drugnet IRELAND

Issue 54
Summer 2015

Alcohol and Drug Research Newsletter

Minimum unit pricing for alcohol

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New Minister of State with responsibility for Drugs

In April 2015 Aodhán Ó Ríordáin TD was appointed Minister of State for the Drugs Strategy in the Department of Health. He is also Minister of State with responsibility for New Communities, Culture and Equality, which brief is spread across the Department of Justice and Equality and the Department of Arts, Heritage and the Gaeltacht.

Minister for Health Leo Varadkar welcomed the appointment, commenting 'There is a lot of merit in appointing a cross-Departmental Minister for Drugs, as there is a significant overlap between Health and Justice in this area, ranging from treatment and prevention to enforcement and diversion. The new role will bring together the work and actions of the HSE and Gardaí among others.'

The Minister went on to note, 'Aodhán is being appointed at a good time as the Department has just started work on the new National Drugs Strategy. Extra funding of €2.1m has been allocated in 2015 to provide more residential treatment and rehabilitation places, more needle-exchanges and the naloxone pilot project. I have also ended the cycle of cuts in funding for Local Drugs and Alcohol Taskforces.' Minister Varadkar also noted the new Minister's commitment to the equality agenda and his 'excellent track record of community work'.

Aodhán Ó Ríordáin TD

See separate report on 'A Better City for All' conference later in this issue for a report on one of the new Drugs Minister's first public speaking engagements.

Mr Richard Guiney (Dublin Town), Mr Aodhán Ó Ríordáin TD, Minister of State with responsibility for the National Drugs Strategy and Dr Johnny Connolly (Health Research Board) at the inaugural Better City for All seminar in May.

Alcohol Action Ireland conference

Alcohol Action Ireland held their conference *Girls, women and alcohol: The changing nature of female alcohol consumption in Ireland* on 21 April 2015 in Dublin. International and Irish speakers examined the factors influencing the changing culture of drinking among Irish girls and women, and the harms they are experiencing as a result.[1]

Katherine Brown, director of the Institute of Alcohol Studies in the UK, described the changes in female alcohol consumption, from having a large role in the temperance movement to the 'ladette' drinking culture in the 1990s, and the recent rise of 'mummy's wine time', whereby wine is now a socially acceptable coping mechanism for women trying to balance work and home life. She said we now live in an 'alcogenic environment', and outlined the role that marketing to women by the alcohol industry had played: alcohol is marketed to women as glamorous, sophisticated, feminine, sexy, often placed alongside lipstick, handbags and shoes.

Lucy Rocca, founder of Soberistas.com, spoke about this non-religious, peer support online resource for women with alcohol dependency issues. Within a year more than 20,000 people had signed up to the site, many from Ireland.

Ann Dowsett Johnston, alcohol policy advocate and author of *Drink: the intimate relationship between women and alcohol,* said that women need to start thinking about their relationship with alcohol. Women tend to use alcohol to self-medicate and turn to alcohol rather than seek help for depression and anxiety. She stated that alcohol is too cheap, too accessible and too heavily marketed.

Clíona Saidléar, executive director of the Rape Crisis Network of Ireland, highlighted the link between alcohol and sexual violence. She said there needed to be a refocus on the perpetrator of such violence and a move away from victim-blaming.

Dr Triona McCarthy, consultant in public health medicine with the HSE's National Cancer Control Programme, spoke about the link between alcohol and cancer. She said that breast tissue is particularly susceptible to alcohol-related cancer and that women who drink a small glass of wine every day increase their risk of getting breast cancer by 7–10%.

Dr Orla Crosbie, consultant gastroenterologist at Cork University Hospital, talked about the link between alcohol and liver disease. Liver cirrhosis is no longer a disease generally seen only in older Irish men.

(Deirdre Mongan)

1. The presentations may be viewed at *http://alcoholireland.ie/girls-women-and-alcohol-the-presentations/#sthash.WM9snKrt.dpuf*

Contents

Drugnet Ireland is published by:

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Alcohol pricing model applied to Ireland

In 2013 the Sheffield Alcohol Research Group (SARG) at Sheffield University was commissioned by the Irish government to adapt the Sheffield pricing model for alcohol to Ireland in order to appraise the potential impact of different pricing policies. The report was published on 11 March 2015.[1] Some key findings from the report are presented here.

Minimum unit pricing (MUP)

The first question posed was *'What are the effects of introducing a legislative basis for minimum pricing per 10 grams of alcohol or per standard drink, i.e. minimum unit pricing (MUP), in Ireland over a 20-year period?'* To answer this question, a pricing model was applied that used a simulation framework based on classical econometrics and cost-benefit analysis techniques. The methods are described in detail in the report.

Two effects of interest are described here – alcohol consumption and individual spending. The effects of interest were examined by drinker type – low-risk, increasing-risk and high-risk.

Table 1: Impact of minimum pricing on off-trade prices of standard drinks

Alcoholic beverage	Average increase in off-trade price on foot of MUP set at 90 cents	Average increase in off-trade price on foot of MUP set at 100 cents
Beer	31.5%	44.2%
Cider	19.4%	24.9%
Wine and spirits	12.2%	19%

Prices of standard drinks

Prices vary by type of beverage. The evidence suggests that the impact of a potential minimum price of 90 cents or 100 cents for a standard drink will be greatest on beer, with average off-trade price increases of 31% and 44% respectively, followed by cider, with average increases of 19% and 25% respectively. The lowest increases will be for wine and spirits, which will rise by an average of around 12% and 19% respectively (see Table 1).

Alcohol consumption

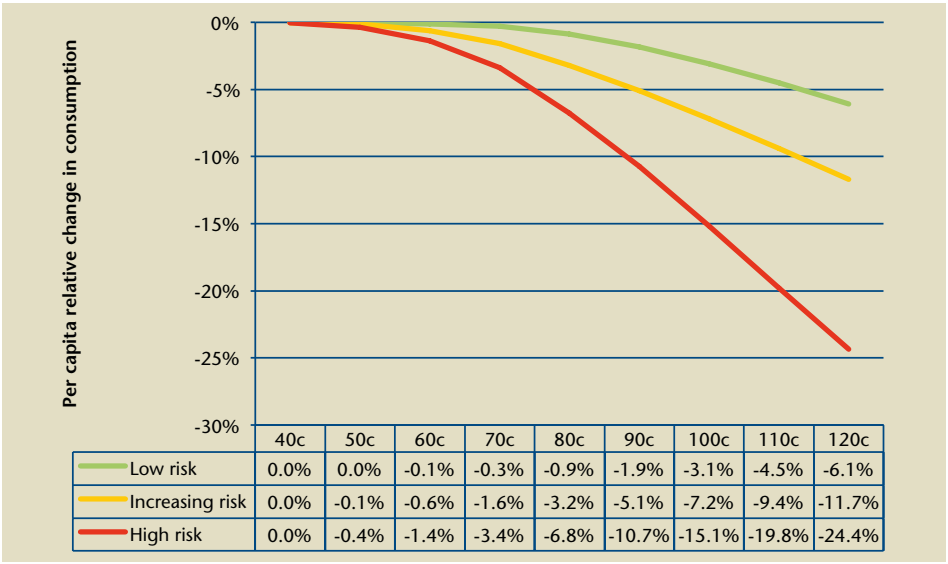
MUPs below 70 cents are estimated to have a very small impact on alcohol consumption (see Figure 1). However, Figure 1 also shows how alcohol consumption across the overall population starts to reduce when the MUP is set at 70 cents or higher (80c = -3.8%; 90c = -6.2%; 100c = -8.8%; 110c = -11.7%).

For a 100c MUP, the estimated per-drinker-reduction in alcohol consumption for the overall population is 8.8% and equates to an average annual reduction of 57.2 standard drinks per drinker per year. As this is a targeted pricing policy, high-risk drinkers have larger estimated reductions in alcohol consumption as a result of an MUP policy than increasing-risk or low-risk drinkers. For example, the estimated reductions in consumption for a 100c MUP are 15.1% for high-risk drinkers, 7.2% for increasing-risk drinkers and 3.1% for low-risk drinkers (see Figures 1 and 2). These reductions correspond to an annual reduction of 494 standard drinks per year for high-risk drinkers, 83.2 standard drinks for increasing-risk drinkers and 5.2 standard drinks for low-risk drinkers.

Individual spending

Under an MUP policy, drinkers are estimated to reduce consumption but pay somewhat more on average for each standard drink consumed, and so the estimated percentage changes in spending are smaller than estimated changes in consumption (see Figure 3). The MUP policies are estimated to have small impacts on overall alcohol–related expenditure, for example expenditure will increase by 1.3% at 90c and 100c MUP, and 1.1% at 110c MUP.

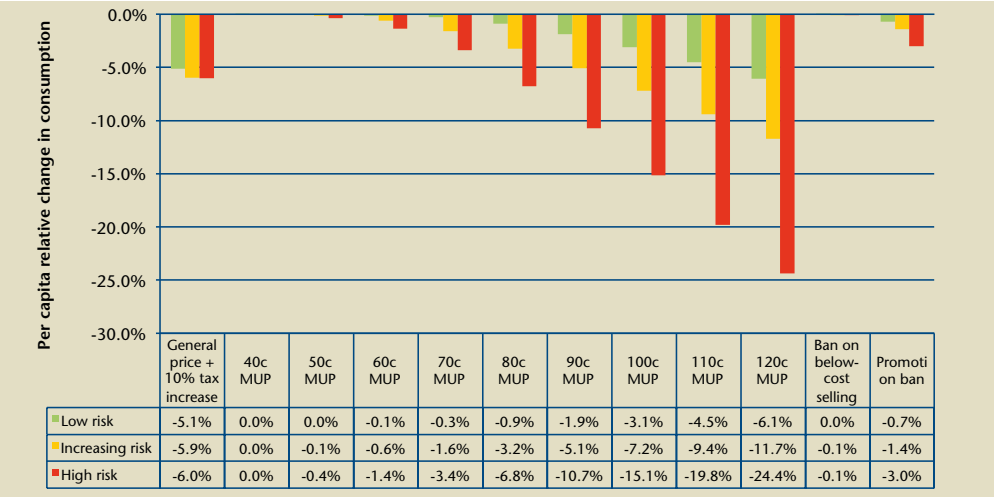
For a 100c MUP, the estimated per drinker change in alcohol expenditure for the overall population is 1.3% and this equates to an average annual increase of €15.70. As this is a targeted pricing policy, high-risk drinkers will save €106.60 (-2.1%) each year as a result of an MUP policy,



	40c	50c	60c	70c	80c	90c	100c	110c	120c
Low risk	0.0%	0.0%	-0.1%	-0.3%	-0.9%	-1.9%	-3.1%	-4.5%	-6.1%
Increasing risk	0.0%	-0.1%	-0.6%	-1.6%	-3.2%	-5.1%	-7.2%	-9.4%	-11.7%
High risk	0.0%	-0.4%	-1.4%	-3.4%	-6.8%	-10.7%	-15.1%	-19.8%	-24.4%

Figure 1: Effect of MUP on alcohol consumption by type of drinker

Alcohol pricing model *(continued)*



	General price + 10% tax increase	40c MUP	50c MUP	60c MUP	70c MUP	80c MUP	90c MUP	100c MUP	110c MUP	120c MUP	Ban on below-cost selling	Promotion ban
Low risk	-5.1%	0.0%	0.0%	-0.1%	-0.3%	-0.9%	-1.9%	-3.1%	-4.5%	-6.1%	0.0%	-0.7%
Increasing risk	-5.9%	0.0%	-0.1%	-0.6%	-1.6%	-3.2%	-5.1%	-7.2%	-9.4%	-11.7%	-0.1%	-1.4%
High risk	-6.0%	0.0%	-0.4%	-1.4%	-3.4%	-6.8%	-10.7%	-15.1%	-19.8%	-24.4%	-0.1%	-3.0%

Figure 2: Proportional (relative) effects of pricing policies on alcohol consumption by type of drinker

while increasing-risk drinkers will spend an extra €25.40 (1.1%) per year on alcohol and low-risk drinkers will spend an additional €24.20 (4.8%).

Value to society

For a 100c MUP policy, the total societal value of the harm reductions for health, crime and workplace absences is estimated at €1.7bn cumulatively over the 20-year-period modelled. This figure includes reduced direct healthcare costs, savings from reduced crime and policing, savings from reduced workplace absences and a financial valuation of the health benefits measured in terms of Quality-Adjusted Life Years (QALYs) valued at €45,000, in line with guidelines from the National Centre for Pharmacoeconomics on the cost-effectiveness of health technologies.

MUP and other pricing policies

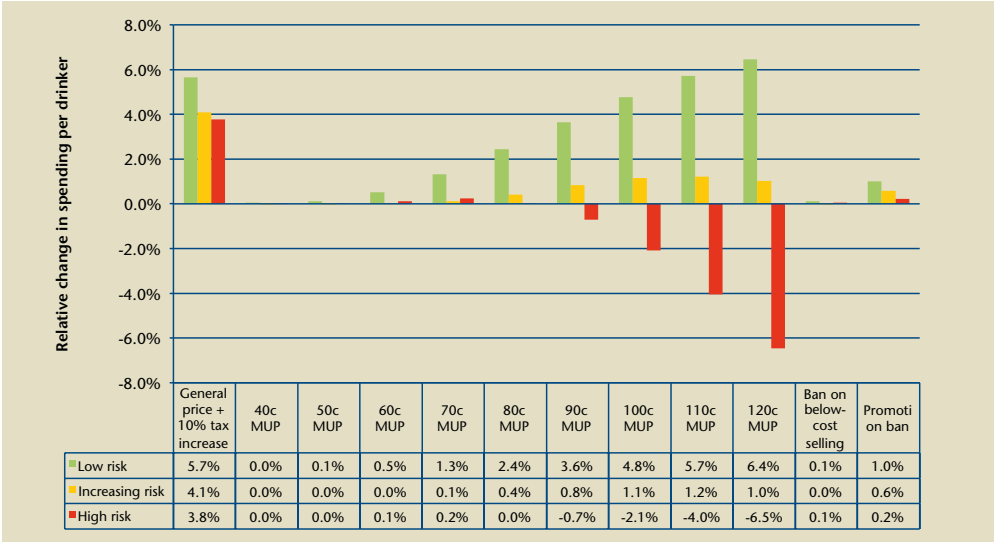
In addition to understanding the impact of MUP in an Irish context, the Irish government wanted to know '*How does MUP compare to, or enhance, other pricing policies?*' Specifically, how does MUP compare to, or enhance, other measures such as a ban on price-based promotions in the off-licence trade, a combination of MUP policies with a ban on price-based promotions, a ban on below-cost selling and a 10% price rise on all alcohol products.

Ban on promotions

Banning all price-based promotions in the off-trade is estimated to reduce per-person alcohol consumption by 1.8%. As this is a targeted pricing policy, high-risk drinkers have larger estimated reductions in alcohol consumption as a result of an MUP policy than increasing-risk or low-risk drinkers. For example, the estimated reductions are 3% for high-risk drinkers, 1.4% for increasing-risk drinkers and 0.7% for low-risk drinkers (see Figure 2).

Under a promotions ban on trade retailers, drinkers are estimated to reduce consumption but pay somewhat more (0.6% or €7.20 each year) for alcohol consumed. As this is a targeted pricing policy, high-risk drinkers will spend an additional €11.40 (0.2%) each year as a result of the promotions ban while increasing-risk drinkers will spend an extra €13.00 (0.6%) on alcohol and low-risk drinkers will spend an additional €5.10 (1%) (see Figure 3).

Over the 20-year period modelled, the total societal value of the harm reductions resulting from a ban on promotions is estimated to be €0.38bn. This societal value equates to one-third that of a 90c MUP.



	General price + 10% tax increase	40c MUP	50c MUP	60c MUP	70c MUP	80c MUP	90c MUP	100c MUP	110c MUP	120c MUP	Ban on below-cost selling	Promotion ban
Low risk	5.7%	0.0%	0.1%	0.5%	1.3%	2.4%	3.6%	4.8%	5.7%	6.4%	0.1%	1.0%
Increasing risk	4.1%	0.0%	0.0%	0.0%	0.1%	0.4%	0.8%	1.1%	1.2%	1.0%	0.0%	0.6%
High risk	3.8%	0.0%	0.0%	0.1%	0.2%	0.0%	-0.7%	-2.1%	-4.0%	-6.5%	0.1%	0.2%

Figure 3: Relative effects of pricing policies on alcohol-related spending by type of drinker

Alcohol pricing model *(continued)*

Ban on below-cost selling

A ban on below-cost selling is estimated to have minimal positive or negative impact on population consumption (see Figure 2), spending (see Figure 3), health outcomes and crime. It would save a cumulative €38.4m over 20 years.

Overall tax increase

The introduction of a 10% (tax) increase on the price of all types of alcohol (cheap and expensive) would decrease alcohol consumption for all drinkers by 5–6% and would affect low-risk, increasing-risk and high-risk drinkers equally (see Figure 2). It would have health benefits as well as reducing crime and workplace absences. The total societal value of the harm reductions arising from a general price increase over the 20-year period modelled is estimated at €1.6bn cumulatively.

(Jean Long)

1. Angus C, Meng Y, Ally A, Holmes J and Brennan A (2014) *Model-based appraisal of minimum unit pricing for alcohol in the Republic of Ireland.* University of Sheffield: ScHAAR. *http://www.drugsandalcohol.ie/23904/*

National Community Action on Alcohol Pilot Project

In 2014 the Alcohol Forum, in partnership with the HSE and the Department of Health, initiated the National Community Action on Alcohol Pilot Project (NCAAPP).[1] It aims to build the capacity of communities, through local and regional drugs and alcohol task forces (L/RDATF), to identify local alcohol-related harm issues and priorities and to develop integrated local alcohol action plans.

A community mobilisation approach is a priority theme cited in the National Substance Misuse Strategy:[2]

> *There is a need for a community-wide, inclusive and coordinated approach to promote greater social responsibility and prevention and awareness raising on alcohol related issues. Communities should be supported to develop the evidence-based skills and methodologies to implement community mobilisation programmes with a view to increasing public awareness and discussion of alcohol problems, and to build community capacity to respond to alcohol problems at local level.* (p. 27)

The National Substance Misuse Strategy also outlines how a public health approach is an appropriate response to reduce the harm from excessive consumption of alcohol in our communities and society as a whole. The local alcohol action plans developed under the pilot project will address the issues and priorities under the four national priority headings listed in the National Substance Misuse Strategy – supply, prevention, treatment and rehabilitation, and research.

The NCAAPP also supports the implementation of recommendations within the Healthy Ireland framework, under themes three and four – Empowering People and Communities, and Health and Health Reform.[3]

Implementation

A steering group comprising representatives from the Alcohol Forum, the Drugs Policy Unit of the Department of Health, from Health Promotion and Improvement and Social Inclusion in the HSE, and from the Ballymun Alcohol Strategy group was set up to guide the NCAAPP.

The objectives of the project are to:

- introduce a model of community action on alcohol to L/RDATFs;
- raise awareness of the evidence of effective measures/sustainable actions under each of the pillars – supply, prevention, treatment and rehabilitation and research – within L/RDATFs;
- build awareness within L/RDATFs of alcohol prevention and related harm to both drinker and others;
- explore effective measures to promote community engagement in the local action planning process;
- develop an action planning template to assist communities to develop their own local alcohol action plan; and
- ensure adequate monitoring, review and evaluation measures are built into the local plans.

L/RDATFs were asked to submit expressions of interest and in December 2014 six L/RDATF participants were selected:

- North West Regional Drugs and Alcohol Taskforce,
- Joint Initiative – Southern Regional Drug and Alcohol Taskforce and Cork Local Drugs and Alcohol Taskforce,
- North Inner City Local Drugs and Alcohol Taskforce,
- Tallaght Local Drugs and Alcohol Taskforce, and
- Dun Laoghaire Rathdown Local Drugs and Alcohol Taskforce.

To date, each of the taskforces has formed an alcohol sub-committee to work on the project and to engage with their community. Currently the Alcohol Forum is providing training to 20 representatives from the pilot projects and they in turn are linking back to their alcohol sub-committees and the full taskforce membership. It is planned that by early autumn 2015 each participating taskforce will have developed a draft alcohol action plan for their area.

An external evaluator has been engaged, following a tender process, to evaluate the effectiveness of the project and to use the findings to strengthen the project for roll-out in other areas.

(Anne Timony Meehan & Suzi Lyons)

1. For further information visit *http://af.mannadev.com/national-community-action-on-alcohol-project/* or contact Anne Timony Meehan at anne@alcoholforum.org
2. Department of Health (2012) *Steering group report on a national substance misuse strategy* Dublin: Department of Health. *http://www.drugsandalcohol.ie/16908/*
3. Department of Health (2013) *Healthy Ireland – a framework for improved health and wellbeing 2013–2025*. Dublin: Department of Health. *http://www.drugsandalcohol.ie/19628/*

Fianna Fáil publishes drugs action plan

On 16 April 2015 Fianna Fáil launched a proposal for a Drugs Action Plan.[1] In his Foreword to the plan, Fianna Fáil Spokesperson on Justice and Equality, Niall Collins TD, wrote about the drugs 'crisis' and the 'inadequate response' of the government; the Fianna Fáil web site hailed the plan as a 'radical new approach'. The plan reprioritises actions under the current policy framework.

Pointing to changes in the nature of the problem, including (1) a changing pattern of drug use, with alcohol and cannabis 'causing problems for a vastly higher proportion of the population [than opiate addiction]', (2) an over-concentration of resources in areas designated as disadvantaged, resulting in 'huge geographical areas with no services at all', and (3) new problems including the 'new poor' and 'social problems such as mental health problems and co-occurring substance misuse issues manifest across the entire socio-economic spectrum', the plan proposes a more equitable redistribution of resources between urban and rural areas, and between regional and local drugs and alcohol task forces, according to need.

Action plan

Under four themes, the action plan prioritises the need to strengthen the governance and co-ordination of drug policy, a stronger response to the needs of communities, a shift from a focus on medically-assisted treatment and maintenance to an emphasis on recovery, and the targeting of children and young people.

New national substance misuse strategy

The action plan commits to implementing a 'new national substance misuse strategy' inclusive of all drugs and including alcohol and cannabis. The current Programme for Government already contains a commitment to publish a national substance misuse strategy that combines illicit drugs and alcohol. The proposed plan also commits to 'reappointing' a Minister for Drugs and establishing a clear governance and co-ordination structure such as the former Office of the Minister for Drugs. Subsequent to the launch of the action plan, the Minister for Health announced the appointment of a dedicated Minister for Drugs (see item on page 1 of this issue of *Drugnet*). Co-ordination has long been recognised as critical for a cross-cutting issue such as illicit drug policy but it has proved difficult to do effectively.[2] An Office of the Minister was briefly introduced by the Fianna Fáil–Progressive Democrats coalition government in 2010, but was disbanded a year later with the change of government.[3]

Community impact and crime

Communities are a priority in the action plan. The plan commits to ensuring an equitable distribution of resources across all communities, both urban and rural, disadvantaged and advantaged, and not just for opiate-related problems but for problems associated with the 'new poor', with problems associated with alcohol, cannabis use, polydrug use and comorbidity. The plan also seeks to tackle the impact of the operation of the drugs market on communities, for example the effects of drug-dealing and -using, anti-social behaviour arising from drug use, drug-related intimidation, the exploitation of young children by drug users, and any negative consequences from having a drug treatment centre located in a community. These issues have been discussed and measures taken to address them in the current or the previous national drugs strategy, predominantly under the Supply Reduction pillar.

Health, treatment and rehabilitation

The action plan commits to shifting from opiate substitution treatment to a recovery-focused approach. In describing the current policy approach, the plan states, '… seriously high levels of public funding has been dispersed via the HSE into methadone maintenance for opiate substitution in this country with little or no emphasis on progression, recovery or movement to drug free status for patients' (p. 2). Among the seven actions listed in relation to treatment and rehabilitation are calls for a shift away from opiate substitution treatment in methadone clinics to treatment in general practices; the establishment of community-based support services providing evidence-based assessment, case management and structured care planning using an integrated care model to tackle the problems associated with alcohol and cannabis use; a stronger emphasis on a recovery-focused service, including a comprehensive after-care service and the creation of pathways to recovery. The increased interest reflects a trend seen in other jurisdictions including the USA, England and Scotland, and recently explored by members of the Oireachtas (Parliament).[4]

Children and young people

Children and young people are specially targeted in the action plan. Under the heading 'Prevention and early intervention', the plan lists four high-level actions focusing on school-children, children of drug misusers, and children and young people out of school. While this segmentation is similar to that in the current national drugs strategy (2009–2016), the drugs action plan specifies different interventions.

Policy questions

Moving directly to the action level, Fianna Fáil forewent an opportunity to start a national debate on possible future directions for Ireland's drug and addiction policies. Questions that might have been asked include:

- What principles should underpin Ireland's substance misuse policy – human rights, public health, social inclusion, reduction of supply, demand and/or harm?[5]
- What substances and/or behaviours should be included in a national substance misuse strategy? Ireland's strategy has already been expanded to include not just controlled (illicit) drugs but also alcohol. In other countries the scope has expanded even further to fully embrace a public health approach to addictions, including not only all licit and illicit psychoactive substances, including tobacco as well as alcohol, but also addictive behaviours such as gambling, Internet addiction, eating disorders.[6]
- How should the supply of substances such as the two substances highlighted in Fianna Fáil's action plan – alcohol and cannabis – be controlled? Both these substances are the subject of ongoing public discussion in Ireland. In November 2013 Dáil deputies debated a private member's motion to regulate the cultivation, sale and possession of cannabis and cannabis products in Ireland. Although the motion was lost, there was support

FF drugs action plan *(continued)*

for decriminalisation and for regulation.[7] In February 2015 the government released the General Scheme of the Public Health (Alcohol) Bill, intended to more strictly regulate the alcohol market.[8]

- What contribution will Ireland make to UNGASS 2016, the special session of the UN General Assembly due to be held in New York on 19–21 April 2016, to assess 'the achievements and challenges in countering the world drug problem, within the framework of the three international drug control conventions and other relevant United Nations instruments'?[9]

(Brigid Pike)

1. Collins N (2015) *Drugs action plan*. Dublin: Fianna Fáil *http://www.drugsandalcohol.ie/23816/*
2. Pike B (2008) *Development of Ireland's drug strategy 2000–2007*. HRB Overview Series 8. Chapter 4: 'Implementing strategy'. Dublin: Health Research Board *http://www.drugsandalcohol.ie/11465/*
3. Pike B (2011) Where do drugs fit in? *Drugnet Ireland* (37): 3–4 *http://www.drugsandalcohol.ie/14983/* and Pike B and Nelson M (2011) National drugs strategy goes to Department of Health *Drugnet Ireland* (38): 3–4 *http://www.drugsandalcohol.ie/15630/*
4. Pike B (2014) Recovery in national drugs strategies. *Drugnet Ireland* (51): 8–10 *http://www.drugsandalcohol.ie/22908/*; Joint Committee on Health and Children (2015, 26 March) 'Drug addiction and recovery models: discussion'. Downloaded on 22 April 2015 at *http://oireachtasdebates.oireachtas.ie*
5. Pike B (2012) What makes for a 'good' drugs policy? *Drugnet Ireland* (44): 11–13. *http://www.drugsandalcohol.ie/19134/*
6. Pike B (2015) How does Ireland's drugs policy compare with others? *Drugnet Ireland* (53): 4–5. *http://www.drugsandalcohol.ie/23687/*
7. Pike B (2014) Dáil debate on cannabis. *Drugnet Ireland* (49): 6–9. *http://www.drugsandalcohol.ie/21673/*
8. Department of Health (2015, 4 February) General Scheme of the Public Health (Alcohol) Bill 2015. Downloaded on 22 April 2015 at *http://health.gov.ie/wp-content/uploads/2015/02/General-Scheme-of-the-Public-Health-Alcohol-Bill-2015.pdf*
9. Since Issue 48, *Drugnet Ireland* has been carrying a column 'Towards UNGASS 2016', which reports on policy initiatives, research and debates launched by UN member states and civil society organisations in the lead-up to UNGASS 2016.

Changing drug trends but static policies

On 21–23 May 2015 the International Society for the Study of Drug Policy (ISSDP) held its ninth annual conference, in Ghent, Belgium.[1] Aileen O'Gorman of the University of the West of Scotland, Glasgow, United Kingdom, gave a paper at the conference based on a study of licit and illicit drug use patterns in the Finglas–Cabra local drugs task force area undertaken in the second half of 2012.[2] The conference paper was titled 'Changing drug trends: static drug policies'. The abstract of O'Gorman's paper is reproduced below.[3] (Citations included in the abstract have been deleted as full publication details were not provided.)

Background

Since the 1990s, patterns and trends in drug consumption have evolved in response to global and local shifts in drug production and supply, and in response to fluctuating levels of demand influenced by accessibility, price, quality, and cultural appeal. The consumption of a combination of licit and illicit substances has become a regular feature of weekend and festive socialising among young people. 'Illegal leisure' had become normalised and accommodated into the social and cultural practices of different social groups [citations deleted], albeit on a differentiated basis [citations deleted]. Nonetheless, internationally, drug policy remains predominantly and intransigently prohibitionist, focused on criminalising users, curtailing supply, and preventing and treating addictions. The gap between drug policies and drug consumption practices is ever-widening.

Aims and methods

This paper draws from the findings of a recent neighbourhood study that explored drug consumption patterns, practices and meanings from the perspective of a group of young people 'from the street', whose public presence was often perceived as problematic and who were regarded as being 'at risk' through their drug use [citation deleted]. Data were collected through individual and focus groups interviews, and ethnographic observations and conversations in the drug users' natural locations. The paper is further informed by a series of neighbourhood drug studies which began in Dublin in 1996 and have been conducted at intervals since [citations deleted]. These studies share a similar critical interpretivist methodological approach, which explored the lived experience of these drug users within a political economy framework of analysis of socio-spatial risk environments.

Findings

Patterns emerged from the drug enthusiasts' narratives illustrating how drug consumption practices were shaped by different intentions mediated by time and space settings, and the negotiation of an intricate interplay between structure and agency. Drug intentions were a key influence on their consumption practices. These intentions ranged from 'chillin', 'buzzin' and 'getting mangled' to 'coming down', and each intention was embedded in a set of polydrug combinations that included alcohol, cannabis, ecstasy, cocaine, new psychoactive substances, and prescription tablets (mainly benzodiazepines and so called 'Z drugs' such as Zimovane, Zopiclone etc.).

The paper describes and analyses the users' drug choices, intentions and risks, and situates them in the context of the role and meaning of drug use in their lives, including their participation in the drugs economy. Glimpses of rational action and cost-benefit analyses in their discourses of choice were seen to be brokered within short-term socio-temporal spaces and bounded by the broader social, cultural and policy contexts they inhabited. Drug users do not exist in isolation from their social, economic and policy contexts. The findings of this study highlight the need for integrated drug and social policies that address broader contextual structural issues and inequalities.

(Brigid Pike)

1. For more information on the ISSDP and its conferences, visit *http://www.issdp.org/*

Drug trends & policies *(continued)*

2. O'Gorman A, Piggott K, Napier K, Driscoll A, Emerson D, Mooney R, Fennelly C, Gately P and Foley M (2013) *An analysis of current licit and illicit drug use patterns in the Finglas–Cabra local drugs task force area.* Dublin: Finglas/Cabra Local Drugs Task Force. *http://www.drugsandalcohol.ie/20723/*

3. The abstract was downloaded from the preliminary version of the book of ISSDP conference paper abstracts at *http://www.issdp2015.ugent.be/wp-content/uploads/2015/03/book_of_abstracts_preliminary_version.pdff*

Ireland participates in innovative policy think-tank

Although the oldest international drug policy think-tank, the Pompidou Group, of which Ireland is a member, is arguably the most innovative intergovernmental body working in the area of policy on psychoactive substances and addictions in the world today. Its achievements over the past forty years are outlined in the following article. The new work programme for 2015–2018 has four thematic priorities:[1]

1. Bring human rights to the forefront

The Pompidou Group will support member states in meeting their obligations under the Council of Europe and United Nations Conventions to protect fundamental rights and freedoms, in particular the right to life and human dignity, the right to protection of health, the right to equitable access to quality health-care services for all, the prohibition of any type of discrimination as well as the right of children to be protected from narcotic drugs and psychoactive substances. Promoting gender equality will also continue to be a transversal aspect to be observed in all Pompidou Group activities. Aims include:

- increasing awareness of human rights obligations and reduction in human rights violations occurring in the pursuit of drug policy goals;
- contributing to reducing stigmatisation and discrimination;
- promoting the right of access to healthcare for drug dependent people in detention;
- highlighting and recognising the pivotal role of the Pompidou Group, as a part of the Council of Europe, in promoting human rights as a fundamental drug policy principle; and
- promoting the mainstreaming of gender aspects in all areas of drug policy.

2. Analyse policy coherence, costs, impact and potentially adverse effects of drug policy measures

Recognising that understanding the costs and effects of different policies not only in terms of their immediate impact but also in view of indirect effects and costs is necessary for making the right choices and for understanding the return on investment, the Pompidou Group is committing to supporting member states to take into account the whole spectrum of drug control costs, as well as the impact of drug control measures on different aspects of life and sectors of policy. At the same time the Pompidou Group will emphasise that policy coherence between policies on licit and illicit drugs, as well as addictive behaviours, is a fundamental determinant of cost effectiveness. Aims include:

- better understanding of how to determine a balanced approach in drug policy and ensuring that different approaches complement each other;
- developing concepts for a cost benefit approach in drug policy planning;
- providing guidance for prioritisation in times of diminishing public funds; and
- promoting more coherence between demand and supply reduction policies, and other policies.

3. Address changing patterns and context of drug use, production and supply

While the international drug control conventions offer the possibility of scheduling new substances, the Pompidou Group identifies the sheer rapidity of emerging new psychoactive substances, as well as the time-consuming and costly way of bringing them under control, as a specific challenge. Other challenges include the rapid spread of methamphetamines in some regions, the continuing high levels of cannabis consumption, the emergence of heroin in social contexts not previously seen, poly-drug use, including mixed consumption of licit and illicit substances, and addictive behaviours.

The Pompidou Group will support the exploration of new ways in which demand reduction, supply reduction and risk prevention and harm reduction approaches can be adjusted or further developed while keeping in mind the need for coherence in policies. Aims include:

- identifying feasible responses for effective prevention in changing environments;
- adapting and refining detection methods in trafficking;
- identifying new precursor products, means of production and means of precursor control;
- adapting and broadening the concept of risk prevention and harm reduction;
- developing concepts for adequate treatment and rehabilitation in pursuit of re-integration; and
- facilitating dialogue between governments, civil society, professional groups and other relevant stakeholders to prevent use and risks.

Policy think-tank *(continued)*

4. Identify opportunities and challenges for drug policies arising from the Internet

Recent developments in information and communication technologies (ICT) have enabled the emergence of a new global black market for drugs sales which is rapidly growing. Easy access and anonymity reduce the threshold to buy drugs via the Internet and have created new distribution channels and payment systems that present new challenges for law enforcement and customs. By the same token, the Internet can potentially reach large groups of youth at both local and global level, including those not currently reached. Offering treatment to drug users via the Internet is rapidly increasing; the Internet can also be used to offer specialised services in remote areas and provide a cost-effective way to support a large number of clients. Aims include:

- charting and better understanding of developments in cyber space in view of opportunities and challenges for demand and supply reduction efforts;
- increasing competences for concerned government agencies;
- providing guidance where action is needed; and
- promoting cooperation with relevant stakeholders from the private sector.

(Brigid Pike)

1. For further information on the *Pompidou Group work programme 2015–2018: 'Drug policy and human rights: new trends in a globalised context'* (P–PG/MinConf [2014] 4), visit *http://www.coe.int/T/DG3/Pompidou/*

Membership of the Pompidou Group (37)

Austria, Azerbaijan, Belgium, Bosnia & Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Estonia, Finland, France, Greece, Hungary, Iceland, Ireland, Israel, Italy, Liechtenstein, Lithuania, Luxembourg, Malta, Republic of Moldova, Montenegro, Morocco, Norway, Poland, Portugal, Romania, Russian Federation, San Marino, Serbia, Slovak Republic, Slovenia, Sweden, Switzerland, the Former Yugoslav Republic of Macedonia and Turkey

What is the Pompidou Group?

The Pompidou Group is an intergovernmental drug policy think-tank and champion of evidence-based drug policy. Formed over 40 years ago, it has spearheaded many new initiatives subsequently taken over by other agencies. For example, the concepts of monitoring trans-national drug abuse and indicator development were introduced by the Pompidou Group, and then taken over by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Methods to measure the use of alcohol, tobacco and drugs were developed by the Pompidou Group, and the European School Survey Project on Alcohol and other Drugs (ESPAD) is now an independent programme that serves governments in 51 countries as the principal data source on drug-use trends.[1]

Pompidou Group extends its 'sphere of influence'

- **1971**: The Pompidou Group (Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs) was formed at the instigation of the French President Georges Pompidou. Initially, this informal forum consisted of seven European countries – France, Belgium, Germany, Italy, Luxembourg, the Netherlands and the United Kingdom – looking to share their experience of combating drug abuse and drug trafficking. Ireland joined on becoming a member of the European Community in January 1973.
- **1980**: The Pompidou Group was incorporated into the institutional framework of the Council of Europe and cooperation was subsequently extended to include new countries. Today the Pompidou Group comprises 37 member states. (See separate box listing member countries.)
- **1990s**: The Pompidou Group began to extend technical co-operation to countries in central and eastern Europe which are not members of the Pompidou Group, most recently to Albania, Latvia and Ukraine. In addition, the Group began to invite non-European countries, such as Canada, the USA, Australia and Mexico, to take part in activities, as well as other international bodies such as the European Union, the European Commission and the EMCDDA. The Holy See also cooperates on an *ad hoc* basis.
- **2006**: The Pompidou Group began developing co-operation activities for and with non-member states from the Mediterranean Basin such as Algeria, Tunisia, Lebanon, Egypt and Jordan.

As its ideas have been taken up by other agencies, the Pompidou Group has had to reinvent itself, not least in the last four years. In wrapping up the 2010–2014 work programme during the French presidency of the Pompidou Group, Executive Secretary Patrick Penninckx described this reinvention:[2]

> *The Pompidou Group has a long tradition in Research, work in Prison settings, work with front line professionals, gender issues, training and capacity building. These traditions were re-invigorated with specific programmes. New areas were explored and flexible working methods introduced. We were all alert to new developments and reacted to them quickly. We provided a space to explore, to question, to debate. … The constructive interaction between all stakeholders created a favourable environment to work with trust and endeavour which allowed the Pompidou Group to develop and continue to provide added value to Member States.*
>
> *Cleary the Pompidou Group continues to provide added value in the following fields: Providing a forum for open debate, linking policy, research and practice, playing a precursor role with innovative ideas together with multidisciplinary and transversal approaches, and acting as a bridge with the European neighbourhood through multi-lateral activities.*

The Pompidou Group *(continued)*

Table 1 illustrates how the Pompidou Group provides a unique forum in which countries can explore new ideas in a climate of openness and trust. Ireland has participated in a number of these activities, being represented either at official level or at non-official level, for example by an expert in a specialist field or by a member of a civil society organisation.

(Brigid Pike)

1. For further examples, see B Pike (2010) Pompidou Group celebrates its first 30 years. *Drugnet Ireland* (34): 21 *http://www.drugsandalcohol.ie/13300/*
2. For further information on the Pompidou Group and *Inventory of activities and outcomes accomplished during the work cycle 2011–2014* , published by the Pompidou Group, visit *http://www.coe.int/T/DG3/Pompidou/*

Table 1: Pompidou Group activities, 2010–2014

Activities of Pompidou Group	Participation by Ireland
Advancing policies	
▪ Guidance for developing coherent policies for licit and illicit drugs	X
▪ Preventing risks and reducing harm linked to the use of psychoactive substances	
▪ Road traffic safety and substitution treatment	
▪ Education and training on substance use disorders	
Supporting law enforcement	
▪ Drug control services at European airports and in general aviation (Airports Group)	X
▪ Prevention of drug precursor diversion	
▪ e-Learning tools for prosecutors on drug precursor diversion	
▪ Elaboration of a framework aimed at reducing drug supply on a world-wide scale	
▪ Drug-related cybercrime	
Linking research with policy	
▪ Experiences with integrated policies for licit and illicit drugs	X
▪ Optimising communication between research and policy makers on ESPAD	
▪ Gender dimension of non-medical use of prescription drugs	X
▪ Review of national regulations on opiate substitution treatment	
▪ European Research Register	
▪ Cooperation with European Society for Social Drug Research (ESSD)	X
Connecting policy with practice	
▪ Executive training for drug policy managers	X
▪ EXASS Net	
▪ Drug policy cooperation in South East Europe and the Balkans (SEE)	
▪ European Drug Prevention Prize	X
Building capacity	
▪ Support for the development, implementation and review of national drug policies	X
▪ Implementing coherent drug strategies in Ukraine	
▪ Co-operation Network in the Mediterranean Region on drugs and drug addiction (MedNET)	X
▪ Drugs in prisons	
▪ Cooperation with the Confidence Building Measures (CBM) Programme of the Council of Europe	

Patterns and trends in cigarette smoking in Ireland, 2003–2013

A cigarette smoking prevalence tracker survey has been conducted in Ireland since 2002. Initiated by the Office of Tobacco Control, when this office was dissolved in 2010 the survey was continued by the Health Service Executive. The survey involves a monthly, nationally representative telephone poll of 1,000 randomly selected people aged 15 years and over.

The smoking prevalence question in the survey is *'Do you smoke one or more cigarettes each week, whether packaged or roll your own?'* In addition, demographic information on gender, age, socio-economic group and region is collected. The basic information from the survey has been available in previous years. However, in 2014 the HSE published a detailed report on the patterns and trends up to and including 2013.[1]

Results outlined in the report show that the overall prevalence of cigarette smoking in 2013 was 21.5%. This was higher among men (22.9%) than women (20.2%). Smoking was most prevalent among the 18–24-year-old age group (30.7%), followed by the 25–34-year-old age group (28.1%). The lowest prevalence was among those aged 65 and older (9.7%). Of note, the prevalence among those aged 15 to 17 years was 13.3%.

The highest prevalence rates were found among the lower socio-economic groups (C2 and DE) at 24.6% and 25.9% respectively. The lowest rates were among higher socio-economic groups (AB) at 13%, and farmers at 15%. There was very little difference in smoking rates by region.

An analysis of trends showed that overall cigarette smoking rates had declined by 6.6% since 2003, which equates to more than 104,000 fewer smokers in Ireland in 2013. This decline was evident in all age groups but was most pronounced in the 25–34-year-old age group (16.1%) and least evident in the 15–17-year-old age group (1.5%). All socio-economic groups have seen a downward trend since 2003. The largest decreases were in the C2 group (11.1%) and the AB group (10.2%), with the smallest decrease among farmers (0.7%).

Trends in daily consumption of cigarettes, by category of smoker, were also reported. While regular smokers have consistently been the largest group since 2003, there is a trend towards lower levels of consumption. In 2013, 57.5% of all smokers were in the occasional or light categories. Moreover, in the last two years there has been a decrease in the proportion of regular smokers, from 39.8% to 36.2%, and a 3% increase in the number of occasional or light smokers. Heavy smokers have declined by 2%.

(Margaret Curtin)

1. Hickey P and Evans DS (2014) *Smoking in Ireland 2013: synopsis of key patterns and trends*. Dublin: Health Service Executive. *http://www.drugsandalcohol.ie/23200/*

Categories of smoker	
Category	**Cigarettes per day**
Occasional	1–5
Light	6–10
Regular	11–20
Heavy	21+

Drug markets and the internet

The importance of the internet in the sale and supply of both licit and illicit drugs and new psychoactive substances (NPS) is reflected in the growing body of research literature dedicated to the investigation of this elusive market. The study of illicit drug markets has traditionally always been methodologically challenging, with researchers often having to negotiate access to buyers, sellers and drug law enforcement officials in order to gain insights into the largely hidden behaviour surrounding drug transactions.[1] And now, the growing role of the internet in facilitating the illicit sale and supply of controlled drugs, and new psychoactive substances (NPS), is transforming the illicit drug market in ways that pose new challenges for law enforcement, public health, research and monitoring. The three studies reported here give an insight into the challenges.

An EMCDDA study, undertaken in September–October 2014, aimed to increase understanding of the online supply of drugs and to map the range of drug markets in existence.[2] A specific focus was on 'the role of social media and apps; online sale of NPS; online sales of medicinal products for illicit use; and the sale of drugs on the deep web' (p.3). The study was based on a literature review and an international meeting of experts who provided insights from information technology, research and monitoring, law enforcement, internet and drug user perspectives. It looked at the role of social media, which operate mostly on the 'surface web', in drug markets, for example Facebook (1.6 billion registered users), YouTube (1 billion active users) and Twitter (500 million registered users). It was reported that social media play a role in the sale of NPS, research chemicals, medicines such as lifestyle products (for erectile dysfunction, slimming or hair restoration) and, more recently, performance enhancement products and controlled prescription drugs such as benzodiazepines. The

Drug markets & the internet *(continued)*

study also investigated law enforcement responses to online drug supply, and reported that they are focused on market disruption through measures such as reducing 'trust around anonymity', and on covert operations seeking to infiltrate online markets. Finally, the study considered the 'deep web', defined as a part of the internet not accessible to traditional search engines such as Google, and the 'dark web', defined as a small portion of the deep web intentionally hidden and inaccessible through standard web browsers.

The dark web is the focus of a recent policy briefing.[3] The sale of illicit substances on dark net drug markets has grown rapidly in recent years, facilitated by the release of The Onion Router (TOR) in 2002, which is 'a technology that bounces internet users' and websites' traffic through "relays" run by thousands of volunteers around the world, making it extremely hard for anyone to identify the source of the information or the location of the user' (p. 5). The policy briefing discusses the limitations of traditional law enforcement strategies in 'matching, let alone exceeding the sophistication and innovation of the hidden web and digital crypto-currencies used for payment on the Dark Net drug markets' (p. 2). The authors raise a number of points for policy-makers to consider:

- For vendors and purchasers hidden markets present a safer environment for drug transactions and they reduce the multiple risks (coercion, violence, arrest, exposure to other drugs) associated with street sales.
- Anonymised user forums and online chat rooms encourage and facilitate information-sharing about drug purchases and effects, representing a novel form of harm reduction for drug users and an entry point for drug support services.
- Enforcement efforts through surveillance, hacking and other forms of interdiction may be successful in closing down a particular site, but at the cost of proliferating hidden drug markets and incentivising technological innovation.

Given the technical and legal challenges facing law enforcement in this area, the authors conclude that 'Dark net interdiction efforts should prioritise high-end crimes such as child sexual exploitation, cyber terrorism and weapons trafficking, and work with self-regulating "ethical" drug sites to enhance understanding of high-level criminality on the dark net' (p.1). The forthcoming 2016 UN General Assembly Special Session (UNGASS) on the world drug problem provides the opportunity, they suggest, to discuss how to 'better deal with the challenges of the increasingly complex illicit drug market in the twenty-first century' (p.1).

That these challenges are likely to intensify in the years ahead is reflected in the findings of the latest update from the EU Early Warning system on NPS, published in March.[4] It is reported that over the past five years there has been an 'unprecedented increase in the number, type and availability of NPS in Europe'.

(Johnny Connolly)

1. See Ritter A (2006) Studying illicit drug markets: disciplinary contributions *International Journal of Drug Policy* (17): 221–228. For recent Irish research, see Connolly J and Donovan A (2014) *Illicit drug markets in Ireland*. Dublin: National Advisory Committee on Drugs and Alcohol. *http://www.drugsandalcohol.ie/23302/*
2. EMCDDA (2014) *The internet and drug markets. Summary of results from an EMCDDA Trendspotter study*. http://www.drugsandalcohol.ie/23352/
3. Buxton J and Bingham T (2015) *The rise and challenge of dark net drug markets.* Global Drug Policy Observatory. Wales: Swansea University. *http://www.drugsandalcohol.ie/23274/*
4. For more information on the EU Early Warning System, established in 1997 to gather and report data on NPS from the 28 EU members states, Turkey and Norway, see *emcdda.europa.eu/activities/action-on-new-drugs*

Young people in drug treatment

Darker and colleagues report on research undertaken with 20 young people aged 15–19 years who were recruited from two addiction treatment programmes in Ireland – a residential programme in the south-east and an out-patient programme in Dublin.[1] Data were collected using in-depth interviews and analysed using thematic analysis.

Initial substance use

Factors reported by respondents as having contributed to their initial use of substances were grouped by the authors as either personal factors or environmental factors. Using substances as a coping strategy or a means of escaping emotional difficulties were the most common themes reported under personal factors. Participants recalled using substances to cope with family dysfunction, including domestic violence, and with inter-personal difficulties at school. Other personal stressors leading to initial substance use included family bereavement, relationship break-up, being bullied, being placed in care and episodes of depression or anorexia. Some participants reported using substances to increase confidence and improve self-esteem.

Environmental factors contributing to initial substance use were friends' substance use and a family history of substance use. Young people described substance use as a normative experience, citing use by peers and influential elders as rendering use acceptable. The neighbourhood was also a factor, with access to substances having been easy and alternative recreational resources limited.

Problematic substance use

All participants were engaged in problematic substance use to a level requiring specialist treatment. Their responses to how they progressed to this stage were grouped by the authors of the research under substance-related factors, substance use as a coping strategy and other factors. Participants reported experiencing cravings, withdrawal symptoms, hangovers, come-downs and other consequences of use, all indicating a cycle of addiction; increased tolerance and a growing desire to be high were other substance-related factors contributing to progression to problematic use. Participants reported continued and increased use of substances as a means of coping with family dysfunction and a myriad of personal life stressors, including family illness or death. Other factors cited by some participants included criminal justice problems and problems at school.

Young people in treatment *(continued)*

Coping with problems and stress

A common theme to emerge from respondents was their reliance on alcohol and drugs before they entered treatment to cope with problems and stress. Some also reported trying to avoid coping, or using emotion-focused coping such as getting angry and aggressive when under stress.

Parental roles

Responses about the roles played by parents in the initiation and development of problematic substance use among participants were grouped under the following themes: relationship difficulties, enabling behaviour, parents' permissive attitude and parents' own substance misuse. Relationship difficulties appeared to arise through resistance to mothers' efforts to control respondents' problem behaviour and through lack of emotional support from some fathers; these experiences contributed to disengagement, anger and frustration among respondents. Parents' lack of boundary-setting and giving money to respondents were perceived as enabling substance use, and parents' tolerance of and participation in respondents' alcohol consumption gave the impression of a permissive attitude. Parents' own substance use was a factor that overlapped with many other factors reported by respondents.

Conclusion

As noted by the authors, this is a small study of 20 young people attending treatment for substance use. It was designed to provide an insight into the factors that influence young people to use substances and the factors that contribute to use becoming problematic to the point where the young user needs specialist treatment. The findings should not be generalised to the wider population of young people in treatment. However, they may be used to inform the design and focus of further research that might test the relevance of these factors among a larger sample.

What is notable in the findings is the pivotal role played by the family in the young person's initiation into and development of problematic substance use. The dysfunctional nature of the respondents' families and their experience of parental conflict, violence and substance use, and the ensuing emotional trauma reported by them, appear to have been key 'triggers' in their decision to use substances. The authors point out that these young people used substances as the 'default' coping mechanism, but they did this in a context where the use of substances among significant others was perceived as the norm. These insights provide a useful basis for discussion about the design of effective prevention programmes.

(Martin Keane)

1. Darker CD, Palmer D, O'Reilly G, Whiston L and Smyth B (2014) Young people in drug treatment in Ireland: their views on substance use aetiology, trajectory, parents' role in substance use and coping skills. *Irish Journal of Psychological Medicine* Available on CJO 2014 doi:10.1017/ipm.2014.77 *http://www.drugsandalcohol.ie/23180/*

Hazardous alcohol consumption among university students

A recently published paper reports on a study undertaken with a sample of 2,275 undergraduate students at University College Cork. The aim of the study was to investigate the prevalence of hazardous alcohol consumption (HAC) and the associated adverse consequences among university students in Ireland, with particular reference to gender differences.

A questionnaire, based on previously validated instruments, was distributed to students during lecture time between 12 and 23 March 2012. HAC was estimated using the Alcohol Use Disorder Identification Test for Consumption (AUDIT-C), developed by the WHO: it measures frequency of consumption, number of units consumed and number of binge drinking occasions. The study took into account the fact that guidelines for safe alcohol consumption are lower for women owing to their increased vulnerability to alcohol-related harm. Body-mass index was estimated based on self-reported height and weight. Logistic regression analysis was used to estimate factors associated with HAC for both men and women.

The study found that the prevalence of HAC was similar in men (65%) and women (67%) and was considerably higher than that previously reported in the general population. Moreover, 57% of women were drinking at a level that would be considered hazardous for men. Over one quarter of hazardous drinkers were consuming more than six units of alcohol (binge drinking) at least 2–3 times per week. Factors associated with HAC were studying law and business, not owning a house, current smoking, illicit drug use and being sexually active.

The pattern and frequency of adverse consequences of alcohol consumption were broadly similar for men and women. However, men were more likely to report getting into a fight and having a one-night stand than women. Among those with a HAC pattern, missing days at work or college as a result of drinking was reported by 60% of men and 57% of women, compared to 15% of men and 14% of women in the non-HAC student population. Hazardous drinkers were also more likely to engage in unplanned sexual activity and were less likely to use protection.

Results show that patterns of alcohol consumption in these Irish university students are similar to those among British students but significantly higher than among students in the USA. Moreover, this paper highlights the association between HAC and the 12–month prevalence of illicit drug use. The authors state that these two behaviours need to be tackled concurrently.

The authors conclude that HAC continues to be a public health concern in Irish universities both in terms of immediate adverse consequences and long-term risks to physical and mental well-being.

(Margaret Curtin)

1. Davoren MP, Shiely F, Byrne I and Perry I J (2015) Hazardous alcohol consumption among university students in Ireland: a cross-sectional study. *BMJ Open*, 5 (e006045)

Evaluating a substance use rehabilitation programme

In partnership with the UCD School of Applied Social Science Community Partnership Drugs Programme, the Ballymun Youth Action Project (BYAP) and partner agencies engaged in an evaluative research process of the Boxing Clever Programme in 2013/2014. The resulting report and the findings of this research project were launched on 6 February 2015.[1]

The Boxing Clever programme is a 20-week integrated educational, substance use recovery and fitness programme that aims to support participants to develop more resilient identities, while encouraging educational achievement, physical wellness and reduction in harmful or risky behaviours. Seven organisations support the programme, with five of these organisations and eleven practitioners, including boxing coaches, directly involved in programme delivery.

The research explored the impact and the outcomes of the programme for both participants and the community. Given the unique inter-agency structure of the programme, the research also investigated the efficacy of inter-agency relationships and communication in delivering the programme. The research methodology comprised a literature review, a comparison of pre- and post-programme measures in regard to attitudes, behaviour, knowledge and physical fitness, focus groups with participants on the programme, and a qualitative exploration from a worker's perspective.

The authors of the report concluded that the research not only demonstrated the important role education and sport can play in substance use rehabilitation, but also the importance of inter-agency work in achieving the goals of rehabilitation and reintegration. The key findings are noted here.

Physical activity

- Positive changes occurred for the majority of participants in terms of physical endurance, core conditioning and upper body strength, and physical flexibility.
- Sport and physical exercise helped with improving mood.
- The majority of participants completing the programme maintained their drug-free status or reduced their drug use, and attributed this to their participation in the programme.

Boxing skills

As well as developing boxing fitness and skills, the boxing element of the programme had other significant impacts:

- Boxing facilitated and enabled the participants to socially re-integrate into their communities, communities that they were typically isolated or excluded from as a result their drug use.
- Boxing facilitated the release of anger and other emotions. Many of the participants lived in situations where personal and community violence were everyday risks, and the discipline and skills involved in the boxing element provided a way for participants both to defend themselves from violence and to express anger and other emotions.
- Boxing is a very individual sport. Boxers do not rely or use the skills of team members; their performance is completely down to them. While more challenging, this provides opportunities for personal growth, self-awareness and self-knowledge. One practitioner noted that the relationship between a boxing coach and participant is intimate: if the intimacy is built on trust and respect, this can also result in positive change, self-awareness and personal growth.
- The structure and approach of the boxing skills and fitness elements of the programme were designed and implemented to challenge gender norms associated with sports such as boxing. The research found that women both engaged, and sustained their participation, in the programme.

Education and social engagement

- The programme supported and facilitated the majority of participants to achieve a QQI minor award at levels 4 and 5, which is seen as a vehicle for further education.
- The CASC element of the programme was pivotal in supporting participants to understand substance use within their family of origin and the wider community.
- Participants reported positive changes as a result of participating in the programme, such as improved communication with their children and family. They also recognised the impact of their substance use on the community and a number identified this recognition as a motivator for sustaining positive change in their lives.
- Participants valued the support of their mentors, who provided a concrete example of the possible progression onto further education, sport or community involvement. The practitioners found the mentoring role pivotal in supporting participants, informing participant support and illustrating the possibilities for progression.

Inter-agency working

- The research found the inter-agency working between the seven agencies was effective due to the presence of trust, respect, giving and taking, flexibility and open and clear communication. Rather than a competitive view of each other's contribution, practitioners valued each other's work, and were found to be flexible and adaptable.

Substance use rehabilitation *(continued)*

- Alongside the content and structure of the Boxing Clever programme, the inter-agency work supported participants through their change processes. Participants reported feeling valued, empowered and encouraged. The practitioners described how they sought to develop leadership, confidence and a sense of community belonging within the participants. This valuing of participants was also demonstrated in the resources and facilities allocated to the programme by all of the stakeholders.

The authors identified two major limitations to their research. (1) The sample size was small, with only 17 programme participants engaging in the research process. (2) The research considered the immediate impacts and outcomes for participants. The authors called for further research to consider the 'long term impact and outcome of programmes that seek to build social and human capital, particularly those that utilise both fitness and education in the programme delivery' (p. 57–58).

(*Brigid Pike*)

1. Morton S, O'Reilly L and O'Brien K (2015) *Boxing Clever: exploring the impact of a substance use rehabilitation programme.* Dublin: Ballymun Youth Action Project. *http://www.drugsandalcohol.ie/23545/*

Motivational intervention for problem substance users in prison

The importance of drug treatment in prison is well recognised, given the prevalence of problem substance use among prisoners. Engagement and retention in drug treatment is a key factor in improving outcomes. An evaluation of a group-based motivational intervention, developed in order to identify and engage with substance users in a prison setting at an earlier stage with regard to their drug use, is described here.[1]

The motivational intervention was based on motivational interviewing and the Prochaska and DiClemente transtheoretical model of behaviour change. Motivational interviewing is defined as 'a client-centred directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence'. After the intervention the authors expected that participants would show:

- increased recognition of their problem behaviour,
- decreased ambivalence towards their drug use, or
- positive behavioural change in relation to their drug use.

Prisoners in Mountjoy prison who were current substance users were invited to participate in the intervention programme. Those with active psychiatric illness or a release date before the end of the programme were not included. There were 76 potential participants: 44 were offered a place on the programme and 38 accepted. Each participant gave informed consent. Eleven potential participants were put on a wait list and formed the control group. The 12-session group-based motivational intervention took six weeks and each session lasted 1½ hours.

Demographic data, sentencing details, drug use history, risk behaviour and current engagement with treatment services were collected for each participant using a semi-structured interview. The primary outcome measure of treatment effectiveness was collected using the internationally validated questionnaire – Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES).[2] This measures a participant's readiness for change. It was filled out by the participant (self-reported) before and after the treatment. Retention rates in the programme were 88% at two weeks and 76% (n=31) at six weeks. Information on the seven who had dropped out by the sixth week was not included in the final analysis.

The mean age of the participants was 31 years and all were male. Most were incarcerated for non-violent drug crimes (39%), followed by violent crime (35%). Opiates were the main drug used (71%). Three quarters (74%) reported ever injecting while nearly half (48%) reported recent injecting drug use. No statistically significant difference was found between the characteristics of the participants and the control group.

Reported limitations of the study included small sample size, lack of randomised or treatment-as-usual control group, and use of self-reported outcome measures. Many of the participants and those in the control group were also engaged in other prison drug treatment services, e.g. methadone maintenance, which may indicate that they already had a higher degree of motivation than other prisoners who were not engaged with the services.

The authors considered the high level of retention and completion rates in the programme very positive. There was a statistically significant reduction in the ambivalence of the participants around their drug use after the intervention. The authors concluded that group-based motivational interventions could be useful in a prison setting but they require further investigation.

(*Suzi Lyons*)

1. Harper S and O'Rourke A (2015) An evaluation of group-based motivational intervention for substance misusers in an Irish forensic setting. *Irish Journal of Psychological Medicine*, early on-line *http://www.drugsandalcohol.ie/23573/*
2. Miller W and Tonigan J (1996) Assessing drinkers motivation for change. The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviours* (10):81–89

Patients on methadone programmes, Wheatfield prison

Methadone maintenance treatment (MMT) became available through the Irish Prison Service in 2002. Wheatfield prison is a closed, medium-secure prison for men, with an official capacity of 700. On 3 October 2011, of the 664 prisoners in the prison, 119 (18%) were receiving MMT. The authors undertook a descriptive study of all 119 prisoners on MMT on that date, from the electronic medical records.[1] The main characteristics are summarised below.

- Mean age was 33 years (range 21 to 58 years).
- 78% were classified as either medium or full security risk.
- Mean sentence length was four years (range 1 month to 15 years); 2% were on remand; 44% were serving a sentence of one month to two years; and 34% were serving a sentence of three to six years.
- Mean methadone dose was 55mg (range 4 mg to 180 mg), and 62% were on 60mg or less.
- 7% were HIV positive, and 7/8 of those who were HIV positive were on antiretroviral therapy.
- 38% were hepatitis C positive, and none were on hepatitis C treatment at the time of the study.
- 1% were hepatitis B positive; 7% were recorded as having a hepatitis B vaccination.
- 2% were being treated for active tuberculosis.
- 50% were prescribed other psychotropic medication – 24% anti-depressants, 18% anti-psychotics, 7% hypnotics, and 1% mood stabiliser.
- 16% were attending addiction counselling services.

The profile of the prisoners on MMT in Wheatfield – their drug use prevalence, demographic data, sentencing details, medical and psychiatric history – was similar to the profile of prisoners who participated in other studies on this topic.

Given that 18% of the population of Wheatfield prison were on MMT the day of the study, the authors concluded that MMT is now a significant medical undertaking in the IPS. They highlighted several issues in the management of MMT in Irish prisons:

- *Viral screening:* there were gaps in documentation of prisoner status with regard to HIV (33%), hepatitis C (29%), and hepatitis B (73%). Using only information on documented hepatitis C status, the authors found that 54% (45/84) of prisoners on MMT were hepatitis C positive. They highlighted the need for improved viral screening for this high-risk group.
- *Methadone dosages*: the authors explained the wide range in methadone dosages as being probably due to an older population, on extended sentences, who had stabilised their opiate use, often through an agreed gradually reduced methadone regime. The highest dosages were explained by well recognised pharmacokinetic interactions with TB medication, which necessitated higher dosages.
- *Extended aftercare*: the authors recommended extended aftercare for prisoners who voluntarily worked to reduce their methadone dosage in order reduce the risk of overdose. They highlighted the need for improved viral screening for this high-risk group.
- *Take-home naloxone*: The authors highlighted the need for take-home naloxone for prisoners when released, to reduce the risk of fatal overdose and also to fast-track prisoners back into MMT where necessary.

(Suzi Lyons)

1. Galander T, Rosalim J, Betts-Symonds G and Scully M (2014) A survey of patients on methadone programmes in Wheatfield Prison, Dublin, Ireland. *Heroin Addiction and Related Clinical Problems* 16(2): 17–22. *http://www.drugsandalcohol.ie/23736/*

Report of the Garda Síochána Inspectorate

The Garda Síochána Inspectorate was established under the Garda Síochána Act 2005, with a remit to ensure that the resources available to the Garda are used 'so as to achieve and maintain the highest levels of efficiency and effectiveness in its operation and administration, as measured by reference to the best standards of comparable police services'.[1] The implementation of the 200-plus recommendations of its latest report, *Crime investigation*, which consolidates outstanding recommendations from previous reports, could lead to the most fundamental reform of policing in the state since the foundation of An Garda Síochána in the mid-1920s – at least in terms of the way the policing service is internally organised and experienced by the public.[2]

The report runs to 500 pages and recommendations are made in each of the 11 parts of the report – crime prevention, divisional policing, first response, incident recording, crime management, investigating crime, the victim experience, intelligence-led policing, investigation and detention of suspects, offender management and detecting and prosecuting crime. This article focuses on the key points made in reference to drug law enforcement, an aspect of policing that is relevant across most of the eleven areas.

The main focus of the report is on the policing of volume crime – assaults, burglary, domestic violence, vehicle crime and robbery. Such crimes are typically committed by prolific offenders and so 'the targeting of police resources on hotspots, recidivist volume crime offenders and repeat victims can have a significant impact on crime levels and community safety' (Introduction, p. 5). The Inspectorate carried out field visits to seven of the 28 garda divisions and to national units, and over 1,000 garda members were interviewed. Interviews with the Probation Service, HSE, Courts Service, County/City Managers, Joint Policing Committees and victim support groups were also conducted. Visits were made to the police services of Northern Ireland, England, Scotland, Wales and Denmark, and the US, Australian and New Zealand police services were consulted. Approximately 1,500 PULSE crime and incident records were examined.

Drugs as a trigger offence

Although drug offences were not one of the main categories of offence analysed in the report, the Inspectorate acknowledges that many volume crimes are carried out by prolific offenders who may commit crime to 'fuel a drug habit' (Part 2, p. 2). A difficulty in establishing the true nature of drug-related crime in Ireland relates to the absence of drug-testing upon arrest. In other jurisdictions police services test persons arrested for so-called 'trigger offences'. These are usually acquisitive crimes such as burglary or robbery. A test can be conducted for six drug types with results in five minutes. This data can clarify the causes of crime and can be used for court purposes. It can also improve health care provision. The report calls for the mandatory drug testing of persons detained for 'trigger offences' (Recommendation 9.17).

Health care and demand reduction in Garda stations

The Inspectorate recommends that the Garda engage with key partners to develop an effective drug arrest referral scheme for those detained in garda stations, whereby those with drug problems can be referred to treatment providers (Recommendation 9.7). The report highlights the trend in other jurisdictions for health services to take responsibility for commissioning medical care provision in police custody, including the employment of nurses to provide immediate care to detained person where needed. This has been found to improve health care and reduce criminal justice costs.

Crime victimisation and community impact

With regard to drug-related crime, recent research has highlighted the disproportionate impact it can have on specific communities, particularly those with embedded drug markets.[3] The Inspectorate suggests that in order to reflect this community experience, the Garda Síochána should, in consultation with the Director of Public Prosecutions, 'consider the use of Community Impact Assessments' (Recommendation 7.5). In some jurisdictions, senior officers can complete such an assessment and this can inform policy responses including restorative justice interventions, partnership activity to tackle issues raised by the community and sentencing. In the context of drug markets, such an approach could be of value in directing responses to towards the most harmful markets – those involving violence, or open drug dealing or those involving young people.

Community policing and partnership approaches

The report highlights a new community policing model introduced in the North Central Division, involving a focused engagement with local stakeholders. However, it also notes that across all garda divisions visited, the number of community gardaí had been reduced, with two divisions effectively having none. The removal of community gardaí in some districts was an indirect consequence of the introduction of a new garda roster in 2012; a further contributory factor was the lack of value that appears to be placed on community policing activity within the police service. Specialist garda units raised concerns that many of their tasks, 'such as community officers running local events or attending meetings, are not recorded on any IT system; so that supervisors can view their good work that contributes to community safety' (Part 2, p. 24). It is acknowledged internationally that partnership responses involving local communities and statutory agencies provide the most sustainable responses to crime issues. However, participants in community meetings attended by the Inspectorate said that recurring anti-social behaviour was not being effectively addressed by the gardaí. The report recommends that the Garda Síochána conduct a review of the use of anti-social behaviour legislation (Recommendation 1.13). The report notes the often complex nature of such activity and the need for a partnership response. However, it highlights the absence of a statutory requirement among agencies to collaborate in tackling crime and disorder, with the consequence that partnership approaches across the divisions visited 'operated in many different ways', and that the 'absence of a statutory footing for partnerships allows

Garda Síochána Inspectorate Report *(continued)*

some agencies to disengage from joint working' (Part 1, p. 10). The report highlights the importance of ensuring that Joint Policing Committees, established under the Garda Síochána Act 2005, 'are fully engaged in crime prevention activity' (Recommendation 1.14).

Crime statistics and the Central Statistics Office

From an examination of entries on the Garda Síochána PULSE IT system, the report identifies a significant number of problems associated with non-recording of crime, inaccurate recording of detection rates and inappropriate criminal prosecutions where original offences are downgraded to less serious offences. This has implications in relation to drug-related intimidation, where the victim might not want to make a written statement of complaint for fear of reprisal from the offender. The report reiterates the rule which is, if there is a reasonable probability that a crime has occurred, and no evidence to the contrary, then even if the victim does not want the matter taken any further, a crime should be recorded (Part 3, p. 27). The report recommends that a 'national standard for incident recording' needs to be introduced (Recommendation 3.32).

In 2006, the responsibility for reporting crime was transferred to the Central Statistics Office (CSO). In order to address the deficiencies identified, the report recommends that the CSO should receive 'all PULSE record incident data including non-crime categories to facilitate analysis and reporting of crime statistics' (Recommendation 4.16), it should have a central role in the development of new crime counting rules (Recommendation 5.4) and the Department of Justice should initiate a process whereby the CSO would have a central role 'towards the designation of a baseline year for crime recording' (Recommendation 5.9). It also calls for the appointment of an independent body to conduct annual audits of incident and crime recording standards (Recommendation 5.10).

Prolific offenders and integrated offender management

Although the Garda Síochána operate a number of case management approaches to youth offenders and to prolific offenders who move across divisional and regional boundaries, the Inspectorate notes that this is limited in the Dublin Metropolitan Region: 'Given the level of organised crime and gang related violence in and around Dublin, this is a missed opportunity…The Inspectorate visited two divisions in the DMR and found little evidence of co-ordinated plans to manage known prolific offenders who move across the city' (Part 10, p. 6). Other jurisdictions in the UK and Europe operate integrated offender management (IOM) approaches. IOM involves the police, probation service, health service, prison service, housing and job seeker agencies in information sharing and joint assessment and planning to reduce offending. Sometimes agencies are co-located, thereby facilitating joint working. One of the aims of such approaches is to 'break the cycle of persistent or prolific offending, particularly where drug or alcohol addiction is a factor in offending behaviour' (Part 10, p. 9). The report provides a description and positive evaluations of such schemes in Cardiff and Hertfordshire, in the UK.

Adult cautions for drug possession offences

A significant drug-related recommendation in the report relates to the adult cautioning system. Adult cautions are used by most police services as an alternative way of dealing with an offender who may be a first –time offender. A person must admit the crime before the caution can be administered, and it is a formal process where bythe crime is then detected against them. This can prevent a lot of less serious crimes from reaching the courts. Although a caution system exists in Ireland for youth offenders and for some crimes committed by adults, adult cautions do not apply to drug possession offences. The Inspectorate states that, from interviewing garda members, some expressed 'strong feelings about taking a young person to court for a small amount of cannabis. … A court conviction for drugs can have enormous consequences and in some cases, members are not issuing a summons' (Part 11, p. 16). As a consequence, audits of drug cases conducted by garda divisions and districts have found 'large numbers of cases where drugs have been seized and no proceedings have been taken'. The Inspectorate recommends that the Adult Caution scheme should be extended to drug possession cases (Recommendation 11.9).

Some final remarks

The overarching recommendation in the report is that the Department of Justice and Equality establish and task a criminal service justice group, involving all agencies and stakeholders responsible for community safety in Ireland, with overseeing the implementation of the recommendations in the report. It also recommends the adoption of a new divisional model for delivering services, including for the deployment of specialist units such as drugs units (Recommendation 2.1).

A central theme throughout the report is the need for an internal reorganisation of the police service, in particular through the better utilisation of police staff and a review of the new garda roster introduced in 2012, so as to release garda members for operational duties. The report concludes: 'From the analysis of deployment data and from field visits to divisions and national units, it is clear…that garda resources are not currently deployed in terms of policing need and crime levels' (Part 2, p. 18). The Inspectorate recommends that the Garda Síochána should design a 'national resource allocation model that allocates resources fairly and matches resources to policing needs' (Recommendation 2.10).

Perhaps the most consistent demand from the public when asked, in a recent study of illicit drug markets in Ireland, what was needed in response to crime was more gardaí on the beat.[4] According to the Chief Inspector, Robert K.Olson, this issue will be addressed further by the Inspectorate as part of a 'forthcoming review of the entire structure and administration of the Garda Síochána under the Haddington Road Agreement' (Foreword, p. ii). Along with the recommendations of this report, this process could begin to address this long-standing community concern about policing.

(Johnny Connolly)

1. See *www.gsnisp.ie*
2. Garda Inspectorate (2014) *Crime investigation. Report of the Garda Síochána Inspectorate.* Dublin: Garda Inspectorate. *http://www.drugsandalcohol.ie/22967/*
3. Connolly J and Donovan A (2014) *Illicit drug markets in Ireland.* Dublin: National Advisory Committee on Drugs and Alcohol/ Health Research Board. *http://www.drugsandalcohol.ie/22837/*
4. Connolly J (2014) Illicit drug markets in Ireland *Drugnet Ireland* (52): 1–5. *http://www.drugsandalcohol.ie/23302/*

Towards 'a better city for all'

The issue of public substance misuse and anti-social behaviour in Dublin's inner city, actual or perceived, has long been a source of media focus and public concern. In 2011 a partnership of stakeholder representatives – drawn from local businesses, drug treatment providers, An Garda Síochána, local drugs task forces and service users – was formed to develop sustainable responses to the many factors contributing to the situation. In June 2012, following research and in-depth discussion over a number of months, a report, *A better city for all*, was published.[1] The report made almost 60 recommendations in relation to treatment, rehabilitation, homelessness, alcohol supply, policing, planning and urban design, legislation and partnership. The members of the *A better city for all* (ABCFA) group agreed that the issue of substance-related anti-social behaviour was primarily a public health issue and any sustainable long-term solution could only be delivered in that context.[2]

Throughout 2013, an implementation committee, chaired by the Area Manager for Dublin City Council, progressed the implementation of the recommendations in the report. Following an evaluation of the process in January 2014, the ABCFA group agreed that it had taken the implementation of the recommendations as far as it could. It highlighted several outstanding issues:

- *Homelessness*: The group called for the 'Housing First' model, which targets people rough-sleeping, to be introduced as a mainstream programme.
- *Treatment*: The group highlighted the cutbacks in daytime services and the need to facilitate and support existing structures and services. It also supported the establishment of residential crisis stabilisation/detoxification units for people with problematic poly-substance use (including alcohol) and multiple needs. The group also supported, in principle, the introduction of a safe-injecting facility pilot project, based on good practice.
- *Public information/communication*: The group called for a strategy to help address the negative perceptions of the city as an unsafe place. It stipulated that the strategy should be evidence-based and cover both about the nature of the problems and the existing responses to them.

The ABCFA group agreed that further progress in addressing the issues in the city would require stronger and more integrated participation by statutory bodies, including senior budget holders, and the establishment of a focused street-outreach team to respond to the needs of some of the most marginalised individuals in the city centre. In early 2014, a Higher Level Statutory Group, comprising representatives of Dublin City Council, An Garda Síochána, the HSE and the Dublin Regional Homeless Executive, was established. Since September 2014 a street-level outreach team, led by the Ana Liffey Drug project and including community Gardaí and HSE workers, was formed to operate on a case management basis with individuals in need of particular social supports.

With the national commemorations in 2016 coming closer, a need was identified by those involved in the process to date for those frontline services responding to the ongoing social, health and economic issues and challenges in the city centre to maintain a partnership and communication network in order to deliver on the overall objectives of ABCFA (see box). In May 2015, to further these objectives, an inaugural ABCFA seminar was held. Presentations explored the challenges of introducing 'Housing First', and of responding to public drug

Mr Aodhán Ó Ríordáin TD, Minister of State with responsibility for the National Drugs Strategy speaking at the inaugural Better City for All seminar in May.

A better city for all *(continued)*

Guiding Principles and Objectives of A Better City for All

Responses should:

- be coordinated and partnership-based,
- be evidence-based,
- complement and not duplicate other relevant policies
- be measurable,
- not make problems worse or simply shift them elsewhere,
- reduce public fears and address perceptions of concern associated with clients receiving drug treatment,
- decrease the visibility of substance misuse,
- address negative perceptions of the city as an unsafe place to be, and
- promote a balanced perspective on the issues.

use in the city centre from the perspective of low-threshold services such as the Ana Liffey Drug Project and Merchants Quay Ireland. Richard Guiney of Dublin Town gave the local business community perspective. The seminar was attended by representatives of frontline services, including members of An Garda Síochána, throughout the city. Commenting in advance of the seminar, the Lord Mayor of Dublin, Christy Burke, said:

> *It is well documented that the city centre has addiction issues and related anti-social behaviour issues, it is an area that I am determined to see solutions. I have made addressing these issues a focus of my term as Lord Mayor of Dublin. I welcome the Better City for All initiative, where agencies and stakeholders across the city are combining their knowledge and expertise to develop sustainable solutions. I would like to particularly praise the inclusiveness of this process and it is focusing on the needs of the most vulnerable in our society, I believe that by focusing on their needs at the core of all activities that we will find solutions. I would also like to acknowledge and commend the dedication and hard work of many of the frontline services that have been responding to the needs of some of the most marginalised of the city's inhabitants. It is only by all of the stakeholders working together that we can achieve the desired progress.*

Minister of State Aodhán Ó Ríordáin, who was attending his second event since being allocated special responsibility for the National Drugs Strategy, stated:

> *I am delighted to be working with the Better City for All initiative. As I said upon my appointment, I want to meet with the various stakeholders involved in this issue and discuss how we can best tackle drug addiction in this country. My Department will shortly be beginning a consultation process on the new Drugs Strategy and as a newly-appointed minister, my priority is to listen to those who have more expertise in this area than I do, and feed their contributions into this process.*

During his address to the seminar, the Minister indicated his interest in radical new drug reforms such as the decriminalisation of cannabis and the establishment in Dublin of a medically supervised heroin injecting facility to address public injecting and associated harms.

(Johnny Connolly)

1. Strategic Response Group (2012) *A better city for all: a partnership approach to address public substance misuse and perceived anti-social behaviour in Dublin city centre*. Dublin: SRG. *http://www.drugsandalcohol.ie/17769/*
2. For further information visit *http://www.abettercityforall.ie*
3. The author of this article was the original independent chair of the Strategic Response Group that produced the 'Better City for All' report, and he chaired the inaugural seminar. To hear the seminar presentations, visit *http://www.drugs.ie/multimedia/*

Stanhope Alcohol Treatment Centre service report for 2013

The Stanhope Centre has provided help to problem alcohol users, gamblers and their families since 1977. It is a dedicated HSE alcohol treatment facility for the northern area of Dublin and extends as far as Balbriggan. However, the catchment area for Barrymore Residential Programme, which is offered by the Stanhope Centre, includes the greater Dublin area and counties Kildare and Wicklow.

In recent years there has been a change in the type of client, with many now presenting with both problem alcohol use and a problem with other drugs. In 2013 the educational programmes were updated and extended to better meet the needs of the client population.

In 2013, 509 clients made contact with the centre, a small increase on 2012, and the demographic profile of the clients remained similar. Sixty-five per cent of clients were male and most (226, 45%) were aged between 35 and 50 years. In 2013, the majority of clients had previously attended the service. Owing to improved management of the waiting list, especially the implementation of a 'call back' procedure, the number of cancellations and 'did not attend' continued to be low – 7% of all appointments

The centre offers a range of outpatient programmes for clients with problem alcohol use with/without problem drug use, and also for family members of those with problem alcohol use. Individual counselling forms the therapeutic basis for clients' engagement with the service. The therapeutic relationship begins with an assessment period and continues as a client moves through the stages of treatment (educational programmes, treatment programmes and aftercare).

Stanhope Alcohol Treatment Centre *(continued)*

Stanhope also offers the Barrymore Residential Programme, which runs for five and a half weeks and provides treatment and support for clients who meet the diagnostic criteria for alcohol dependency with/without other problem drug use or gambling. The programme runs on average seven times a year. It includes group therapy, education and life-skills training. After completion, clients move on to a six-week relapse prevention group and to an afternoon or evening aftercare group. These groups give clients the opportunity to successfully navigate the early days of recovery following a residential programme. On average, the programme has 52 clients a year, of whom approximately 73% complete the programme. In 2013 the outcomes continued to be positive after completion, with half of clients who completed the residential programme also completing 26 weeks of aftercare.

For further information on the programmes offered by the Stanhope Alcohol Treatment Centre, see http://www.stanhopeservice.com

(Regina Bannigan, Senior Counsellor and Service Coordinator, Stanhope Centre, with assistance from Suzi Lyons, Health Research Board)

Evaluation of a mental health early-intervention programme for young people

Jigsaw is an early-intervention mental health service developed by Headstrong, the national centre for youth mental health. The service currently operates in 10 communities across Ireland and is staffed by multi-disciplinary teams of allied health professionals. The service targets young people aged 12–25 with mild and emerging mental health problems; young people presenting with more serious mental health problems are referred to other services.

Jigsaw was developed to fulfil three objectives:

1. ensure access to youth-friendly, integrated and community-based mental health support,
2. build capacity of frontline workers and volunteers, and
3. promote community awareness around mental health.

It is estimated that more than 8,000 young people have received a service from Jigsaw.

Data have recently been published on the profile of young people presenting to Jigsaw, the services they receive and a before-and after-comparison on the severity of their mental health problems.[1] Data were collected from young people (n=2,420) who received support from Jigsaw from 1 January to 31 December 2013. Fifty-one per cent (n=1,237) received brief interventions comprising 1–6 sessions of goal-focused therapeutic support; 34.3% (n=829) received indirect support through services engaging with their parents and other professionals about their mental health needs; and 14% (n=354) had brief contact with the Jigsaw service but their mental health needs exceeded the scope of the services provided by Jigsaw. The majority (56.5%, n=1,367) presenting to Jigsaw in 2013 were female and the most frequent users were aged 15–17 years. Almost a third of the 1,608 young people (31.3%, n=504) who engaged directly with the service self-referred; this cohort included those receiving brief interventions and those who were brief contacts.

Young people presenting to the Jigsaw service reported a large number of mental health problems (see Table 1). Anxiety was the most common mental health problem.

Table 1: Most common presenting issues for males (n = 1,053) and females (n = 1,367) in 2013

Presenting problem	Males n (%)	Females n (%)
Anxiety[a]	329 (31.2)	489 (35.8)
Anger[a]	277 (26.3)	232 (17.0)
Family problems	217 (20.6)	289 (21.1)
Isolation from others	204 (19.4)	285 (20.8)
Feelings of depression	191 (18.1)	282 (20.6)
Stress	176 (16.7)	246 (18.0)
Parent/youth conflict	170 (16.1)	226 (16.5)
Sleep changes	165 (15.7)	253 (18.5)
Feelings of sadness/loss[a]	129 (12.3)	233 (17.0)
Drug use[a]	128 (12.2)	40 (2.9)
Thoughts of hurting self[a]	118 (11.2)	228 (16.7)
Low self-esteem[a]	103 (9.8)	248 (18.1)

Source: O'Keeffe et al (2015)

[a] Denotes a significant difference between males and females

Young people & mental health *(continued)*

Levels of psychological distress were assessed in young people via a brief intervention using the Clinical Outcome Routine Evaluation (CORE) questionnaires, either the CORE 10 or the YP-CORE. The CORE questionnaires are validated instruments and were used to assess symptoms of anxiety and depression, and associated aspects of social functioning. Questionnaires were completed by 709 young people at their first session, and by 315 young people at their final session. The authors report that 89% presented to Jigsaw with clinical levels of psychological distress pre-intervention, and 52% reported moderate/severe or severe levels of distress. After engaging with Jigsaw, 47.2% had healthy, and 28.8% had low, levels of psychological distress.

The authors acknowledge the limitations of this study in that '…self-reported levels of distress should be interpreted with caution as a multitude of other influences on young people's lives make it difficult to attribute any change directly to the use of a specific service…'. (p. 76)

Commentary

This retrospective analysis of data on young people attending the Jigsaw service provides a useful insight into the mental health issues experienced by this cohort. In the first instance, it is positive to learn that these young people were open to discussing and seeking support for their mental health, and particularly encouraging that almost a third of the cohort who engaged directly with the service referred themselves. Additionally encouraging, and a point picked up on by the authors, was that almost half of all young people presenting were young males, who are traditionally less likely to seek psychological help compared to their female counterparts. The number of different mental health problems reported by these young people is also concerning. However, it must be noted that these reported problems were not diagnosed as disorders and, again, it is positive that these young people are receiving an early intervention which may prevent the condition deteriorating. Finally, although the reported reductions in psychological distress among some of these young people post-intervention could not be attributed solely to the effect of the intervention, it remains positive that for some their distress is being reduced, regardless of the cause or causes.

(Martin Keane)

1. O'Keeffe L, O'Reilly A, O'Brien G, Buckley R and Illback R (2015) Description and outcome evaluation of Jigsaw: an emergent Irish mental health early intervention programme for young people. *Irish Journal of Psychological Medicine* (32): 71–77. *http://www.drugsandalcohol.ie/23291/*

Tusla publishes first corporate plan

Tusla, the Child and Family Agency, came into existence on 1 January 2014 under the Child and Family Agency Act 2013. Merging the HSE Children and Family Service, the Family Support Agency and the National Education and Welfare Board, Tusla is the dedicated state agency responsible for improving the well-being of and outcomes for children.

Tusla's services include child welfare and protection services, family resource centres, pre-school inspection, educational welfare responsibilities, alternative care (e.g. foster care, residential care, special care and aftercare), domestic, sexual and gender-based violence services, psychological welfare, assessment, consultation, therapy and treatment services, and adoption services.

In February 2015 Tusla published its first corporate plan for the period 2015–2017.[1] The corporate plan was developed in four stages – stakeholder consultation, development of a social change model, creation of a vision, mission and values, followed by a set of strategic objectives. These stages are outlined below.

Social change model

Feedback from an extensive a stakeholder consultation, the first stage in developing the corporate plan, was used to develop a 'social change model' to map out a path to Tusla's desired long-term outcomes. The social change model is a process whereby the social problem that an organisation needs to address is identified and the various levers within that organisation's control that can be used to affect the change are isolated. The social problem that Tusla needs to address was identified as:

A lack of long-term, evidence-informed planning and insufficient resources leads to disjointed services and inadequate supports for children and families.

Having defined the problem, the social change model was used to identify the long-term outcomes that Tusla needs to achieve for children and families over the next seven to ten years. The first three years will focus on putting in place the foundation stones to enable Tusla's medium and longer term outcomes to be achieved (see Table 1).

Vision, mission and values

Tusla's vision, mission and values outline what the organisation wants to achieve, how it wants to achieve it and how it wants to go about its business.

- *Vision*: All children are safe and achieving their full potential.
- *Mission*: With the child at the centre, our mission is to design and deliver supportive, coordinated and evidence-informed services that strive to ensure positive outcomes for children.
- *Values*: courage and trust; respect and compassion; empathy and inclusion.

Strategic objectives

Tusla will start work towards achieving its desired outcomes by delivering on eight strategic objectives due to be completed in the next three years, i.e. more specific and time-bound targets than the higher-level outcomes. The strategic objectives are:

1. Improve the quality and focus of the delivery of services for children and families.
2. Develop the governance structures, processes and supporting infrastructure to ensure that Tusla is in a position to carry out its functions in an effective and efficient manner.

TUSLA Corporate Plan *(continued)*

Table 1: Pathways to achieving desired long-term outcomes, Tusla 2015–2025

Short-term outputs (1–3 years)	Medium-term outputs (4–6 years)	Long-term outputs (7–10 years)
A. Tusla's child protection processes and systems are responding to children at risk in a timely manner.	A. Revised systems are significantly reducing the numbers of children at risk.	A. All children are safe from abuse, neglect and exploitation.
B. All processes and systems underpinning children and family policy and services are evidence-informed.	B. Children and family services are more user-friendly, strengths-based and co-produced.	B. All children and families are capable of making informed decisions about their health and lifestyles.
C. A targeted range of family and parenting supports.	C. Children and family services are properly coordinated and aligned.	C. All parents are providing stable and loving home environments in which children thrive.
D. Attendance, participation and retention in full-time education is embedded in service delivery for all children.	D. The benefits of increased child and family participation in education is acknowledged across all sectors of society.	D. All children and their families are actively engaged in their education.

Source: Tusla (2014) p. 18

3. Establish a new and distinct values-based culture that empowers children and families through high-quality services.
4. Develop an organisation that lives within its means and utilises its resources in an efficient and cost-effective manner.
5. Develop a workforce that is valued and supported within a learning organisation.
6. Position the Agency as a responsive, trustworthy and respected body with its own unique identity.
7. Build on our research strategy to develop policy and enable evidence-based decision-making and high-quality service delivery.
8. Ensure a strategic approach to quality assurance, information management and risk management that supports continuous improvement and good governance.

In conclusion, the plan outlines two key systems that will be put in place to ensure delivery – a corporate risk register, and a quality assurance function that will report regularly on progress.

(Brigid Pike)

1. Tusla – Child and Family Agency (2014) *Corporate plan 2015–2017* Dublin: Tusla. *http://www.drugsandalcohol.ie/23497/*

NDC drugs library – new resource for practitioners

Every year we add hundreds of new articles and reports to our library collection. In order to help relieve information overload we have a number of summarised aids, such as *Drugnet Ireland*, *NDC newsletter*, and factsheets.

Practitioners in the alcohol and drugs area have limited time to keep up-to-date with research and evidence, so need easy access to research on subjects related to their work or profession. In order to facilitate this, the NDC librarians have developed a 'practitioner' resource. The homepage *http://www.drugsandalcohol.ie/practitioners* has links to a number of subject areas. The 'key Irish data' link and those on the bottom row are relevant to most workers. Clicking on a link will show you recent Irish and international articles and reports on that subject.

With the help of some wonderful advisers from social work and social care work professions, we have also developed pages for specific professions. We hope to add more of these in the future. Each of these pages lists key documents and has links to subjects of particular interest to that profession.

The resource includes a page called 'doing research', which has links to useful online tools providing help on finding and using information for research. We are interested in collecting and making available local Irish drug or alcohol research done by those working in the area. If practitioners are doing any such research, even a small piece in their organisation, they can submit it to us at *ndc@hrb.ie*

We would also welcome feedback with recommendations for key documents, subject areas and anything else practitioners would like to see in their resource.

EMCDDA Insights

In April 2015 the EMCDDA published the 17th in its Insight series – *Treatment of cannabis-related disorders in Europe.* Opening with an overview of cannabis use and its health effects, the report presents the latest evidence underpinning interventions, maps the availability and provision of cannabis treatment in 30 countries (including Ireland), and compares treatment needs with provision.

'Treatment for cannabis-related problems', states the report, 'relies primarily on psychosocial approaches combining elements of classical psychotherapy with social support and care.' To highlight the interventions most likely to succeed, the study weighs up the published evidence on a range of treatment programmes. It differentiates between those targeting adults and those targeting adolescents, and between cannabis-specific and general substance-use programmes. Telephone and online approaches are among those examined.

No evidence is reported showing the superiority of specific over general treatment, as 'both approaches can work'. Comparing indicators of treatment needs with treatment provision, the report concludes that, despite exceptions, 'the overall situation in Europe looks positive'.

First published in 1997, EMCDDA Insights are topic-based reports that bring together current research and study findings on a particular issue in the drugs field.

The Insight reports are available for download at *http://www.emcdda.europa.eu/publications/*

From *Drugnet Europe*

New EMCDDA review studies effectiveness of overdose antidote, naloxone

Cited from *Drugnet Europe* No 89

January–March 2015

Can naloxone provided in the community help reduce the thousands of drug-induced deaths recorded in Europe every year? This is the question explored in a new EMCDDA Paper released in January: *Preventing fatal overdoses: a systematic review of the effectiveness of take-home naloxone* (1).

Naloxone — a pharmaceutical drug used to reverse the effects of opioid overdose — has been used in emergency medicine (e.g. by ambulance crews, hospital emergency-room teams) for over 40 years. But as many overdoses occur in the presence of drug users' family members or peers, empowering bystanders to act effectively, before emergency services arrive at the scene, can save lives (2).

Following pilot initiatives in the 1990s, measures to scale up naloxone availability to those likely to witness an overdose have emerged in the last decade. This has been driven partly by the epidemic of opioid-related deaths (heroin and non-heroin) in the USA (3).

Analysing 21 studies conducted in four countries — Canada, Germany, UK and the USA — the new review examines the latest evidence on the role of take-home naloxone (THN) in reducing opioid overdose fatalities. It concludes that THN provision, delivered with educational and training interventions, can be effective in reducing overdose-related deaths and improving knowledge on the signs of overdose and the correct management of patients.

Listed by the World Health Organization (WHO) as an 'essential medicine', naloxone is available in injectable form, with non-injecting administration under investigation. Programmes and trials with THN distribution are currently run in seven European countries: Denmark, Germany, Estonia, Spain, Italy, UK and Norway (see Annex 3 of review). Since September 2013, Estonia has offered a naloxone programme to tackle the sharp rise in deaths caused by illicit use of the synthetic opioid fentanyl. In 2014, Norway began a pilot of a nasal spray naloxone programme.

The report shows how evidence supports THN provision as part of a comprehensive harm reduction response. WHO guidelines on community-based naloxone provision were launched in November 2014 and a number of European countries have now developed national guidelines (4). Knowledge exchange on THN is important to allow potential implementers to take informed decisions (5).

Drug use is one of the major causes of mortality among young people in Europe. Overall, some 6 100 overdose deaths were reported in Europe in 2013. Substances associated with the risk of overdose include: opioids (non-medical or prescribed); benzodiazepines and synthetic opioids (e.g. fentanyls).

Marica Ferri and Lucas Wiessing

(1) www.emcdda.europa.eu/publications/emcdda-papers/naloxone-effectiveness

(2) www.emcdda.europa.eu/topics/pods/preventing-overdose-deaths (EMCDDA Perspectives on drugs).

(3) www.whitehouse.gov/ondcp/national-drug-control-strategy

(4) www.emcdda.europa.eu/best-practice/guidelines

(5) The role of take-home naloxone (THN) in reducing opioid-related fatalities was the focus of an EMCDDA meeting held in Lisbon on 14 October 2014. www.emcdda.europa.eu/events/2014/meetings/naloxone See video at www.youtube.com/user/emcddatube

Dangerous drug PMMA makes a comeback

Cited from *Drugnet Europe* No 89

January–March 2015

Over the last three months, PMMA — a stimulant-type drug of the phenethylamine group — has been seen to be making a comeback on the European illicit drug market in ecstasy tablets bearing a Superman logo. Since the end of December 2014, these tablets have been associated with the deaths of at least six individuals in Europe.

From *Drugnet Europe (continued)*

PMMA (para-methoxymethamphetamine) underwent a formal EMCDDA risk assessment in 2001 and, following a Council Decision in February 2002, was subjected to control measures and criminal penalties across the EU Member States (1)(2)(3).

PMMA is considered to elicit entactogenic effects in users — similar to those provoked by MDMA. However, the substance has weaker stimulant effects, is slower-acting and more toxic than MDMA, particularly when combined with other substances. Users believing tablets to be MDMA, and experiencing the weak stimulant effects and delayed onset of action, may believe that they have consumed 'weak ecstasy'. As a result, they may be tempted to re-dose, increasing the risk of adverse effects and possible overdose.

From 1993 to 2013, the EMCDDA is aware of approximately 47 deaths in 10 European countries associated with the use of PMMA, with a notable cluster in Norway in late 2010.

Rachel Christie, Andrew Cunningham and Roumen Sedefov

(1) Risk assessment report at www.emcdda. europa.eu/publications/risk-assessments/pmma

(2) www.emcdda.europa.eu/news/2002

(3) www.emcdda.europa.eu/news/2012/10

Mortality among drug users in Europe

Cited from *Drugnet Europe* No 89

January–March 2015

Drug use is one of the major causes of mortality among young people in Europe, both directly through overdose (drug-induced deaths) and indirectly through drug-related diseases, accidents, violence and suicide. Every year, over 6 000 drug users die of overdose in the EU, most of these deaths involving opioids and occurring among problem drug users. To gain a clearer picture of the overall number of lives lost due to drug use in Europe, this new EMCDDA paper builds on the results of earlier work investigating 'all-cause' mortality among problem drug users. By linking data on entrants to drug treatment programmes with information from death registries, mortality cohort studies can determine death rates from all causes within the study population.

Available in English at: www.emcdda.europa.eu/publications/emcdda-papers

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). It is available at www.emcdda.europa.eu.

If you would like a hard copy of the current or future issues, please contact:

Health Research Board, Grattan House, 67–72 Lower Mount Street, Dublin 2.

Tel: 01 2345 148; Email: drugnet@hrb.ie

Recent publications

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

Depression and alcohol withdrawal syndrome: is antidepressant therapy associated with lower rates of hospital readmission?

Schoonover K, Burton MC, Larson SA, Cha SS, Lapid MI (2015) *Irish Journal of Medical Science* Early online

http://www.drugsandalcohol.ie/23871/

This study highlights the high frequency of depression and antidepressant use in patients admitted with Alcohol withdrawal syndrome (AWS) to an acute care hospital. As alcohol withdrawal is associated with increased morbidity and mortality and depression is common in those with alcohol use disorder, further research is necessary to clarify the optimal treatment of comorbid depression and alcohol use disorder in reducing these revolving door admissions.

Three hundred and twenty-two patients were admitted with AWS during the study period. One hundred and sixty-one patients (50%) had no history of depression, 111 patients (34%) had a history of depression and antidepressant use, and 50 patients (16%) had a history of depression and no antidepressant use. There was no significant difference in the number of hospitalizations for AWS between these three groups. Patients with a history of depression on antidepressant medication were more likely to be retired or work disabled compared to the other two groups ($p<0.05$). The antidepressant class most commonly used was SSRI (63 %).

Prevalence and predictors of smoking in 'smoke-free' bars. Findings from the International Tobacco Control (ITC) Europe surveys

Nagelhout GE, Mons U, Allwright S, Guignard R, Beck F, Fong GT, de Vries H, Willemsen MC (2011) *Science & Medicine* (72/10): 1643–1651.

http://www.tara.tcd.ie/handle/2262/56861

http://www.drugsandalcohol.ie/23855/

National level smoke-free legislation is implemented to protect the public from exposure to second-hand tobacco smoke (SHS). The first aim of this study was to investigate how successful the smoke-free hospitality industry legislation in Ireland (March 2004), France (January 2008), the Netherlands (July 2008), and Germany (between August 2007 and July 2008) was in reducing smoking in bars. The second aim was to assess individual smokers' predictors of smoking in bars post-ban. The third aim was to examine country differences in predictors and the fourth aim was to examine differences between educational levels (as an indicator of socioeconomic status). This study used nationally representative samples of 3147 adult smokers from the International Tobacco Control (ITC) Europe Surveys who

Recent publications *(continued)*

were surveyed pre- and post-ban. The results reveal that while the partial smoke-free legislation in the Netherlands and Germany was effective in reducing smoking in bars (from 88% to 34% and from 87% to 44%, respectively), the effectiveness was much lower than the comprehensive legislation in Ireland and France which almost completely eliminated smoking in bars (from 97% to 3% and from 84% to 3% respectively). Smokers who were more supportive of the ban, were more aware of the harm of SHS, and who had negative opinions of smoking were less likely to smoke in bars post-ban. Support for the ban was a stronger predictor in Germany. SHS harm awareness was a stronger predictor among less educated smokers in the Netherlands and Germany. The results indicate the need for strong comprehensive smoke-free legislation without exceptions. This should be accompanied by educational campaigns in which the public health rationale for the legislation is clearly explained.

Educational interventions: equipping general practice for youth mental health and substance abuse. A discussion paper

O'Regan A, Schaffalitzky E, Cullen W (2015) *Irish Journal of Medical Science* Early online

http://www.drugsandalcohol.ie/23824/

Youth mental health issues and substance abuse are important causes of morbidity and mortality in Ireland. General practice is a frequent point of contact for young people, however, reluctance amongst this population group to disclose mental health issues and a lack of confidence amongst GPs in dealing with them have been reported. Focussed training interventions with formal evaluation of their acceptability and effectiveness in achieving learning, behavioural change and impact on clinical practice are needed.

This paper aims to examine the literature on general practice in youth mental health, specifically, factors for an educational intervention for those working with young people in the community.

This review paper was carried out by an online search of PubMed on the recent literature on mental health and on educational interventions for health care workers in primary care.

A number of papers describing educational interventions for GPs and primary care workers were found and analysed. Key areas to be addressed when identifying and treating mental health problems were prevention, assessment, treatment, interaction with other services and ongoing support. Important elements of an educational intervention were identified.

Several barriers exist that prevent the identification and treatment of these problems in primary care. An educational intervention should help GPs address these issues. Any intervention should be rigorously evaluated.

With the shift in services to the community in Irish health policy, the GP with appropriate training could take the lead in early intervention in youth mental health and addiction.

Ireland's Public Health (Alcohol) Bill: policy window or political sop?

Butler S (2015) *Contemporary Drug Problems* Early online

http://www.drugsandalcohol.ie/23822/

In the wake of the Steering Group Report on a National Substance Misuse Strategy in 2012, the Irish government announced in October 2013 that it had approved a number of alcohol policy measures to be incorporated into a Public Health (Alcohol) Bill to be drafted and enacted as quickly as possible. Against a historic backdrop of previous alcohol policy proposals in Ireland in recent decades, this article looks critically at this recent development with a view to determining to what extent it represents, in Kingdon's terms, a ''policy window'' for the public health approach to alcohol issues. It is argued that while some specific public health measures may be introduced, the various ''streams'' of the Irish policy process have not joined together in an unambiguous, consensual acceptance of the public perspective on alcohol, and that the ''politics stream'' has not to date deemed this perspective to be consonant with the ''national mood.''

Increasing the potential for diversion in the Irish criminal justice system: the role of the Garda Síochána adult cautioning scheme

Tolan G, Seymour M (2014) *Irish Journal of Applied Social Studies* 14 (1)

http://arrow.dit.ie/cgi/viewcontent.cgi?article=12...

http://www.drugsandalcohol.ie/23801/

Established in 2006, the Garda Síochána Adult Caution Scheme provides a mechanism to divert adult offenders, aged 18 years and over, from the criminal justice system by way of a formal police caution in lieu of prosecution before the courts. Drawing on statistical data provided by the Central Statistics Office, this paper explores the use of the scheme over a five year period from 2006 to 2010. It identifies the types of offences for which cautions are most commonly administered, the age and gender profile of offenders involved, variability in the application of the scheme across the country, and the extent to which offenders come to the attention of An Garda Síochána post-caution. Overall, the paper analyses the role of adult cautioning in the Irish context and provides some observations on the potential for increased diversion, through expanding the remit of the scheme in future years.

Close practice encounters of the teenage kind

Wallace V, Doorley E, Wallace D, Hollywood B (2015) *Forum* (32/4): 12–14

http://www.drugsandalcohol.ie/23769/

Research by GPs in Ballymun provides an informative snapshot of the health needs of teenage patients and some important pointers from dealing with this often vulnerable group.

Substance misuse and recording of this issue was reviewed. In general, it was noted that whether or not the person attending used alcohol, smoked cigarettes or used other substances was not recorded. No reference was made to alcohol in any of the 380 teenagers' records, but that this was not recorded does not in our view indicate that none of

Recent publications *(continued)*

these 380 teenagers drinks alcohol. Seven teenagers were noted to be smokers of cigarettes, seven were noted to be smokers of hash, and there was not mention in the clinical records of other drugs being used.....

Benzodiazepine use in a methadone maintained opiate dependent cohort in Ireland

Gilroy D, O'Brien S, Barry J, Ivers JH, Whiston L, Keenan E, Darker CD (2014) *Heroin Addiction and Related Clinical Problems* (16/2): 23–30

http://www.drugsandalcohol.ie/23737/

Benzodiazepines (BZDs) are one of the most widely abused substances by opioid dependent patients.

This research aims to identify patterns of BZD use in methadone maintained opioid dependent patients attending an addiction treatment clinic in Dublin, Ireland. Methods: Patients (n=78) testing positive for BZDs by urinalysis completed a face-to-face survey.

Daily BZD use was reported by 70.1% (n=54) with 67.9% (n=53) consuming up to 5 tablets a day. A BZD prescription was provided for 50% (n=39) and 61.5% (n=48) used illicit BZDs. The primary BZD of use was Diazepam reported by 93.6% (n=73) of patients. Analysis showed source of BZDs is related to frequency of consumption [$\chi 2(2)= 10.98$, $p < 0.01$] and use of others drugs [$\chi 2(2)= 6.97$, $p< 0.04$].

Source of BZDs is associated with frequency of consumption and use of other drugs. Current patterns of BZD use is between 1 to 5 years which is considerably longer than recommended duration of BZD use.

A survey of patients on methadone programmes in Wheatfield Prison, Dublin, Ireland

Galander T, Rosalim J, Betts-Symonds G, Scully M (2014) *Addiction and Related Clinical Problems* (16/2): 17–22

http://www.drugsandalcohol.ie/23736/

This article is described in a report 'Patients on methadone programmes, Wheatfield prison' elsewhere in this issue of *Drugnet Ireland*.

The prevalence of common mental and substance use disorders in general practice: a literature review and discussion paper

Klimas J, Neary A, McNicholas C, Meagher D, Cullen W (2014) *Mental Health and Substance Use* (7/4): 497–508

http://www.drugsandalcohol.ie/23733/

Enhanced primary care management of common mental and substance use disorders is a key healthcare target. Though primary care may be well placed to achieve this target, a greater understanding of the prevalence and profile of common mental and substance use disorders in primary care settings is needed. We searched the MEDLINE database (2002–2012) to provide an update on biomedical literature describing the prevalence of common mental and substance use disorders in European general practice. Following 'PRISMA' guidelines, 17 studies were kept for qualitative synthesis. Prevalence, profile, screening instruments, associated co-morbidities, and gender distribution were tabulated. Depending on the screening method, the prevalence of common mental and substance use disorders ranged from 10.4% (Luxembourg) to 53.6% (Spain). Mood disorders were the most common. High co-morbidity with anxiety and somatisation hindered early identification and management. The continuing burden of common mental and substance use disorders, coupled with poor identification described in the updated EU biomedical literature, suggests that the unmet need for health care – identified by the World Health Organization a decade ago – remains unmet. Understanding the prevalence of common mental and substance use disorders, associated morbidity, and the extent to which general practice represents an important catchment mechanism can enhance their management at this level. General practitioners should be trained in accurate screening. Short screening instruments for general practitioners should be unified and promoted.

Pregabalin for detoxification from opioids: a single case study

Scanlon A (2014) *Mental Health and Substance Use* (7/4): 263–285

http://www.drugsandalcohol.ie/23730/

The objective of this research is to develop a clearer understanding as to whether pregabalin is an appropriate and efficacious method to treat individuals presenting with withdrawal symptoms following cessation of opiate drug abuse. The focus of this study is to identify the value of a particular medicine within a particular case, representative of a particular group. The author has identified the participant in advance of the study to meet criteria of opiate dependence and will explore the dynamics of the case in great detail. The sample for this study was a purposive sample of one female lady who has been diagnosed as opiate dependent (DSM-IV criteria). The analysis of data is an inductive cyclical process that involves a process of observing the particular phenomenon from more general to specific observations. Data analysis commenced with interviews with the patient with emphasis on history taking, information gathering, and treatment. Data analysis will include a cross-tabulation of the subjective and objective data and the measurement of change using an evidence-based rating scale. The Clinical Opiate Withdrawal Scale was used to compare the analysis of the presenting symptoms longitudinally. From the objective data, it was a reasonable assumption that the symptoms of withdrawal were controlled better with pregabalin for the subject of this study. The patient acknowledged that this detoxification episode was 'a lot easier than previous ones'. It was a positive response in relation to the prescription of pregabalin that she first of all completed the prescribed detoxification regime and second it was acknowledged that the symptoms were alleviated more effectively than previous detoxification episodes.

Psychological distress and lifestyle of students: implications for health promotion

Deasy C, Coughlan B, Pironom J, Jourdan D, Mcnamara PM (2015) *Health Promotion International* (30/1): 77–87

http://www.drugsandalcohol.ie/23717

Poor diet, physical inactivity, tobacco smoking and alcohol consumption are major risk factors for chronic disease and premature mortality. These behaviours are of concern among higher education students and may be linked to psychological distress which is problematic particularly for students on programmes with practicum components such as nursing and teaching. Understanding how risk behaviours aggregate and relate to psychological distress

Recent publications *(continued)*

and coping among this population is important for health promotion. This research examined, via a comprehensive survey of undergraduate nursing/midwifery and teacher education students' (n = 1557) lifestyle behaviour (Lifestyle Behaviour Questionnaire), self-reported psychological distress (General Health Questionnaire) and coping processes (Ways of Coping Questionnaire). The results showed that health-risk behaviours were common, including alcohol consumption (93.2%), unhealthy diet (26.3%), physical inactivity (26%), tobacco smoking (17%), cannabis use (11.6%) and high levels of stress (41.9%). Students tended to cluster into two groups: those with risk behaviours (n=733) and those with positive health behaviours (n=379). The group with risk behaviours had high psychological distress and used mostly passive coping strategies such as escape avoidance. The potential impact on student health and academic achievement is of concern and suggests the need for comprehensive health promotion programmes to tackle multiple behaviours. As these students are the nurses and teachers of the future, their risk behaviours, elevated psychological distress and poor coping also raise concerns regarding their roles as future health educators/promoters. Attention to promotion of health and well-being among this population is essential.

Young people in drug treatment in Ireland: their views on substance use aetiology, trajectory, parents' role in substance use and coping skills
Darker CD, Palmer D, O'Reilly G, Whiston L and Smyth B (2014) *Irish Journal of Psychological Medicine* Available on CJO 2014 doi:10.1017/ipm.2014.77

http://www.drugsandalcohol.ie/23180/

This article is described in a report 'Young people in drug treatment' elsewhere in this issue of *Drugnet Ireland*.

Upcoming events

June

26 June 2015

International Day against Drug Abuse and Illicit Trafficking

Further information: http://www.unodc.org/drugs/en/june-26/index.html

Each year, 26 June is International Day against Drug Abuse and Illicit Trafficking. Established by the United Nations General Assembly in 1987, this day serves as a reminder of the goals agreed to by member states of creating an international society free of drug abuse. The United Nations Office on Drugs and Crime (UNODC) selects themes for the International Day and launches campaigns to raise awareness about the global drug problem. Health is the ongoing theme of the world drug campaign.

September

23 September 2015

Lisbon addictions conference 2015

Venue: Lisbon, Portugal

Further information: http://www.lisbonaddictions.eu/start

The first European conference on addictive behaviours and dependencies will be held in Lisbon on 23–25 September 2015.

This will be a comprehensive and multi-disciplinary event, showcasing leading European addiction research in the specialist areas of illicit drugs, alcohol, tobacco, gambling and other addictive behaviours. It will address new challenges and cover developing fields such as new psychoactive substances, online sales and gambling, cannabis legalisation and alcohol pricing.

This conference will provide a unique networking opportunity for researchers, practitioners and policy experts across countries and disciplines to discuss latest findings on the prevention, treatment and control of addiction. It is the ideal venue to forge collaborative partnerships and explore funding opportunities.

This conference is jointly organised by the Portuguese General Directorate for Intervention on Addictive Behaviours and Dependencies (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências — SICAD), the journal *Addiction*, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the International Society of Addiction Journal Editors (ISAJE). It will take place at the FIL Expo conference centre in the beautiful city of Lisbon.