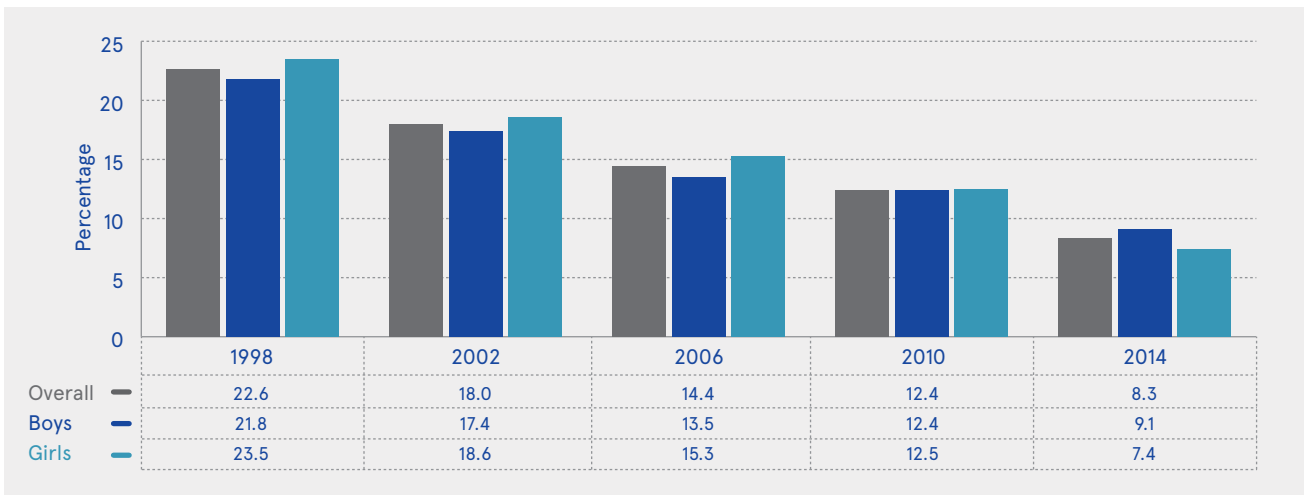
Children were asked if they had ever had so much alcohol that they were really drunk. The response options ranged from 'never' to 'yes, more than 10 times'. Findings indicated that there has been a statistically significant decrease in the proportion of children who reported having ever been drunk between 1998 and 2014 (Figure 1). Statistically significant decreases in the proportion of those who had ever been drunk were observed in boys and girls and in children from all age groups, and all social class groups, over time. Overall, 58.2%, 57.2%, 52.7% and 41.2% of 15–17-year-olds reported having ever been drunk in 2002, 2006, 2010 and 2014, respectively. Of those who had ever been drunk, there was a statistically significant decrease between 2002 and 2014 in the proportion of 15–17-year-old boys and girls who reported having their first alcoholic drink aged <11, <13 and <15 years.

Figure 1: Percentage of 10–17-year-olds who reported having ever been drunk, overall and by gender from 1998 to 2014



Source: HBSC Ireland, 2017

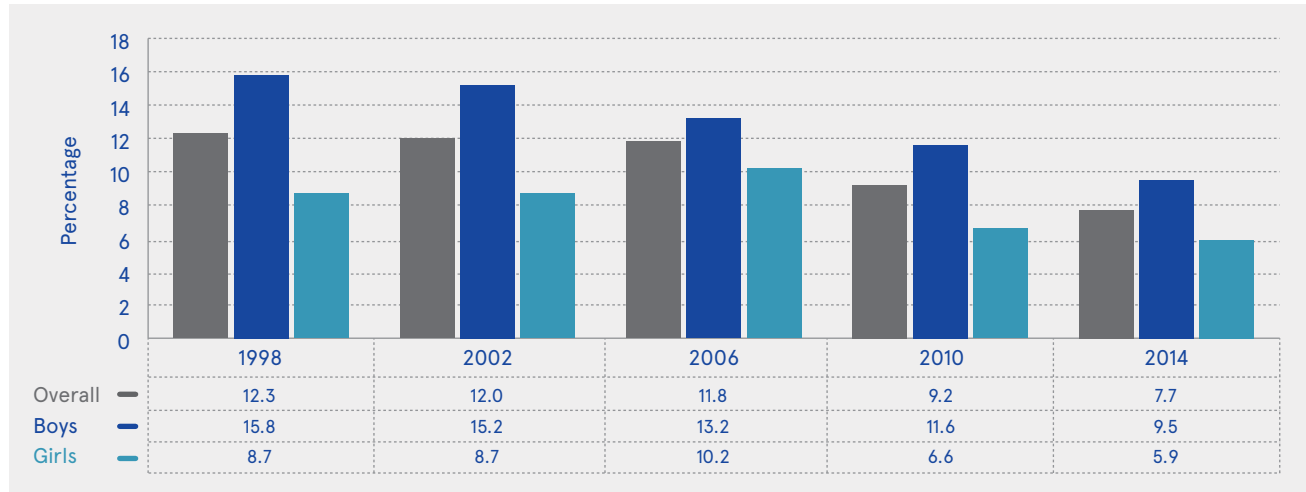
Figure 2: Percentage of 10–17-year-olds who reported being a current smoker, overall and by gender from 1998 to 2014



Source: HBSC Ireland, 2017

Trends in alcohol, tobacco and cannabis use continued

Figure 3: Percentage of 10–17-year-olds who reported using cannabis in the last 12 months, overall and by gender from 1998 to 2014



Source: HBSC Ireland, 2017

Tobacco use

Children were asked how often they smoke at present. The response options ranged from 'I do not smoke' to 'every day'. Current smoking as presented below is defined as smoking monthly or more frequently. Between 1998 and 2014, there was a statistically significant decrease in the proportion of children who reported being a current smoker (Figure 2). Compared to 1998, significantly fewer boys and girls reported being a current smoker in 2014. Over time, statistically significant decreases in the proportion of current smokers were apparent in all age and social class groups. Overall, 61.7%, 54.2%, 46.1% and 27.5% of 15–17-year-olds reported ever having smoked in 2002, 2006, 2010 and 2014, respectively. Of those who had ever smoked, there was a statistically significant decrease between 2002 and 2014 in the proportion of 15–17-year-old boys and girls who reported having smoked their first cigarette aged <11, <13 and <15 years.

Cannabis use in the last 12 months

Children were asked if they had used cannabis in the last 12 months. The response options ranged from 'never' to '40 times or more'. The findings below present the proportion of children who reported cannabis use in the last 12 months. Between 1998 and 2014, there was a statistically significant decrease in the proportion of children who reported using cannabis (Figure 3). Statistically significant decreases in the proportion of children who reported cannabis use over time were apparent in the majority of the age and social class groups.

International ranking (15-year-olds)

In 2014, 15-year-olds in Ireland were below the international HBSC average for being a current smoker (Ireland 10.8%; HBSC average 17.1%). Ireland ranked 12th in 1998, 20th in 2002, 13th in 2006, 23rd in 2010 and 25th in 2014. With regard to children reporting ever having been drunk, 15-year-olds in Ireland were below the international HBSC average for this indicator (Ireland 27.0%; HBSC average 37.6%). Ireland ranked 18th in 1998, 21st in 2002, 17th in 2006, 17th in 2010 and 21st in 2014. No internationally comparable data were available regarding cannabis use.

Conclusions

In summary, results from the HBSC surveys suggest a decline in the use of alcohol, cigarettes and cannabis among school-aged children in the Republic of Ireland. In a commentary on the report, the Minister of State for Health Promotion at the Department of Health, Marcella Corcoran Kennedy TD, noted that the HBSC surveys provide policy-makers and researchers with access to key data to inform policy and service development. The data are also a key factor in designing policy for the prevention of poor health behaviours and for the promotion of healthy ones.

Seán Millar

1 Keane E, Gavin A, Perry C, Molcho M, Kelly C and Nic Gabhainn S (2017) *Trends in health behaviours, health outcomes and contextual factors between 1998–2014: findings from the Irish health behaviour in school-aged children study*. Dublin: Department of Health and National University of Ireland Galway. <http://www.drugsandalcohol.ie/27365/>

Increase in cocaine use among OST patients

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) annual report for 2017 on estimates of drug use in the European Union (EU),¹ cocaine is the most commonly used illicit stimulant drug in Europe. It is estimated that 17.5 million European adults (aged 15–64 years), or 5.2% of this age group, have experimented with cocaine at some time in their lives. Among these are about 2.3 million young adults aged 15 to 34 years (1.9% of this age group) who have used the drug in the last year. Only Ireland, Spain, the Netherlands and the United Kingdom (UK) report last-year prevalence of cocaine use among young adults of 2.5% or more.¹ The 2014/15 general population survey reported that 2.9% of young Irish adults had used cocaine in the last year.² Around one million seizures of illicit drugs are reported annually in Europe. Cocaine is the second most commonly seized drug (after cannabis). In total, around 87,000 seizures of cocaine were reported in the EU in 2015. Both the number of cocaine seizures and the quantity seized increased between 2014 and 2015 in Europe.¹

Cocaine use in Ireland

In Ireland, in 2015, drug seizures conducted by An Garda Síochána alone included 108,817 grams of cocaine at an estimated street value of €7,617,223.³ Increased seizures of cocaine have been reported by Forensic Science Ireland.⁴ Information on the strength of cocaine currently in circulation in Ireland is not known. However, in 2015, Forensic Science Ireland reported that the average purity of 158 bulk cocaine samples analysed was 40% (range 0.03–91%), while that of 36 street cocaine samples analysed was 24% (range 0.1–78%); 21 from Dublin (average 28%) and 15 from outside Dublin (average 19%).⁴

The National Drug Treatment Reporting System (NDTRS) recorded cases of treated problem drug and alcohol use in Ireland between 2009 and 2015. Cocaine remains the third most common drug reported. In 2015, 10.4% of cases reported problem cocaine use, the highest proportion since 2010.⁵

European drug data

European Drug Emergencies Network (Euro-DEN Plus) monitored 5,054 drug-related hospital emergency presentations in 15 sentinel hospitals in nine European countries over a 12-month period (October 2013–September 2014), including two Irish hospitals. These were Our Lady of Lourdes Hospital, Drogheda and the Mater Misericordiae University Hospital, Dublin. Presentations had a median age of 31 years, and most were male (77%). On average, about 1.5 drugs were reported per presentation. Cocaine was the second most common drug involved in presentations overall; in the Mater Misericordiae University Hospital, cocaine was involved in 102 (19.4%) of presentations, second only to heroin at 154 (29.3%) of presentations.⁶

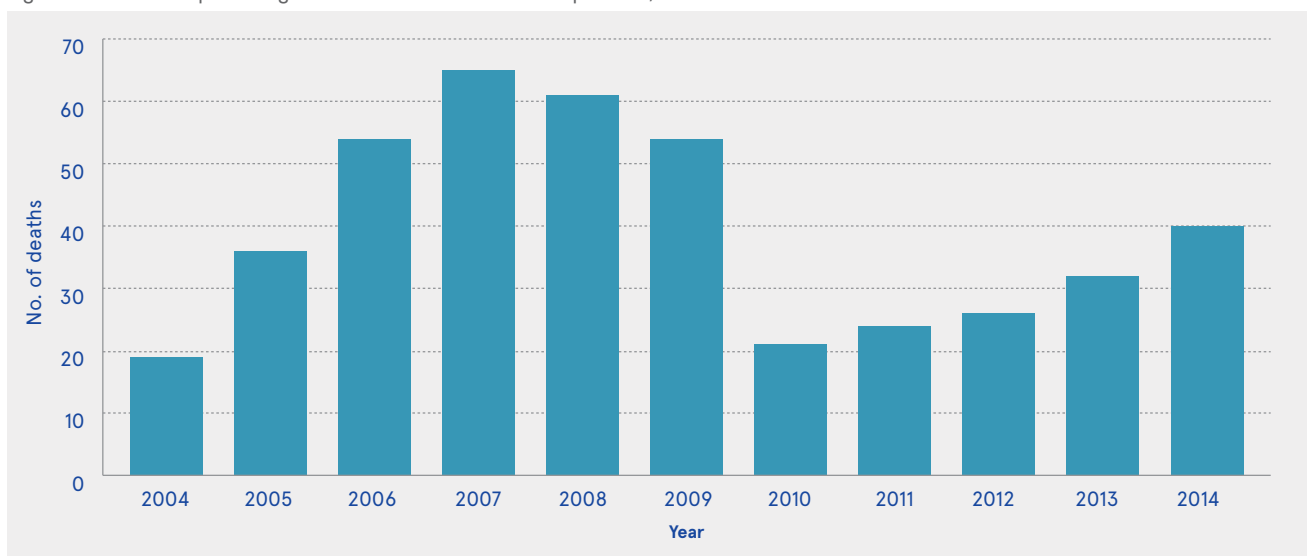
Drug use is a recognised cause of avoidable mortality among European adults. Ireland has the fourth highest drug overdose death rate in Europe (71 per million).¹ Poisoning deaths in Ireland where cocaine was implicated decreased over the years of economic recession from a high of 65 in 2007 to 21 in 2010. However, since 2010, the number of deaths where cocaine was implicated have been increasing again. There was a 25% increase from 32 deaths in 2013 to 40 deaths in 2014 (NDRDI data) (Figure 1).⁷

National Drug Treatment Centre drug testing

The Health Service Executive (HSE) National Drug Treatment Centre (NDTC) laboratory provides a national service to the HSE Addiction Services, hospitals, general practitioners, voluntary organisations, juvenile detention centres, the Probation Service, and the Courts Service. The laboratory is accredited by the Irish National Accreditation Board (INAB) to ISO/IEC 17025 standard (INAB scope 169T). The majority of the testing carried out is for patients who are on opioid substitution treatment (OST). Because of the large sample throughput per annum, the NDTC laboratory is ideally placed to monitor trends in the prevalence of drug use in the addiction population. The percentage of samples testing positive for drugs of abuse may be used as a quantitative measure of the extent of their use.

The number of samples positive for cocaine were high in this cohort during the years 2004–2009 (which roughly correspond to the Celtic Tiger years), but decreased between 2008 and 2012, from 9.6% to 4.9%, respectively, which again could be attributed to the recession years.

Figure 1: Number of poisoning deaths where cocaine was implicated, NDRDI 2004–2014



Cocaine use among OST patients continued

Figure 2: Numbers of samples testing positive for cocaine

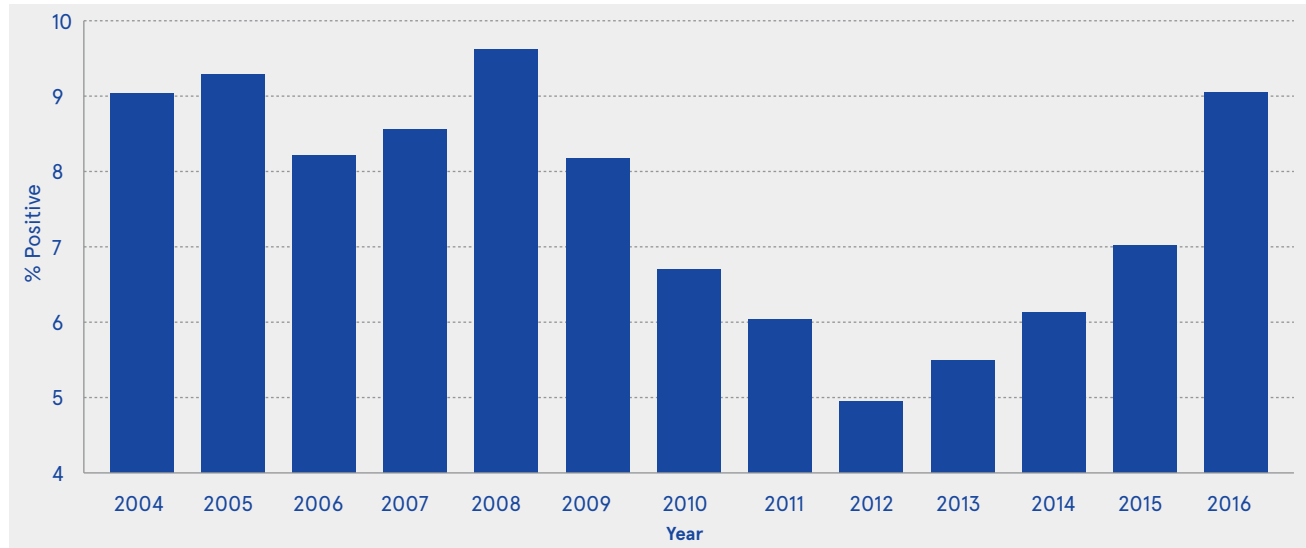
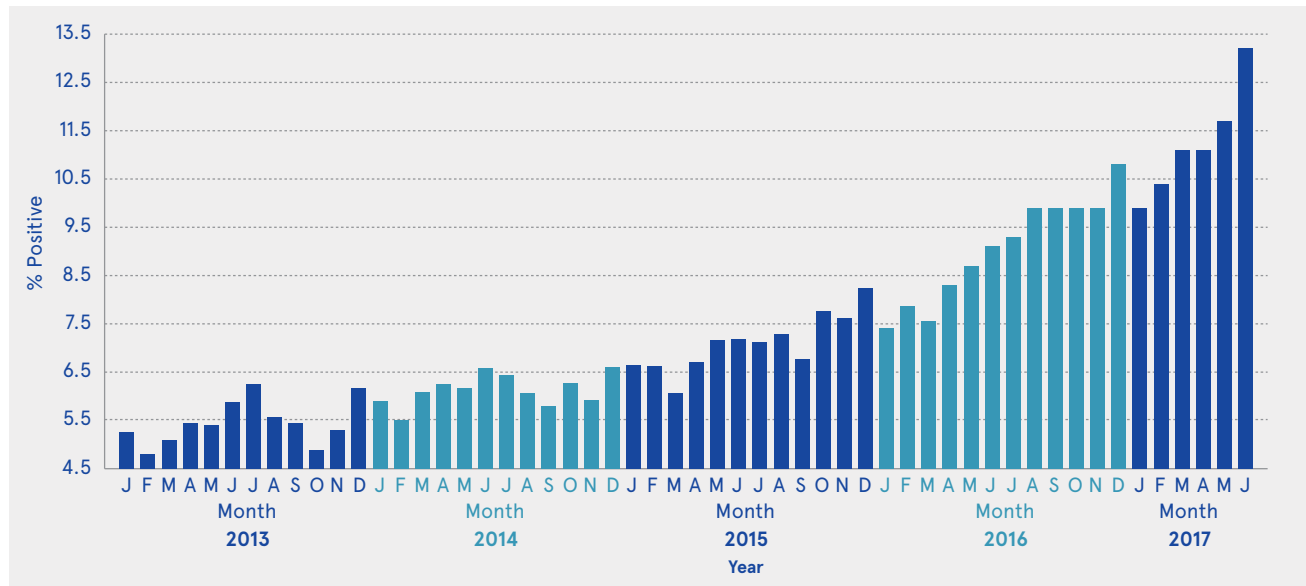


Figure 3: NDTC laboratory monthly cocaine average positive samples, January 2013–June 2017



However, since 2012, there has been year-on-year increases in the numbers of samples testing positive for cocaine (Figure 2).

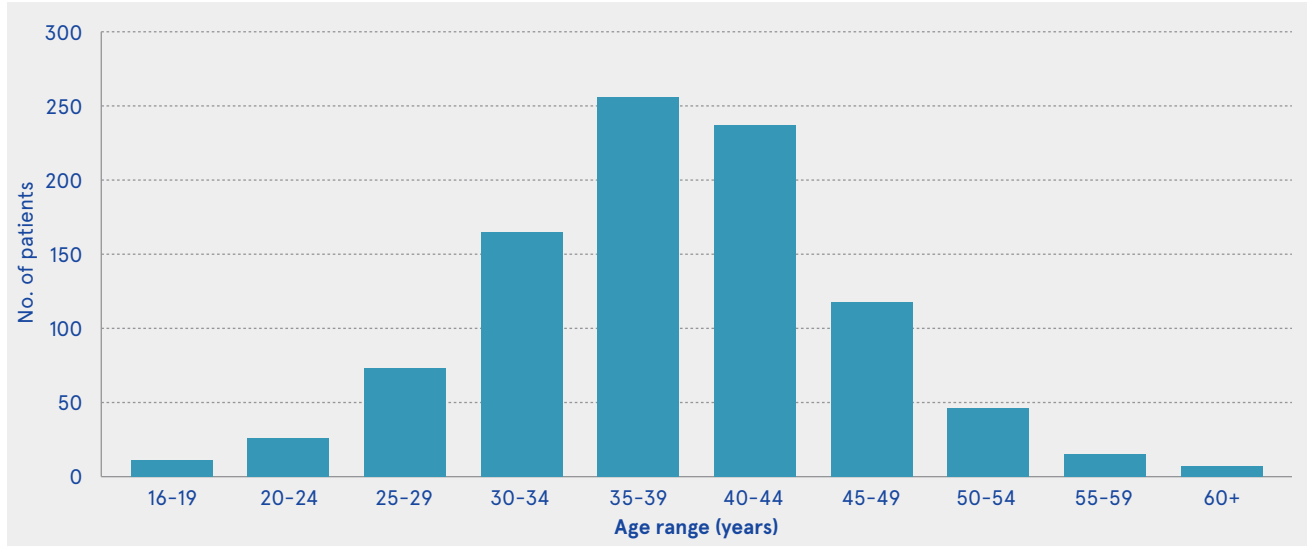
A degree of correlation between the number of deaths where cocaine was implicated and patient samples testing positive for cocaine seems evident (as would be expected). With increased cocaine usage in 2015 and 2016, one might anticipate increased deaths involving cocaine in these years (figures not yet available) and further increases into the future, as cocaine positive samples are continuing to increase month by month (Figure 3). In June 2017, 13.2% of all samples tested positive for cocaine. This is significantly higher than what was seen at the height of the Celtic Tiger from 2004 to 2008 and the ongoing trajectory appears to be upwards.

It should be noted that these percentages represent the average positive samples over all of the patients and include patients in abstinence programmes. While the average in June 2017 reached a high of 13.2%, further breakdown of the data shows that there are significant regional variations, with the use of cocaine being much greater in Dublin. Positive samples over Dublin OST clinics in June 2017 averaged 17.6%, with one clinic as high as 34%. The routine testing used does not distinguish between cocaine powder and crack cocaine.

In Europe overall, reflecting the ageing nature of its opioid-using population who are at greatest risk of drug overdose death, overdose mortality rates peak at age 35–39 years for males and age 30–34 years for females. While the NDTRS data⁷ show that the median age of cases in treatment for problem drug use (excluding alcohol) increased from 28 years in 2009 to 30 years in 2015, the median age for this group who tested positive for cocaine was 38 years.

Cocaine use among OST patients continued

Figure 4: Age profile of patients testing positive for cocaine, April 2017



Eleven (1.2%) patients were aged 16–19 years; 26 (2.7%) were aged 20–24; 73 (7.7%) were aged 25–29; 165 (17.3%) were aged 30–34; 237 (28.8%) were aged 35–39; 237 (24.8%) were aged 40–44; 118 (12.4%) were aged 45–49; 46 (4.8%) were aged 50–54; 15 (1.6%) were aged 55–59; and 7 (0.7%) were over 60 (Figure 4).

Of 954 patients who tested positive for cocaine in the NDTC laboratory in April 2017, 71% were male and 29% female.

Discussion

It is evident that cocaine use is increasing again among this vulnerable cohort. With increased numbers of patients attending OST also using cocaine, treatment needs to be adapted to address the different challenges presented and to try to reduce the ongoing death toll from cocaine. The general public should also be made aware of the very real risk of fatality from cocaine use.

Siobhan Stokes

- 1 European Monitoring Centre for Drugs and Drug Addiction (2017) *European drug report 2017: trends and developments*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/27401/>
- 2 National Advisory Committee on Drugs and Alcohol (NACDA) and Department of Health (UK) (2016) *Prevalence of drug use and gambling in Ireland and drug use in Northern Ireland*. Bulletin 1. Dublin: NACDA and Department of Health (UK). <http://www.drugsandalcohol.ie/26364/>
- 3 An Garda Síochána (2016) *Annual report of An Garda Síochána 2015*. Dublin: An Garda Síochána. <http://www.drugsandalcohol.ie/26524/>
- 4 O'Neill G, Clinton D and Lynch B (2015) *Purity of illicit drugs submitted to Forensic Science Ireland 2015*. Dublin: Forensic Science Ireland. <http://www.drugsandalcohol.ie/26311/>
- 5 Health Research Board (2017) *Drug treatment in Ireland: NDTRS 2009–2015*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/27023/>
- 6 European Drug Emergencies Network (2015) *Final report of the European Drug Emergencies Network (Euro-DEN)*. Available online at http://www.emcdda.europa.eu/attachements.cfm/att_250356_EN_Euro_DEN%20final%20report%202015.pdf
- 7 Health Research Board (2016) *National Drug-Related Deaths Index 2004 to 2014 data*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/26299/>

RESPONSES

SAOR: Screening and brief intervention for problem alcohol and drug use

The Health Service Executive (HSE) has published the second edition of the SAOR (Screening and Brief Intervention for Problem Alcohol Use) model first introduced in 2009. Developed by O'Shea, Goff and Armstrong, SAOR II provides an evidence-based framework for screening and brief intervention (SBI) for problem substance use for application in a range of settings and with all levels of need.¹ The document provides a step-by-step guide as well as outlining the context, rationale and evidence underpinning the model.

Background and context

Originally, the SAOR model was developed for the delivery of brief interventions for problem alcohol use in emergency departments and acute settings. SAOR II expands the model by making it applicable in a broader range of health, social care, social and recreational settings and for other substances in addition to alcohol.

SAOR II is underpinned by a biopsychosocial model, which understands problem substance use as the complex interaction of the individual, social and family factors, and substance-related characteristics. From this perspective, an effective response to problem substance use must involve a range of different interventions that are readily available to individuals depending on their needs and circumstances. SBI is one of a continuum of supports that may be offered. SBI aims to enhance an individual's motivation to change substance-using behaviour. The more SBIs experienced, the greater the potential impact on a person's motivation to change. SBI enables early intervention with at-risk groups in a variety of settings and referral onwards to specialised services as appropriate. A body of literature supports the use of SBI with those with low-to-medium alcohol problems as well as those with drug/alcohol dependence, and suggests it may also be valuable as part of a range of interventions for those receiving opiate substitution.

The use of SBI as part of a continuum of interventions reflects international and national policy and guidelines addressing problem drug and alcohol use. In Ireland, priorities of the National Drug Rehabilitation Framework (NDRF)² and National Drugs Strategy (NDS) 2017–2015,³ which reflect the Four-Tier Model of Care,⁴ include ensuring that people with substance use problems can access the necessary supports close to home and at a level appropriate to their needs. Action 2.1.26 of the NDS 2017–2025 emphasises training in the delivery of SBI and onward referral to ensure early intervention for at-risk groups.

SAOR II screening and brief intervention

SAOR II is underpinned by a person-centred approach, recognising the power of the therapeutic relationship and the individual's capacity to make positive behaviour changes. It reflects the principles of respect, care and compassion, and acknowledges the person's autonomy in decision making. New to SAOR II is an emphasis on aspects of motivational interviewing (MI),⁵ which is used to express the person-centred approach. MI is 'a form of collaborative conversation which strengthens a person's own internal motivation and commitment to change' (p. 39).¹

The four processes of MI (engaging, focusing, evoking, and planning) are reflected in the four stages of SAOR II:

- 1 Establishing a supportive relationship through listening and making the person feel comfortable.
- 2 Asking questions to determine the existence and extent of a problem.
- 3 Offering assistance, guidance or advice.
- 4 Referring on to other specialised services as appropriate.

Using MI techniques, SBI can be provided in an extended form (20–30 minute interventions), allowing for a more extensive interaction for those with more complex needs. SAOR II can be used in any setting in the treatment continuum, regardless of the level at which care is provided.

SAOR training

Since 2012, a one-day training programme in SAOR SBI has been provided by the National SBI Project for Problem Alcohol and Substance Use in partnership with the National Addiction Training Programme. A SAOR Train the Trainer programme has also been rolled out. An eLearning resource based on the SAOR model was developed in 2017 and has enabled the model to have greater reach. A suite of SBI online training resources based on SAOR II is being prepared through the National Office for Social Inclusion and Ana Liffey Drug Project and will be available to support the delivery of training and implementation of SBI.

SAOR II is an evidence-based psychosocial intervention that aims to effect behavioural change in persons experiencing problem substance use. As an SBI, SAOR II can be one of a comprehensive set of supports that together address the context, causes and maintenance of problem substance use. SAOR II can be delivered in multiple settings and with a range of substances and levels of need.

Cathy Kelleher

- 1 O'Shea J, Goff P and Armstrong R (2017) *SAOR: Screening and brief intervention for problem alcohol and drug use*. 2nd edn. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/27443/>
- 2 Doyle J and Ivanovic J (2010) *National drugs rehabilitation framework document*. National Drugs Rehabilitation Implementation Committee. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/13502/>
- 3 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 4 For further details, see *Reducing harm, supporting recovery* (2017, p. 33).
- 5 Miller WR and Rollnick S (2013) *Motivational interviewing: helping people change*. 3rd edn. New York: Guilford Press.

Audit of hepatitis C testing and referral, 2015

In 2014/15, an audit was carried out in Ireland of hepatitis C (HCV) testing and referral in Addiction Treatment Centres in Health Service Executive (HSE) Community Health Organisation (CHO) Area 7 (formerly HSE Dublin Mid-Leinster). CHO Area 7 covers Dublin 2, 4 (part of), 6, 6W, 8, 10, 12, 16 (part of), 22 and 24. The audit was not carried out in the satellite clinics or in West Wicklow and Kildare as services there are in community-based general practice. The number of patients attending the addiction treatment centres in CHO 7 at the time of starting the audit was 1,255.

The purpose of this audit was to inform the Audit Sub-Group of the Addiction Treatment Clinical Governance Committee of CHO 7 of compliance with the expected standard of care in relation to HCV, and to make recommendations for improvement where necessary. A secondary aim of the study was to collect and collate data on the prevalence of HCV infection in this sample of patients.¹

Methods

A customised audit form was developed. One form was to be completed for each patient attending the centre. Data were requested on age, gender, and whether or not the patient was tested for HCV. Risk factors for infection, co-infection with HIV, referral to a specialist clinic (hepatology or infectious diseases), attendance at a specialist clinic and what level of treatment, if any, was provided were also requested. No personally identifiable information was collected on patients. In order to encourage cooperation and to avoid making comparisons between centres, the form did not contain the name of the doctor or the treatment centre.

A letter accompanied by the audit form was sent to 20 GPs in 11 addiction treatment centres in CHO 7 outlining the audit project and requesting their assistance in completing the forms. A total of 319 audit forms were returned, representing 25% of the patients attending the services at that time.

It was not possible to determine how many doctors or treatment centres participated, as the study was anonymous. The main findings from this audit are outlined below.

Findings

Age and sex

Where data were available, 63% (198/315) of the population were male and the age range was 24–65 years. The median age for males was 38 years, while the median age for females was 36 years. The majority of patients (81%) were between the ages of 25 and 44 years.

Risk factors for HCV infection

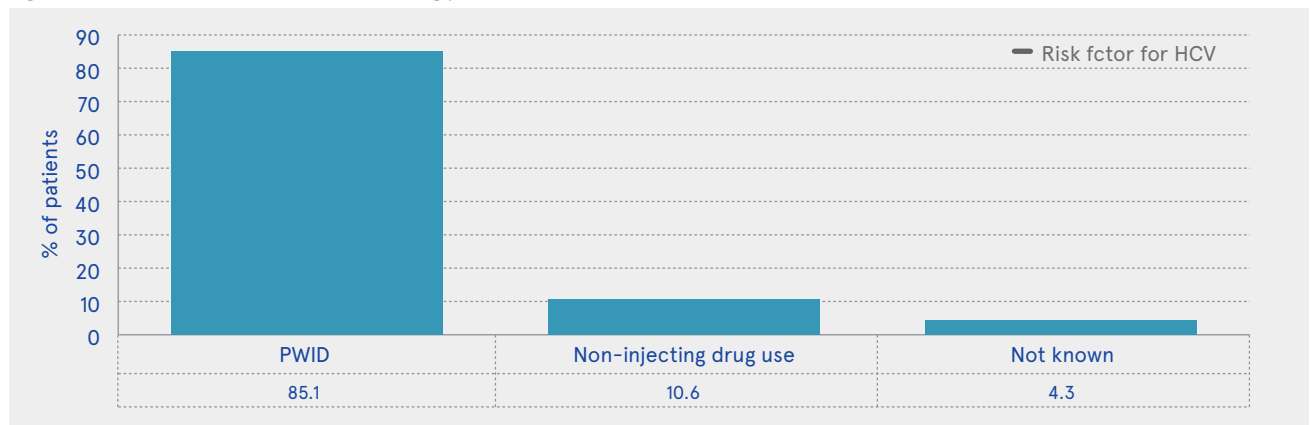
Information on possible risk factors for infection was available for 65% (208/319) of patients (Figure 1). Of these patients, 85.1% (177/208) had a history of injecting drug use (people who inject drugs – PWID), 10.6% (22/208) had non-injecting drug use risk factors and 4.3% (9/208) had no known risk factor. Of those with non-injecting drug use risk factors, 17 reported cocaine use, 4 reported unprotected sex with a HCV positive person, and 1 reported both cocaine use and unprotected sex with an HCV positive person.

Of the 177 patients who had a history of injecting drug use, 72% (128) were HCV antibody positive and 44% (78) were HCV antigen or polymerase chain reaction (PCR) positive. In those with HCV antigen or PCR positive results, the age range was 24–56 years, with a median age of 40 years. The likelihood of having HCV increased with age in those with a history of injecting drug use, with 63% (10/16) of 25–34-year-olds testing positive for HCV antigen or PCR compared to 68% (45/66) of 35–44-year-olds and 80% (20/25) of 45–54-year-olds. Data on HCV testing were available for 14 patients, of whom 5 were positive for HCV antibodies. Two of these 5 patients were also HCV antigen or PCR positive.

HIV infection

HIV status was recorded on 242 patients, of whom 39 (16%) were HIV positive. The median age of HIV positive patients was 39 years (range 31–56 years). Of these, 37 were also HCV antibody positive; 20 of these were HCV antigen or PCR positive. The majority (70%) of those co-infected with HIV were male. Where data were available, 97% (34/35) of all HIV positive patients were reported to have a history of injecting drug use. Overall, 19% (34/177) of those with a history of injecting drug use were HIV positive.

Figure 1: Risk factors for HCV infection among patients* in selected addiction treatment centres in Ireland, 2014/15



Source: Health Protection Surveillance Centre, 2017
*Risk factor data available for 65% of patients.

Audit of hepatitis C testing and referral continued

Referral and attendance at hepatology or infectious diseases clinics by gender

Where data were available, 86% (88/102) of HCV antigen or PCR positive patients were referred to a specialist clinic and, of those, 66% (52/79) attended. Males were more likely than females to attend a specialist clinic following referral, with a 74% (39/53) attendance rate, compared to just 50% (13/26) of females. The likelihood of attendance at a specialist clinic also increased with age, with just 36% (4/11) of those in the 25–34-years age group having attended following referral, compared to 68% (30/44) of 35–44-year-olds and 76% (16/21) of 45–54-year-olds.

Treatment uptake and completion

Data were collected on whether or not treatment was offered, accepted, completed and successful in antigen positive patients. Out of 105 patients who tested positive for the HCV antigen or PCR, data were available on offer of treatment for 57 patients. Of those, 28 patients (49%) were recorded as having been offered treatment and 29 were not offered treatment. Of the 28 patients who were offered treatment, 6 were awaiting treatment at the time of audit, 3 were still in treatment, 4 had refused treatment, 7 had completed treatment and there was no further information on the remaining 8 patients. Of the 7 patients who had completed their treatment, it was successful in 4, and no information was provided on the remaining 3 cases.

Conclusions and recommendations

One aim of this audit was to provide information on the current prevalence of HCV infection in patients attending addiction treatment clinics in Ireland. Two-thirds (67%) of patients who had been tested were positive for HCV antibodies. This figure is in keeping with previous studies in Ireland among PWID, which found the prevalence to be 62% to 81%.² The prevalence was slightly higher (72%) in those with a recent history of injecting drug use. The prevalence of HCV markers was higher in older patients, which may reflect their longer injecting history and opportunity for exposure to HCV, or may indicate a reduction in incidence in recent years.

Data from nationally collated notifications of HCV infection show a substantial downward trend in notifications, and rising age at diagnosis, since peak levels in 2007.³ However, it must be borne in mind that, given the overall low response rate to this audit, the findings may not be representative of the population of patients attending addiction treatment services in this region, or in Ireland.

The following were among the recommendations suggested by the authors to further understand infectious disease prevalence among drug users in Ireland:

- A computerised-patient management system for addiction treatment clinics is urgently needed. This would improve the efficiency of the clinics and make better use of staff resources, and would improve quality of care for patients.
- The under-resourcing of clinics is an ongoing cause for concern and should continue to be highlighted on the HSE Risk Register.
- Improved communication from specialist hospital clinics to the referring doctors in the addiction treatment clinics regarding patients who have been offered treatment would be helpful to patient care. In particular, it would be useful for the referring doctor to have timely information on uptake of treatment and response to treatment, and also to know if the patient has refused treatment. The HCV liaison nurses may have a role to play in improving this information flow.
- Individual doctors and clinics should be supported in maintaining compliance with HCV testing and referral.
- Attendance at specialist hepatology and infectious diseases clinics, particularly for younger patients, should be encouraged by referring doctors and by the HCV liaison nurses. The reasons for poor attendance should be investigated.
- Addiction treatment doctors and HCV liaison nurses have a role in educating patients about the risks and prevention of blood-borne virus transmission, and about the availability of new antiviral treatments.

In addition, the authors recommend that the audit should be repeated. It was suggested that the next audit should explore the practices in relation to retesting those patients who initially test HCV negative but have ongoing risk-taking behaviour. It should also seek to gather more detailed information about treatment uptake and outcome. A repeat study would be helpful to indicate if recently observed increases in the incidence of HIV infection in drug users has been mirrored by a rise in HCV infection. It is hoped that the circulation of this report may encourage a better response rate for the next audit. A better response would allow for more confidence in the representativeness of the findings and more clearly indicate opportunities for improvement.

Seán Millar

- 1 Bourke M, Hennessy S, Thornton L (2015) *Audit of hepatitis C testing and referral: Addiction Treatment Centres, Community Health Organisation Area 7*. Lenus, the Irish Health Repository. Available online at <http://www.drugsandalcohol.ie/28118/>
- 2 Health Service Executive (2012) *National hepatitis C strategy 2011–2014*. Dublin: Health Service Executive. Available online at <http://www.drugsandalcohol.ie/18325/>
- 3 HSE – Health Protection Surveillance Centre (2015) *Annual epidemiological report 2014: hepatitis C*. Dublin: Health Service Executive. Available online at <http://www.drugsandalcohol.ie/28119/>

Relationship between supervised methadone consumption and retention in treatment in primary care

A J-shaped relationship between supervised methadone consumption and retention in methadone maintenance treatment in primary care represents a 'double edge sword', according to authors of a study recently published in *Drug and Alcohol Dependence*.¹ Funded by the Health Research Board (HRB) through the HRB Centre for Primary Care Research, the study is the first to examine the influence of supervised methadone consumption on retention in methadone treatment over multiple treatment episodes in primary care.

Supervised methadone consumption

Supervised methadone consumption entails the administration of methadone to patients by a pharmacist or clinician, thus ensuring patients take methadone as prescribed. Ensuring patient compliance can prevent diversion of methadone to illicit drug markets and can reduce relapse to heroin use. Research has found supervised methadone consumption to be associated with a reduction in drug-related deaths, including those attributed to methadone. However, long-term supervision is resource intensive and may promote dropout from treatment due to the disruption to patients' lives. Conflicting findings have emerged from the few studies that have compared supervised and unsupervised consumption.

At the time of the study, and consistent with World Health Organization recommendations, Irish guidelines for methadone maintenance treatment in primary care advised a minimum of one dose per week administered under pharmacy supervision.^{2,3} A dose of 60–120 mg daily, with prescriptions issued to dispense methadone for up to seven days, was further recommended.

Method

The sample consisted of 6,393 patients who experienced at least one methadone treatment episode between 2004 and 2010, and 19,715 treatment episodes. Patients were mostly male (68.5%) and aged under 30 years (58.6%).

The sample was identified by linking data from the Central Treatment List (the national register for methadone maintenance treatment); records from the Health Service Executive's Methadone Treatment Scheme; the General Medical Services (GMS) pharmacy claims; and the HRB's National Drug-Related Deaths Index (NDRDI). Included were persons aged 16–65 years who had at least three methadone prescriptions prescribed and dispensed in primary care during the study period. GMS provided data on all other prescription medications dispensed to these patients, while

data from the NDRDI enabled the identification of persons who had died during the timeframe.

Prescription refill data were used to assess the level of supervised methadone for each treatment episode, with those dispensing a single dose categorised as supervised. For each patient, the percentage of supervised prescriptions was calculated and classified as 20%, 20–39%, 40–59%, 60–79%, or 80% or more. Prescription data were also used to calculate the total number of prescriptions (comorbidity score) for other drugs issued to each patient across the timeframe.

Patients were deemed to be in continuous treatment if they had received a new prescription within seven days of the end of coverage of a prescription, and as ceased treatment if they had not. Retention in treatment was designated for treatment episodes that had no interruption in prescribed methadone lasting more than seven days. The length of treatment episodes was based on the date of the first prescription and coverage of the last. Only episodes that started within the timeframe of interest were included in the analyses.

Statistical analyses examined the relationship between supervised methadone consumption and time to discontinuation of treatment across multiple treatment episodes, accounting for recurrent methadone treatment episodes, and including age, gender, median daily methadone dose and comorbidities as potential confounders.

Results

- 36% of patients were supervised for less than 20% of prescriptions, 16% for 20–59%, and 48% for 60% or more during the initial treatment episode.
- Across episodes, treatment discontinuation was least among patients supervised for 20–59% of prescriptions, and was greatest among patients supervised for 60% or more (indicating a J-shaped relationship).
- 67% of patients experienced more than one treatment episode; the median episode length for the initial treatment episode was 224 days; and the overall median episode length was 104 days.
- Daily methadone doses ranging from 60 to 120 mg per day were more effective at retaining patients in treatment than doses of less than 60 mg, or greater than 120 mg per day.
- The minimum recommended daily dose (60 mg) was not received by one-third of patients during the initial treatment episode.
- Many patients received co-prescriptions, most commonly for benzodiazepines (72%) and antidepressants (49%). Those with 11 or more were significantly more likely to have shorter treatment episodes than those with five or fewer.

Discussion

The J-shaped relationship identified suggests that with too little or too much supervision, patients may drop out of methadone treatment. This finding is consistent with trials in the US and Scotland, and is supported by qualitative research suggesting that supervision can be acceptable to patients in the short-term, as they develop a routine and establish relationships with staff, but that patients prefer to be unsupervised in the longer-term. The authors propose that other studies that found no differences in retention based on whether consumption was supervised or

Retention in treatment continued

unsupervised failed to account for the relapsing nature of opioid addiction and the recurrence of treatment episodes. Consistent with research from Canada, many patients in the current study experienced multiple treatment episodes and were retained longer in later treatment episodes. Findings from a Scottish cohort study also suggest that cumulative exposure to opiate substitution improves patient survival. Although one-third of patients in the current study did not receive the recommended dosage, this proportion is lower than in the UK (57%) and Canada (51%). A further key finding is that many patients have comorbid conditions, and these patients tend to have shorter treatment episodes.

Conclusion

The findings highlight a challenge for clinicians: reducing supervision risks increasing the availability of street methadone and hence the population level risk of methadone deaths, while increasing supervision risks dropout from treatment and greater patient mortality.

The authors emphasise that further research is needed to profile patients suitable for unsupervised dosing, with the aim of retention in treatment and reduced diversion. The authors caution that the study methodology did not capture patients transferring from primary care to specialised settings, may have underestimated retention, and did not consider the quality of treatment.

Cathy Kelleher

- 1 Cousins G, Boland F, Barry J, Lyons S, Keenan E, O'Driscoll D, Bennett K and Fahy T (2017) J-shaped relationship between supervised methadone consumption and retention in methadone maintenance treatment (MMT) in primary care: national cohort study. *Drug and Alcohol Dependence*, 173: 126–131. <http://www.drugsandalcohol.ie/26891/>
- 2 Irish College of General Practitioners (2003) *Working with opiate users in community based primary care*. Dublin: Irish College of General Practitioners. <http://www.drugsandalcohol.ie/5450/>
- 3 Health Service Executive (2016) *Clinical guidelines for opioid substitution treatment*. Dublin: Health Service Executive. Available online at <http://www.drugsandalcohol.ie/26573/>

Brief intervention with methadone patients

The use of a brief intervention (BI) has been recommended by the World Health Organization (WHO) as an intervention to address problematic substance use.¹ It recommends a two-step approach, whereby the most problematic substance is first identified using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Once identified, the clinician can deliver a BI tailored for the identified substance. WHO advises refining and tailoring the BI to meet the needs of the target population, to consider the context and culture of the service setting, thus ensuring it meets local needs and is both culturally and contextually suitable.²

This paper outlines the development and process used to customise a BI for use with opioid-dependent methadone-maintained patients and to ensure its compatibility with the culture of an Irish drug-using population.³ The authors sought to tailor all intervention materials for use in a subsequent cluster randomised controlled trial.

Method

Clinicians and patients took part in the process, which occurred in Dublin between December 2012 and February 2013.

- Fifteen clinicians participated in two focus group sessions, which were conducted in two large addiction treatment centres in Dublin.
- Patient participants were opioid-dependent methadone-maintained polydrug users not attending any of the study sites. They were recruited through a forum representing service users of addiction services.

- One-to-one qualitative semi-structured interviews were conducted with 10 patients, which were carried out in a neutral setting.
- Clinicians and patients were given a participant information sheet about the research, a draft of the intervention manual, and all relevant draft materials.
 - The intervention manual contained a description of the main elements of the ASSIST screening tool and brief interventions.
 - Draft material included a step-by-step guide for use by the clinician during the BI. Patient materials included items such as example pros and cons for changing substance use behaviour and take-home materials.
- The main points of the focus groups and interviews were summarised and presented at the end of each session. Participants were asked to confirm whether it accurately reflected what had been discussed.
- Thematic analysis was chosen for data analysis. Themes were not determined in advance but emerged as patterns in the data and were grouped into themes. Themes were reviewed and refined.

Results

Feedback from clinicians and patients was used to guide the development of the BI and associated materials. Suggested changes were implemented if there was majority agreement, if in line with the key elements of BIs, and if practical.

- WHO uses two manuals to describe the ASSIST and a BI; these were combined into a single BI manual and the style of the manual refined.
- A sample script of a screening and BI session was developed as well as an algorithm to facilitate clinicians during the BI session.
- A Substance Risk Card had been created for each individual substance assessed within the ASSIST screening tool. These cards outlined risks associated with the use of certain substances.

Brief intervention continued

- The cards were modified: changes included weighting the severity of the risks, reordering associated risks with the more problematic risks at the top and the inclusion of how particular substances might interact with methadone and exacerbate problems for users.
- Tickboxes were added to the risk cards. These boxes allow risks that are pertinent to a patient to be ticked by the clinician during a session, therefore tailoring the BI to the patient based on their own individual risk profile.
- To address literacy concerns for illiterate or semi-literate patients, photographs were added to illustrate key risk factors.
- The language on the card was simplified and written in the first person to personalise the feedback.
- Patients recognised the physical risks of taking drugs, such as dental damage and the physical damage that long-term drug use can have on appearance.
- The 'Pros and Cons of Substance Use' section of a BI was used by the clinician to help patients explore why they use a substance and to consider reasons to reduce use or quit. Issues such as addiction, financial reasons to quit or cut down, risk of criminal activity and court conviction were important to patients and included as categories. More detail was added to examples.
- The value of proposed patient take-home material from the BI session, comprising the Feedback Report Card with results from the ASSIST screening tool and a personalised Substance Risk Card, was discussed. Patient opinion was divided on its usefulness. Concerns for patient confidentiality led to the adoption of a generic folder with a neutral title and cover.

Conclusion

The authors adhered to WHO recommendations to tailor BI programmes to be culturally and contextually appropriate to the treatment cohort and clinical environment. Qualitative methods were used to identify and implement modifications to the BI and material for use in a later trial. The BI manual was used to standardise training of clinicians for the later trial. Outcome data published elsewhere demonstrated that the tailored intervention was effective.⁴

Ita Condrón

- 1 Humeniuk R, Henry-Edwards S, Ali R, Poznyak V and Monteiro MG (2010) *Brief intervention: the ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care*. Geneva: World Health Organization. <http://www.drugsandalcohol.ie/18939/>
- 2 Humeniuk R, Dennington V and Ali R (2008) *The effectiveness of a brief intervention for illicit drugs linked to the alcohol, smoking and substance involvement screening test (ASSIST) in primary health care settings: a technical report of phase III findings of the WHO ASSIST randomized controlled trial*. Geneva: Department of Mental Health and Substance Dependence, World Health Organization. Available online at <http://www.drugsandalcohol.ie/28120/>
- 3 Darker CD, Sweeney B, Keenan E, Whiston L, Anderson R, Barry J (2016) Tailoring a brief intervention for illicit drug use and alcohol use in Irish methadone maintained opiate dependent patients: a qualitative process. *BMC Psychiatry*, 16(1): 373.
- 4 Darker CD, Sweeney B, Keenan E, Whiston L, Anderson R, Barry J (2016) Screening and brief interventions for illicit drug use and alcohol use in methadone maintained opiate-dependent patients: results of a pilot cluster randomized controlled trial feasibility study. *Subst Use Misuse*, 51(9): 1104–15.





National Drugs Library

UPDATES

Recent publications

The following abstracts are cited from published journal articles recently added to the repository of the HRB National Drugs Library at www.drugsandalcohol.ie

POLICY AND LEGISLATION

The emergence of the affected adult family member in drug policy discourse: a Foucauldian perspective

Devaney E (2017) *Drugs: Education Prevention and Policy*, 24(4): 359–367. <http://www.drugsandalcohol.ie/27534/>

The affected adult family member has increasingly received attention in drug research, policy and practice fields; however, this development has received limited critical and theoretical examination with respect to the presuppositions underpinning its rationale.

The findings may be used as a starting point for critical reflection on the assumptions and privileged forms of knowledge and expertise that are shaping policy and practices relating to affected families.

Irish General Practitioner (GP) perspectives toward decriminalisation, legalisation and cannabis for Therapeutic Purposes (CTP)

Van Hout MC, Collins C, Delargy I and Crowley D (2017) *International Journal of Mental Health and Addiction*, 15(5): 670–683. <http://www.drugsandalcohol.ie/27072/>

The study aimed to investigate Irish general practitioner (GP) attitudes toward decriminalisation of cannabis and

assess levels of support for therapeutic purposes (CTP).

The study reflects concerns around the mental health consequences of cannabis use and potential for misuse in the event of legalisation, and the need for product regulation and an enhanced evidence base to support treatment decision making. Further research and medical education is warranted.

SERVICES

An exploratory service-based study of deliberate self-harm (DSH) in Ireland: 'A hidden population'?

Quinn P, Surgenor P and McGilloway S (2017) *Irish Medical Journal*, 110(5): 561. <http://www.drugsandalcohol.ie/27340/>

The aim of this study was to investigate the nature and extent of deliberate self-harm (DSH) amongst those attending national crisis centres in Ireland, and to assess clients' views of the service. A secondary analysis was undertaken of a large data set of clients presenting with DSH (n=823).

This is the first study in Ireland to provide insights into a 'hidden population' of people who engage in DSH. A need for greater awareness of DSH and its links to suicidal ideation/behaviour is indicated.

Outcomes from a large 10 year hepatitis C treatment programme in people who inject drugs: no effect of recent or former injecting drug use on treatment adherence or therapeutic response

Elsherif O, Bannan C, Keating S, McKiernan S, Bergin C and Norris S (2017) *PLOS ONE*, 12(6): e0178398. <http://www.drugsandalcohol.ie/27486/>

We evaluated for differences in treatment adherence and response to Peginterferon-alfa-2a/Ribavirin (Peg-IFN α /RBV) in a large urban cohort with and without a history of remote or recent injection drug use.

Conclusions: PWID have comparable treatment adherence and SVR rates when compared to non-drug users treated with Peg-IFN α /RBV. These data support a public health strategy of HCV treatment and eradication in PWID in the DAA era.

Exploring patient characteristics and barriers to hepatitis C treatment in patients on opioid substitution treatment attending a community based fibro-scanning clinic

Crowley D, Cullen W, Laird E, Lambert JS, McHugh T, Murphy C and Van Hout MC (2017) *Journal of Translational Internal Medicine*, 5(2): 112–119. <http://www.drugsandalcohol.ie/27666/>

Hepatitis C virus (HCV) infection is a major public health issue. There is substandard uptake in HCV assessment and treatment among people who inject drugs (PWID). Community fibroscanning is used to assess disease severity and target treatment.

Conclusions: The study highlights the usefulness of community fibroscanning. Identifying barriers to treatment in this cohort affords an opportunity to increase the treatment uptake. The availability of afternoon clinics and enhanced prison linkage are warranted.

Community pharmacist experiences of providing needle and syringe programmes in Ireland

McVeigh J, Hearne E, Bates G and Van Hout MC (2017) *Research in Social Administration and Pharmacy*, 13(4): 767–777. <http://www.drugsandalcohol.ie/27519/>

The aim was to understand and illustrate pharmacist experiences of providing needle and syringe programmes (NSP).

Conclusions: Further enhancement of NSP coverage and targeted service delivery within national care pathways for drug and alcohol services is warranted.

Recent publications continued

RESPONSES

Enhancing alcohol screening and brief intervention among people receiving opioid agonist treatment: qualitative study in primary care

McCombe G, Henihan AM, Klimas J, et al. (2016) *Drugs and Alcohol Today*, 16(4): 247–258.
<http://www.drugsandalcohol.ie/26946/>

The purpose of this paper is to describe a qualitative feasibility assessment of a primary care-based complex intervention to promote screening and brief intervention for PAU, which also aims to examine acceptability and potential effectiveness.

Although a complex intervention to enhance alcohol screening and brief intervention among primary care patients attending for OAT is likely to be feasible and acceptable, time constraints and patients' reticence to discuss alcohol as well as GPs underestimating patients' alcohol problems is a barrier to consistent, regular and accurate screening by GPs.

Effectiveness of a national 'Minnesota Model' based residential treatment programme for alcohol dependence in Ireland: outcomes and predictors of outcome

Gallagher C, Radmall Z, O'Gara C and Burke T (2017) *Irish Journal of Psychological Medicine*, Early online
<http://www.drugsandalcohol.ie/27545/>

The aims of this study were (a) to examine the effectiveness of an inpatient treatment programme for alcohol dependence based on the 'Minnesota Model' and (b) to examine potential predictors of outcomes from such treatment.

This study provides evidence of the potential for a Minnesota-based treatment programme to be effective in helping people with alcohol dependence to reduce the amount of alcohol they consume and sustain this reduction beyond the treatment period.

Media coverage of alcohol issues: a critical political economy framework – a case study from Ireland

Mercille J (2017) *International Journal of Environmental Research and Public Health*, 14(6): 1–13.
<http://www.drugsandalcohol.ie/27433/>

This paper presents such a framework that conceives of news organisations as corporations that share the values and interests of political and economic elites.

Results show that, overall, 44.0% of articles support public health measures and 56.0% are opposed or remain neutral.

A systematic review of the relationship between staff perceptions of organizational readiness to change and the process of innovation adoption in substance misuse treatment programs

Kelly P, Hegarty J, Barry J, Dyer KR and Horgan A (2017) *Journal of Substance Abuse Treatment*, 80: 6–25.
<http://www.drugsandalcohol.ie/27435/>

The aim of this review was to describe the relationship between staff perceptions of organizational readiness to change (ORC) and the process of innovation adoption: exposure, adoption, implementation and integration into practice, in substance misuse treatment programs. This systematic review was conducted in accordance with PRISMA guidelines and fourteen papers were identified as being eligible for inclusion. This review was designed to include all constructs of ORC, but only one tool was used in all of the included papers. Despite this, the heterogeneity of studies in this review made a direct comparison of ORC related variables challenging.

Supportive text messages for patients with alcohol use disorder and a comorbid depression: a protocol for a single-blind randomised controlled aftercare trial

Hartnett D, Murphy E, Kehoe E, Agyapong V, McLoughlin DM and Farren C (2017) *BMJ Open*, 7(5): e013587.
<http://www.drugsandalcohol.ie/27406/>

Alcohol use disorders (AUDs) and mood disorders commonly co-occur, and are associated with a range of negative outcomes for patients. Mobile phone technology has the potential to provide personalised support for such patients and potentially improve outcomes in this difficult-to-treat cohort. The aim of this study is to examine whether receiving supporting SMS text messages, following discharge from an inpatient dual diagnosis treatment programme, has a positive impact on mood and alcohol abstinence in patients with an AUD and a comorbid mood disorder.

The trial has received full ethical approval.

PREVALENCE AND CURRENT SITUATION

The involvement of alcohol in hospital-treated self-harm and associated factors: findings from two national registries

Griffin E, Arensman E, Perry IJ, Bonner B, O'Hagan D, Daly C and Corcoran P (2017) *Journal of Public Health*, Early online
<http://www.drugsandalcohol.ie/27314/>

Alcohol is often involved in hospital-treated self-harm. Therefore it is important to establish the role of alcohol

in self-harm as well as to identify associated factors, in order to best inform service provision.

Conclusions: This study has highlighted the prevalence of alcohol in self-harm presentations, and has identified factors associated with presentations involving alcohol. Appropriate out-of-hours services in emergency departments for self-harm presentations could reduce the proportion of presentations leaving without being seen by a clinician and facilitate improved outcomes for patients.

Daily and occasional smoking and quitting in Irish university students

McKee G, Barry J, Mullin M, Allwright S and Hayes C (2017) *Health*, 9: 435–450.
<http://www.drugsandalcohol.ie/27184/>

This study assessed prevalence of student smoking and quitting behaviors and associated demographic, contextual and attitudinal factors.

Intentions to quit smoking and quit attempts were high among all smokers although use of on-site cessation supports was less than the optimal. These combined factors indicate a need for better targeting of our prevention strategies and the need to promote greater awareness of cessation supports for successful implementation of a smoke-free campus.

Non-medical use of olanzapine by people on methadone treatment

James PD, Fida AS, Konovalov P and Smyth BP (2016) *BJPsych Bulletin*, 40(6): 314–317.
<http://www.drugsandalcohol.ie/27140/>

We examined non-medical use (NMU) of olanzapine among adults on methadone treatment. A small minority show features of dependency. All doctors should be aware of the potential NMU of olanzapine, especially among patients with history of addiction.

The dynamic landscape of novel psychoactive substance (NPS) use in Ireland: results from an expert consultation

Van Hout MC (2016) *International Journal of Mental Health and Addiction*, 15(5): 985–992.
<http://www.drugsandalcohol.ie/27073/>

The study aimed to investigate expert perspectives on the NPS situation with regard to changing and emergent trends in use, health and social consequences and service implications.

Findings underscored the mental health and addiction related consequences of NPS use, with prevention, clinical and treatment services ill-equipped to deal with the particular characteristics of this form of drug abuse.

Enhanced strategies, services and clinical responses are warranted to address the challenges encountered.

Shake 'N Bake: the migration of 'pervitin' to Ireland

Van Hout MC and Hearne E (2016) *International Journal of Mental Health and Addiction*, 15(4): 919–927. <http://www.drugsandalcohol.ie/27074/>

We present the first single case study of clandestine production of 'Pervitin' to Ireland, a country with low reporting history of methamphetamine.

The study yielded unique insight into migration of this culturally specific drug, and how continued cultural contexts for use and 'cooking' remain intact when residing in the host country. Given its unique cultural nature and national characteristics, continued migration of Eastern European citizens across Europe, diffusion of clandestine production warrants continued surveillance. Appropriate service responses require culturally appropriate information and outreach services to Eastern European service users.

Out of sight, out of mind? A national survey of paediatricians in Ireland regarding Fetal Alcohol Spectrum Disorders

Gill I and Sharif F (2017) *Irish Medical Journal*, 110(3): 528. <http://www.drugsandalcohol.ie/27024/>

We aimed to evaluate self-reported knowledge and practice of doctors working in paediatrics in Ireland with regards to FASDs and alcohol consumption during pregnancy. Our survey suggests prenatal alcohol exposure may not be routinely considered in the evaluation of children with developmental delay by paediatric doctors in Ireland.

Opiate addiction and overdose: experiences, attitudes, and appetite for community naloxone provision

Barry T, Klimas J, Tobin H, Egan M and Bury G (2017) *British Journal of General Practice*, 67(657): e267–e273. <http://www.drugsandalcohol.ie/26952/>

The study aimed to establish GPs' views and experiences of opiate addiction, overdose care, and naloxone provision.

Conclusions: GPs report extensive contact with people who have opiate use disorders but provide limited opiate agonist treatment. They support wider availability of naloxone and would participate in its expansion. Development and evaluation of an implementation strategy to support GP-based distribution is urgently needed.

Exploring Irish Travellers' experiences of opioid agonist treatment: a phenomenological study

Claffey C, Crowley D, MacLachan M and Van Hout MC (2017) *Heroin Addiction and Related Clinical Problems*, Early online <http://www.drugsandalcohol.ie/27566/>

The study aimed to explore and describe Irish Travellers' experiences of drug use and opioid agonist treatment (OAT), with a view to improving service delivery and expanding the limited research base.

Conclusions: The development of culturally appropriate, gender sensitive and integrated OAT and mental health support services, designed with input from addiction and mental health specialists, alongside community members is warranted.

A national audit of smoking cessation services in Irish maternity units

Reynolds CME, Egan B, Cawley S, Kennedy R, Sheehan SR and Turner MJ (2017) *Irish Medical Journal*, 110(6): 580. <http://www.drugsandalcohol.ie/27564/>

There is international consensus that smoking cessation in the first half of pregnancy improves foetal outcomes. We surveyed all 19 maternity units nationally about their antenatal smoking cessation practices.

Although smoking is an important modifiable risk factor for adverse pregnancy outcomes, smoking cessation services are inadequate in the Irish maternity services and there are variations in practices between hospitals.

Exploring smoking, mental health and smoking-related disease in a nationally representative sample of older adults in Ireland – A retrospective secondary analysis

Burns A, Strawbridge J, Clancy L and Doyle F (2017) *Journal of Psychosomatic Research*, 98: 78–86. <http://www.drugsandalcohol.ie/27274/>

Smoking is the leading preventable cause of death among individuals with mental health difficulties (MHD). The aim of the current study was to determine the impact of smoking on the physical health of older adults with MHD in Ireland and to explore the extent to which smoking mediated or moderated associations between MHD and smoking-related diseases.

The challenge of complex drug use: Associated use of codeine-containing medicines and new psychoactive substances in a European cross-sectional online population

Kimergård A, Foley M, Davey Z, Wadsworth E, Drummond C and Deluca P (2017) *Human Psychopharmacology*, 32(3): e2611. <http://www.drugsandalcohol.ie/27423/>

This study characterises codeine consumption amongst NPS users and non-NPS users to provide warning of health issues.

Conclusions: Amongst NPS users, codeine is less likely to be used daily but more likely to be used for recreational purposes. Smaller populations engaging in high-risk use exist who take multiple drugs in high doses. Combinations of misused codeine and NPS highlight the need for policy to respond to a more complex drug situation.

Health student regard for substance-using patients as measured by the Medical Condition Regard Scale: a systematic review

Ducray K and Pilch M (2017) *Irish Journal of Psychological Medicine*, 34: 183–196. <http://www.drugsandalcohol.ie/27344/>

The purpose of this review was to identify trends and patterns in health student, namely future practitioners', regard for substance-using patients using the Medical Condition Regard Scale.

This review found that patients with drug-use problems were consistently held in the lowest echelons of regard by trainee health practitioners. The impact of sex, age, year of course, and personal exposure to mental health difficulties in predicting negative regard was unclear.

Unless addressed, patients with drug problems may have a high potential for future treatment marginalisation by tomorrow's health professionals. This scenario needs to be proactively managed by all stakeholders through a greater investment in educational and clinical training placement opportunities.

Recent publications continued

The paradox of public holidays: hospital-treated self-harm and associated factors

Griffin E, Dillon CB, O'Regan G, Corcoran P, Perry IJ and Arensman E (2017) *Journal of Affective Disorders*, 218: 30–34.
<http://www.drugsandalcohol.ie/27285/>

This study used national data to examine the patterns of hospital-treated self-harm during public holidays, and to examine associated factors.

Conclusions: Public holidays are associated with an elevated number of self-harm presentations to hospital, with presentations to hospital involving alcohol significantly increased on these days. Hospital resources should be targeted to address increases during public holidays, including during out-of-hours. Involvement of alcohol may delay delivery of care to these patients in emergency settings.

Suicide among young people and adults in Ireland: method characteristics, toxicological analysis and substance abuse histories compared

Arensman E, Bennardi M, Larkin C, Wall A, McAuliffe C, McCarthy J, Williamson E and Perry IJ (2016) *PLOS ONE*, 11(11): e0166881.
<http://www.drugsandalcohol.ie/27275/>

The aim of this study was to identify socio-demographic characteristics and circumstances of death associated with age among individuals who died by suicide.

Conclusions: Based on this research it is recommended that strategies to reduce substance abuse be applied among 25–34-year-old individuals at risk of suicide. The wide use of hanging in young people should be taken into consideration for future means restriction strategies.

An investigation into the effect of alcohol consumption on health status and health care utilization in Ireland

Ormond G and Murphy R (2017) *Alcohol*, 59: 53–67.
<http://www.drugsandalcohol.ie/27149/>

This paper presents a study of the effect of alcohol consumption on individual health status and health care utilization in Ireland using the 2007 Slán National Health and Lifestyle Survey, while accounting for the endogenous relationship between alcohol and health.

Findings show that in Ireland, moderate drinkers enjoy the best health status. More moderate drinkers report having very good or excellent health compared with heavy drinkers, non-drinkers, or those who never drank. While heavy drinkers do not report having as good a health status as moderate drinkers, they are better off in terms of health when compared with non-drinkers and those who are lifetime abstainers.

Codeine use, dependence and help-seeking behaviour in the UK and Ireland: an online cross-sectional survey

Kimergård A, Foley M, Davey Z, Dunne J, Drummond C and Deluca P (2017) *QJM*, 110(9): 559–564.
<http://www.drugsandalcohol.ie/27129/>

Codeine misuse and dependence poses a clinical and public health challenge. However, little is known about dependence and treatment needs in the UK and Ireland.

Conclusions: Codeine dependent users were more likely to seek help on the Internet to control their use of codeine than from a GP, which may indicate a potential for greater specialised addiction treatment demand through increased identification and referrals in primary care.

Anxiety and depression among patients with alcohol dependence: co-morbid or substance-related problems?

Gallagher C, Radmall Z, O'Gara C and Burke T (2017) *Irish Journal of Psychological Medicine*, Early online
<http://www.drugsandalcohol.ie/27544/>

The aim of this study was to characterise rates of co-morbid psychiatric symptoms among a group of individuals commencing treatment for alcohol dependence, and to examine the stability of these symptoms following treatment of the alcohol problem.

The significant change in rates of reported symptoms following completion of treatment suggests that a large proportion of symptoms reported at treatment entry were substance related. Diagnosing co-morbid conditions is best left until after a period of abstinence during which the alcohol problem has been treated.

Home manufacture of drugs: an online investigation and a toxicological reality check of online discussions on drug chemistry

Hearne E, Alves EA, Van Hout MC and Grund JPC (2017) *Journal of Psychoactive Drugs*, 49(4): 279–288.
<http://www.drugsandalcohol.ie/27580/>

We illustrate here how online communal folk pharmacology of homemade drugs on drug website forums may actually inform home manufacture practices or contribute to the reduction of harms associated with this practice. Discrepancies between online information around purification and making homemade drugs safer, and the synthesis of the same substances in a proper laboratory environment, exist.

Drug discussion forums should consider reevaluating their policies on chemistry discussions in aiming to reach people who cannot or will not refrain from cooking their own drugs with credible information that may contribute to reductions in the harms associated with this practice.