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Alcohol and Drug Research Newsletter

Recovery: Irish and international perspectives

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Alcohol in Ireland

Dr Graham Love, CEO Health Research Board, and authors Dr Deirdre Mongan and Dr Jean Long at the launch of the report of the National Alcohol Diary Survey

The Irish have a complex relationship with alcohol. Its use is embedded in our national identity and it is often associated with significant cultural and religious events. It is generally accepted that the overall volume of alcohol consumption and the pattern of binge drinking predict the incidence of alcohol-related harm. The HRB's recently published 2013 National Alcohol Diary Survey supports these international findings.[1]

The results of a 2012 survey, *Alcohol: Public knowledge, attitudes and behaviour*,[2] showed that 85% of 1,020 respondents believed that the current level of alcohol consumption in Ireland was too high, and 73% believed that Irish society tolerated high levels of alcohol consumption. The 2013 National Alcohol Diary Survey confirms these perceptions. Among those who participated in the survey and who reported consuming alcohol, 75% consumed their alcohol during a binge-drinking session. In addition, 37% of participants who were drinkers engaged in binge drinking at least once per month, and almost two-fifths had consumed six or more standard drinks during a typical drinking session in the last year. More than half (54%) of 18–75-year-old drinkers who participated in the survey were classified as harmful drinkers, which equates to 1.35 million harmful drinkers in Ireland. Using the World Health Organization's DSM-IV criteria for measuring dependence, which is the gold standard for identifying dependence in a clinical setting, 7% of participants were dependent on alcohol, which equates to an estimated 176,000 dependent drinkers in Ireland. (continued on page 3)

Joan Moore

Joan Moore, *Drugnet Ireland's* content editor, retired recently. Joan began working in the Alcohol and Drugs Research Unit of the HRB in 2005, joining us after a number of years in the Mental Health Research Unit. She also edited the reports from the HRB Overview and Trends series and proofed a vast amount of historical material on the NDC research repository. Joan is a highly-skilled editor and was relentless in her efforts to ensure that the HRB's published output, particularly *Drugnet Ireland*, was accurate, understandable, clearly written, well presented and conformed to the highest publication standards. Despite the rigour and thoroughness of her work she was never dogmatic and understood that language, including scientific language, evolves and the rules of grammar and syntax serve clarity and style and are not immutable laws. She brought to her work a remarkable range of knowledge and interests, a quick, sometimes irascible, wit and a dogged determination. The success of *Drugnet* over the past 30 or so issues owes a great deal to Joan's exacting standards, her understanding of scientific communication and her commitment to make each issue as close to flawless as possible. We wish her well in her retirement.

Contents

Policy and legislation

5 Drug, alcohol and tobacco policy after Cabinet reshuffle

5 National policy framework for children and young people

6 Addiction recovery: a contagious paradigm

8 Recovery in national drugs strategies

11 Legislation on new psychoactive substances

12 Illegal drugs activity to be included in national accounts

12 Towards UNGASS 2016

Prevalence and current situation

14 Polydrug use in Ireland: 2010/11 survey results

15 Suicide and self-harm among Irish adolescents

15 Self-cutting and intentional overdose as methods of deliberate self-harm

16 Young people's access to drugs

16 Gambling in Europe and Ireland

Consequences

17 Drug-related intimidation

18 Drug-facilitated sexual assault

Responses

19 SPHE and substance use education

20 Promoting participation by seldom heard young people

21 Youth mental health and substance misuse disorders in deprived urban areas

21 Supporting children in families experiencing mental health difficulties

22 Therapeutic communities in Europe

23 Pharmacist–patient structured methadone detoxification in Mountjoy Prison

Services

24 Women in prison

25 Effective team-working in mental health services

Updates

26 Recent publications

28 Upcoming events

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Alcohol in Ireland *(continued)*

Source: Health Research Board – National Alcohol Diary Survey 2013

Why should we be concerned about these patterns of alcohol consumption in Ireland? Patterns of drinking, especially binge-drinking, play an important role in causing alcohol-related harm. It is the large number of low- to medium-volume drinkers in a population who binge-drink on occasion who account for many of our alcohol-related problems, such as injuries, violence, and poor work performance. In the National Alcohol Diary Survey, 30% of drinkers reported experiencing economic, health or social harms as a result of their alcohol use, with men 1.5 times more likely than women to report harms (men 35.7%, women 24.1%). Binge drinkers, when compared to other drinkers (who did not binge), were between two and three times more likely to experience harms from their own drinking.

The range and magnitude of the harm caused by alcohol in Ireland is considerable. Between 1995 and 2009 the number of people discharged from Irish hospitals with a diagnosis of alcoholic liver disease increased by 191%, with the largest increase observed among those aged 15–34 years.[3] In 2012, alcohol was found to have been consumed in four out of ten episodes of self-harm in Ireland. Alcohol was associated with 2,000 beds occupied every night in Irish acute hospitals, at a time when the health service is seriously stretched.[3] This does not include emergency departments, although anecdotal evidence indicates that people with alcohol-related conditions constitute a huge burden and enormous cost to emergency departments, particularly at night and at weekends. The cost to the health service is estimated at €1.2 billion, which would go a long way towards clearing waiting lists, paying for medical cards, and providing badly needed home-help and respite care.

Dr Joe Barry (centre), TCD and authors Dr Deirdre Mongan and Dr Jean Long at the launch of the report of the National Alcohol Diary Survey

Our perceptions of what we drink differ hugely from the reality. In the 2013 National Alcohol Diary Survey, respondents were asked to classify their own drinking behaviour. A small proportion of respondents (2.1%) classified themselves as heavy drinkers even though 7% met the criteria for dependence. In addition, one in five

Definitions

A standard drink

The HSE defines a standard drink as 10g of pure alcohol, i.e. half a pint of beer, 100ml of wine (one bottle contains 750ml) or a pub measure of spirits. Guidelines on low-risk drinking recommend maximum weekly consumption of 11 standard drinks for women and 17 standard drinks for men, which is roughly a maximum of one and a half bottles of wine spread over five nights of the week for a woman, and a maximum of eight and a half pints of beer spread over five nights of the week for a man.

Binge drinking (more correctly known as single-occasion risky drinking)

Binge drinking has been calculated as six or more standard drinks, i.e. three or more pints of beer, six or more pub measures of spirits or 600ml or more of wine.

Harmful drinking

Harmful drinking is determined by the amount you drink on a typical occasion, how frequently you drink and how often you binge-drink. A typical example of a harmful drinker is someone who drinks 7–9 standard drinks (e.g. 4–5 pints or a bottle of wine) on a typical drinking occasion, who does this two to three times per week and who binge-drinks one or more times per week.

Alcohol in Ireland *(continued)*

Source: Health Research Board – National Alcohol Diary Survey 2013

who self-defined as 'light drinkers who do not binge drink' and half of those who self-defined as 'moderate drinkers who do not binge drink' did engage in binge-drinking on a typical drinking occasion. These findings indicate that brief interventions are required during routine health visits and that clear and accurate information on low-risk drinking needs to be promoted.

The 2012 *Alcohol: Public knowledge, attitudes and behaviour* survey found that people have difficulty measuring their own drinking against the standard drink measure, although almost 6 out of 10 (58%) had heard of the term 'standard drink'.[2] Only one in ten respondents (9%) correctly identified the number of standard drinks in each of the four measures of alcohol asked about in the survey, and knew the recommended maximum number of standard drinks (proxy for low-risk drinking) that they could safely consume in one week. The Department of Health and the HSE currently provide information on low-risk drinking and standard drinks through the website www.yourdrinking.ie

Research has shown that a combination of measures is needed to tackle alcohol consumption effectively. These include pricing, availability, advertising and sponsorship as well as information. The Public Health (Alcohol) Bill aims to reduce Irish consumption to the maximum low-risk level of 9.2 litres per capita per year.[4] It will focus on a combination of measures to achieve this.

(Jean Long and Deirdre Mongan)

1. Long J and Mongan D (2014) *Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey.* Dublin: Health Research Board. www.drugsandalcohol.ie/22138
2. Ipsos MORI (2012) *Alcohol: public knowledge, attitudes and behaviours.* Dublin: Health Research Board. www.drugsandalcohol.ie/18022
3. Mongan D, McCormick PA, O'Hara S, Smyth BP and Long J (2011) Can Ireland's increased rates of alcoholic liver disease morbidity and mortality be explained by per capita alcohol consumption? *Alcohol and Alcoholism* 46 (4): 500. www.drugsandalcohol.ie/14978
4. Department of Health (2012) *Steering group report on a national substance misuse strategy.* Dublin: Department of Health. www.drugsandalcohol.ie/16908

Drug, alcohol and tobacco policy after Cabinet reshuffle

Following the Cabinet reshuffle announced on 11 July 2014, responsibility for the National Drugs Strategy and for alcohol policy passed to the Minister for Health, Leo Varadkar TD. This means that responsibility for drug and alcohol policy now rests with a senior government minister with a seat at the Cabinet table. Prior to the reshuffle, responsibility for both policy domains was held by a junior minister without a seat in Cabinet, Alex White TD, Minister of State in the Department of Health with responsibility for Primary Care.

Upcoming challenges for the new Minister for Health in relation to alcohol and drugs include steering the Public Health (Alcohol) Bill through the Oireachtas, and leading on the preparation of Ireland's first national substance misuse strategy (including both drugs and alcohol), and on the preparation of Ireland's contribution to the UN General Assembly Special Session on illicit drugs, both of which are due in 2016.

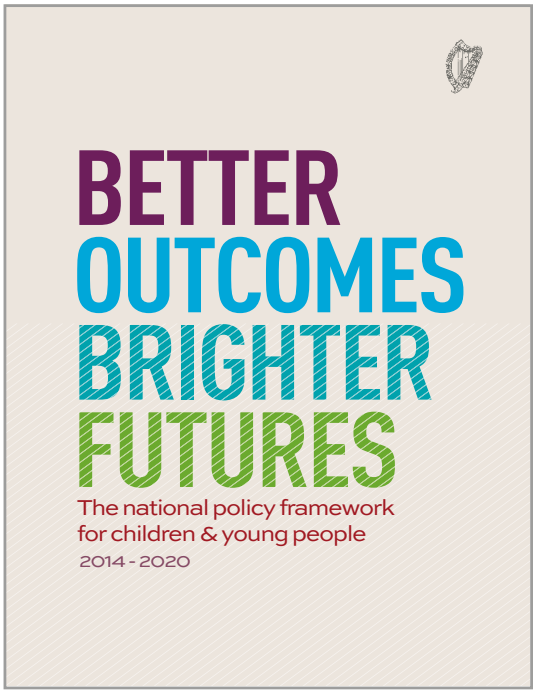
Responsibility for tobacco policy will be shared with the former Minister for Health, James Reilly TD, who has been appointed Minister for Children and Youth Affairs. A key Ministerial task in this policy domain will be steering the Public Health (Standardised Packaging of Tobacco) Bill through the Oireachtas.

(Brigid Pike)

National policy framework for children and young people

The Department of Children and Youth Affairs (DCYA) recently published the long awaited national policy framework for children and young people, which will run from 2014 to 2020.[1] The framework sets out an ambitious plan to achieve five national outcomes, which are that all Irish children and young people:

1. are active and healthy, with positive physical and mental wellbeing,
2. are achieving their full potential in all areas of learning and development,
3. are safe and protected from harm,
4. have economic security and opportunity, and
5. are connected, respected and contributing to their world.



To support children and young people to achieve these outcomes, the framework includes a commitment to transform existing policies, services and resources to be more effective. It sets out six aims to achieve this transformation:

1. Support parents in the important task of parenting
2. Provide earlier interventions and prevention efforts
3. Build a culture that listens and involve children and young people in key decisions affecting their lives
4. Ensure quality services that are outcome-driven, effective, efficient and trusted
5. Enable effective transitions at key developmental stages and between child and adult services
6. Improve cross-government and interagency collaboration and coordination

The framework includes a small number of key indicators, which will be used to measure progress in several areas; a more extensive set of indicators will be developed in the course of 2014. Table 1 overleaf lists the indicators relating to substance use among young people and closely related correlates of substance use that will be used to assess progress towards achieving outcome 1, which relates to the health and wellbeing of children and young people.

The framework adopts both a universal (general population of children and young people) and a targeted (children and young people with elevated risk factors) approach. Given that children and young people make up 34% of the overall population of Ireland, it is important that policy makers both respond to the specific needs of over a third of the national population with investment in evidence-based policies, and also recognise that a significant minority of young people are at an elevated risk of poorer outcomes compared to the general population of young people and respond with approaches targeting this minority.

(Martin Keane)

National policy framework for children and young people *(continued)*

Table 1: Indicators relating to substance use to be used to measure progress towards health and well-being of children and young people, National Policy Framework for Children and Young People[1]

Key indicator	Current baseline in Ireland	Current international average	Data source
% of 15–16 year olds who have ever used cannabis	18%	17%	European School Survey Project on Alcohol and Other Drugs (ESPAD)
Cigarette use in past 30 days	21%	28%	ESPAD
Alcohol volume (cl of pure alcohol) consumed last drinking day among alcohol consumers aged 15–16	6.7cl	5.1cl	ESPAD
15-year-olds who report being drunk once in last 30 days	26.4%	24.1%	Health Behaviour in School-Aged Children study (HBSC)
Early school leaving rate	9.7%	12.7%	Eurostat
% of 15–24-year-olds not in education, employment or training	18.7%	13.2%	Eurostat

1. Department of Children and Youth Affairs (2014) *Better outcomes brighter futures: The national policy framework for children and young people 2014–2020.* Dublin: Stationery Office. http://www.drugsandalcohol.ie/21773/

Addiction recovery: a contagious paradigm

On 17 July 2014, Councillor Mannix Flynn, representing the Lord Mayor of Dublin, Christy Burke, launched a report on behalf of Soilse, the drug rehabilitation service in HSE Dublin North City.[1] The report entitled *Addiction recovery: a contagious paradigm* sets out a case for a recovery-focused approach to addiction treatment. It was co-authored by Martin Keane, Health Research Board, Gerry McAleenan of Soilse and Joe Barry, Professor of Population Health at Trinity College Dublin.

The report contains three main sections:

- a review of the evidence underpinning the principles of recovery,
- a review of Irish drug policy in relation to recovery/ rehabilitation, and
- the inputs that build policy, and the personal narratives and perspectives of people in recovery.

There are increasing calls in the literature to draw on the experiences of people in recovery as a means of building effective policy and practice. This paper draws on the outputs of a symposium on recovery held in north inner-city Dublin in the summer of 2012. Over 100 people attended the symposium, the vast majority living or working in communities deeply stigmatised by opiate addiction.

Gerry McAleenan, Soilse, Professor Joe Barry, TCD, and Martin Keane, HRB (author) at the launch of the recovery report in the Mansion House

The report also contains the detailed narratives of four people in recovery, plus a number of vignettes from Soilse participants speaking about their recovery journeys. One Soilse graduate talks about how having allies in recovery helped him reconnect with society:

Table 1: Four dimensions of recovery capital[2]

1. Social Capital	The sum of resources that each person has as a result of their relationships with, support from and obligations to groups to which they belong.
2. Physical Capital	Tangible assets such as property and money that may increase recovery options.
3. Human Capital	Personal skills and education, positive health, aspirations and hopes.
4. Cultural Capital	Values, beliefs and attitudes that link the individual to social attachment and the ability to fit into mainstream social behaviour.

Addiction recovery: a contagious paradigm *(continued)*

> *In recovery I began to feel a part of something. For the first time in life I moved around with people who were happy. Felt comfortable and safe and wanted to hold onto it. I got structure into my life for the first time. Up to then had lost job, no prospects, drinking in house, no light in the tunnel, no way out.*

The report sets out a case for the reorientation of drug treatment and rehabilitation policy and practice towards a recovery-focused paradigm. The authors argue that such a shift can be achieved by placing the framework of recovery capital at the centre of policy and grounding practice in the principles of recovery. Table 1 captures the essence of recovery capital: a framework that contains the properties of what initiates and sustains addiction recovery. Recovery capital is referred to as an 'assets-based model', i.e. a way of recognising and prioritising the assets that people bring to their recovery and the attributes they need to develop and sustain their journey. This model differs from the 'deficits-based' model which seeks to emphasise the reduction of risks and problems such as drug use and crime. The report contains a detailed exploration of this debate.

Table 2 lists the principles of recovery that are grounded in robust research and inputs from extensive consultations with service users and providers. There is also consensus in the literature regarding these principles, a consensus echoed in the testimonies of Soilse participants. These principles recognise that there are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration. Central to the vision encapsulated in these principles is the recognition that the person in recovery is an 'active agent' in their own journey and that change for them via an improved quality of life is the key outcome to be pursued. The report contains an exploration of the evidence from robust research to support the transfer of these principles into practice.

The report concludes with recommendations on how to promote the reorientation of addiction policy and practice towards a recovery-focused paradigm. These include the proposal that recovery replace rehabilitation as the fifth pillar in the National Drugs Strategy.

The Lord Mayor, Christy Burke, speaking about the report, said:

> *As Lord Mayor and first citizen of Dublin, in my time in office, I will promote the need for dialogue around recovery from drug addiction, to highlight and challenge the barriers preventing people getting away from the drug culture and ensure the voices and positive stories of those in recovery echo across our communities, motivating others to reclaim their lives.*

(Martin Keane)

1. Keane M, McAleenan G and Barry J (2014) *Addiction recovery: a contagious paradigm! A case for the re-orientation of drug treatment services and rehabilitation services in Ireland.* Dublin: Soilse. http://www.drugsandalcohol.ie/22291/
2. Table from Cloud W and Granfield R (2008) Conceptualizing recovery capital: expansion of a theoretical construct. *Substance Use and Misuse* 43 (12–13): 1971–1986.
3. List from Sheedy C K and Whitter M (2009) *Guiding principles and elements of recovery-oriented systems of care: what do we know from the research?* HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Table 2: Twelve principles of addiction recovery[3]

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-redefinition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

Recovery in national drugs strategies

In the last decade 'recovery' has emerged as a priority in several national drug strategies. It is also included in the EU drug strategy and action plan, and is the subject of a recent UN resolution, 'Supporting recovery from substance use disorders'.[1] This article explores how recovery has been incorporated in the national drug strategies of the USA, England/Wales and Scotland, and in particular how it relates to the goals and objectives of the strategies, how it is integrated with other policy measures, and how it is proposed to support recovery. It is clear that understanding of the concept and its operationalisation varies considerably across the three jurisdictions.

While the benefits of 'recovery' may be self-evident at practice level, at policy level, where recovery is placed alongside competing policy options and approaches, in what Duke calls 'nested contexts',[2] the concept is more open to interpretation. In 2012 the journal *Drugs: education, prevention and policy* published a special issue on Recovery. The editors included articles on the origins and development of the concept in the United Kingdom, and explored some of the policy debates.[3] In the strategies described below some of the same debates are still being worked through, for example the relationship between recovery and harm reduction (abstinence versus maintenance), between criminal justice and public health responses, and the role of sanctions.

United States – expanding support for recovery

In July 2014 the White House released its 2014 *National drug control strategy* (NDCS).[4] It has two short-term goals: (1) to curtail illicit drug consumption in America, and (2) to improve the public health and public safety of the American people by reducing the consequences of drug abuse. The strategy contains a balance of supply and demand reduction measures. Recovery is linked with treatment in a chapter entitled 'Integrate treatment for substance use disorders into health care and expand support for recovery'.

Citing research showing that 'addiction is a disease from which people can recover… [and that] success rates for treating addictive disorders are roughly on a par with recovery rates for other chronic diseases such as diabetes, asthma, and hypertension', the NDCS pledges to substantially increase the number of Americans who can access high-quality treatment for their substance disorder. Under the Affordable Care Act 2010 insurance companies will be required to cover treatment for addiction just as they cover any other chronic disease, and 'health homes', set up under the same Act, will be required to provide integrated and coordinated care for those presenting with chronic conditions including substance use disorders. The NDCS also emphasises harm reduction, including drug overdose and the transmission of HIV/AIDS, hepatitis C and other infectious diseases. The strategy pledges support for the development of new medications for addiction, including naloxone and vaccines against substance use disorders, and to inform public health systems on the implementation of needle exchange programmes, which protect the public, reduce infections, and encourage involvement in substance use disorder treatment.

Regarding recovery, it is acknowledged that those who successfully make the journey from addiction to recovery too often face barriers to maintaining their sobriety, including a lack of access to housing, employment, or even failing to get a driver's licence or student loan. The NDCS commits to reviewing laws and regulations that impede recovery from addiction and to fostering the expansion of community-based recovery support programmes, including recovery schools, peer-led programmes, mutual aid groups, and recovery community organisations (RCOs). The Office of National Drug Control Policy has established a Recovery Branch to support Americans in recovery and to help lift the stigma associated with addiction.

Special provision is made in the NDCS for the creation of supportive communities to sustain the recovery of the 'reentry population', i.e. offenders leaving prison. Measures include transitional recovery programmes, access to safe, stable and affordable housing, assistance in competing for appropriate work opportunities, and provision of work-related training. The Federal Interagency Reentry Council is helping reentering offenders compete for appropriate work opportunities.

Acknowledging that the war on drugs has been 'counter-productive, inefficient and costly', this new NDCS emphasises prevention over incarceration. It promises to expand national and community-based prevention programmes and early intervention programmes, particularly the Screening, Brief Intervention and Referral to Treatment (SBIRT) programme, to identify and treat problematic drug use before it becomes a chronic substance use disorder. In the law enforcement area the NCDS signals a shift from a 'tough on crime' to a 'smart on crime' approach. It calls for lower incarceration rates and reduced recidivism while also protecting public safety through measures such as expanding the range and use of specialised courts that divert non-violent drug offenders into treatment instead of prison, and reducing the use of mandatory minimum sentencing.

While welcoming the adoption of harm reduction policies in the NDCS, the Drug Policy Alliance (a US-based non-profit organisation which advocates for 'drug policies grounded in science, compassion, health and human rights') has challenged the assertion in the NDCS that drug use is a health issue: 'Until the Drug Czar says it is time to stop arresting people for drug use, he is not treating drug use as a health issue no matter what he says. I know of no other health issue in which people are thrown in jail if they don't get better.'[5]

England and Wales – building recovery into communities

The current national drugs strategy for England and Wales was launched in 2010.[6] It has two overarching aims: (1) to reduce illicit and other harmful drug use, including alcohol and prescription and over-the-counter drugs, through reducing demand and restricting supply, and (2) to increase the numbers recovering from their dependence. In her foreword to the strategy, the Home Secretary expressed reservations about the harm reduction approach: '…we are determined to break the cycle of dependence on drugs and alcohol and the wasted opportunities that result. Individuals do not take drugs in isolation from what is happening in the rest of their lives. The causes and drivers of drug and alcohol dependence are complex and personal. The solutions need to be holistic and centred around each individual, with the expectation that full recovery is possible and desirable.'

Recovery in national drugs strategies *(continued)*

After chapters on reducing demand and restricting supply, the final chapter of the strategy focuses on 'building recovery into communities'. Drug treatment is dealt with in a single paragraph in the introduction to this chapter, where it is stated that the treatment system now has sufficient capacity to enable people 'to access treatment for a sufficient period of time to bring about substantial health gains'. The only additional step needed is 'to make the same progress in treating those with more severe alcohol dependence'. The thrust of the new strategy is to take treatment to a higher level of ambition: 'We will create a recovery system that focuses not only on getting people into treatment and meeting process-driven targets, but getting them into full recovery and off drugs and alcohol for good. It is only through this permanent change that individuals will cease offending, stop harming themselves and their communities and successfully contribute to society.'

The strategy sets out the steps to 'full recovery':

- *Recovery is an individual, person-centred journey*, based on three over-arching principles – well-being, citizenship and freedom from dependence;
- *Built on the recovery capital available to individuals*, i.e. social, physical, human and cultural;
- *In a system that is locally led and locally owned*, and in which local accountability is key;
- *Where all services are outcome-focused*, with outcomes determined locally and central government's role is restricted to researching and publishing the evidence base as to 'what works';
- *Delivered using a 'whole systems' approach*, including education, training, employment, housing, family support services, wider health services, and where relevant, probation and youth justice services;
- *By an inspirational recovery orientated workforce*;
- *Supported by recovery networks* comprising 'recovery champions'; and
- *Keeping children safe and rebuilding families*.

As well as spelling out how to support people in recovering from the symptoms and causes of dependence, the strategy addresses the question of how to enable people to successfully reintegrate into their communities. This involves tackling housing needs and helping people to find sustained employment. The strategy outlines two specific methods of incentivising the take-up of initiatives to help meet accommodation and employment needs:

- *Payment by results (PBR)* is an approach to allocating resources to services that rewards activity or outcomes. Payment depends on what the service does or achieves. The government planned six pilots to explore how PBR could work for drugs recovery for adults. This work is ongoing.

A recent service providers' summit on the PBR pilots in the drugs field concluded that while PBR was broadly compatible with a recovery approach, care was needed to contain the costs of transition to a PBR approach and to allay suspicions among service providers as to the 'real' intentions behind the scheme.[7]

- *Benefit conditionality:* To ensure the benefit system supports engagement with recovery services, benefit claimants dependent on drugs or alcohol are offered a choice between 'rigorous enforcement of the normal conditions or sanctions' where the claimants are not engaged in structured recovery activity, or 'appropriately tailored conditionality' for those who are engaged. The strategy goes on to explain: '… this means that those not in treatment will neither be specifically targeted with, nor excused from, sanctions by virtue of their dependence, but will be expected to comply with the full requirements of the benefits regime or face the consequences. Where people are taking steps to address their dependence, they will be supported, and the requirements placed upon them will be appropriate to their personal circumstances and will provide them with the necessary time and space to focus on their recovery.'

In a joint submission to a recent review of Jobseeker's Allowance sanctions in the UK, DrugScope and Homeless Link (both UK-based national membership charities supporting respectively those working in drug and alcohol treatment, drug education and prevention and criminal justice, and those working with homeless people) concluded, with regard to problem drug users: 'the current sanctions regime is frequently harmful, often perceived as unfair, and may even be counter-productive – moving people further away from the labour market rather than closer to it'. Among their eleven recommendations the authors proposed that conditionality should be appropriate to individuals' needs and realistically reflect their ability to comply, that a range of sanctions including non-financial sanctions should be considered, and that tailored conditionality should be considered for individuals who are homeless and/or substance dependent. This last provision would allow them to address immediate needs which may act as barriers to employment, e.g. homelessness, insecure accommodation or chaotic substance use.[8]

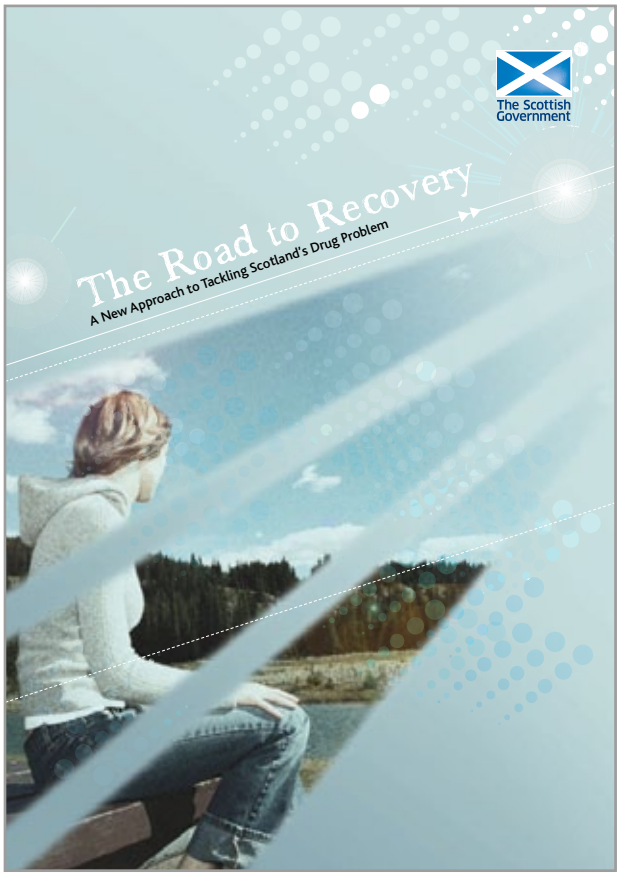
Scotland – promoting recovery

The current Scottish drug strategy, launched in 2008,[9] is explicitly located within the context of the Scottish government's 'overarching purpose, which is to increase sustainable growth'. This overarching purpose is supported by a National Performance Framework, a hierarchy of objectives, outcomes and indicators designed to help realise the 'overarching purpose' by 2018. In this framework, 'Reducing the estimated number of problem drug users in Scotland by 2011' is one of 45 national indicators developed to measure progress towards 15 national outcomes, which in turn are intended to support achievement of five strategic objectives – to make Scotland wealthier and fairer, smarter, healthier, safer and stronger, and greener.

The drug strategy adopts a balanced approach to demand and supply reduction. As well as the usual range of prevention measures, the strategy highlights the need to address the underlying factors associated with drug use – poverty, deprivation and inequality – and to promote inclusion. As well as reducing supply and targeting dealers, law enforcement agencies are explicitly required to promote recovery, providing opportunities at all stages of the criminal justice system for people 'to access treatment to promote recovery from drug addiction', for example through arrest referral schemes, mandatory drug testing, drug courts, and drug treatment and testing orders.

The drug strategy states emphatically that harm reduction and recovery are two sides of the one coin, that maintenance and abstinence both have roles depending on the drug, the drug user and the particular circumstances of each case. The strategy defines recovery as 'a process through which an

Recovery in national drugs strategies *(continued)*



individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society'. It emphasises that recovery is 'an aspirational, person-centred process'. It states that recovery as an achievable goal was first pioneered in the field of mental health. It argues that the strength of the recovery principle lies in its capacity to bring about a shift in thinking – a change in attitude both by service providers and by the individual with the drug problem. It sets out the three principles on which drug treatment in Scotland should be delivered:

- Recovery should be the explicit aim of all services providing treatment and rehabilitation for people with problem drug use;
- A range of appropriate treatment and rehabilitation services should be available at a local level , since different people with different circumstances inevitably need different routes to recovery; and
- Treatment services should integrate effectively with a wider range of generic services to fully address the needs of people with problem drug use, not just their addiction.

The following ten pages of the strategy spell out how this recovery-based approach to treatment and rehabilitation is to be implemented. In 2012 the Scottish Minister for Community Safety and Legal Affairs, with responsibility for the Scottish drugs strategy, reflected on progress.[10] Expressing satisfaction overall, she identified the next big priorities as looking at existing treatment standards and guidelines to ensure that recovery is 'clearly set front-and-centre as the goal of all that we do to help people with drug problems develop individual strengths to recover', and maintaining a critical view:

If we are serious about tackling the stigma of having a drug problem, we will need to continue to listen to those people who have direct experience of the problem. We need to challenge our own perceptions and values and to ensure that we are ensuring fairness and equality for often the most vulnerable people in Scotland. Scotland will be a better country not just by tackling drug problems, but by virtue of the cultural growth and development we will require to undertake to do this well.

(Brigid Pike)

1. See Pike B (2013) EU action plan on drugs 2013–2016 adopted. *Drugnet Ireland* 47: 14–15 www.drugsandalcohol.ie/20735/ , and Pike B (2014) UN body passes drug resolutions. *Drugnet Ireland* 50: 3–4 www.drugsandalcohol.ie/22297/
2. Duke K (2013) From crime to recovery: the reframing of British drug policy? *Journal of Drug Issues* 43 (1): 39–55.
3. *Drugs: education, prevention and policy* (2012) Special Section, The 'Recovery' Debate, 19 (4): 275–308. See in the same issue, book review and discussion by S MacGregor of *Addiction recovery: a movement for social change and personal growth in the UK* by David Best, pp. 351–352.
4. Office of National Drug Control Policy (2014) *National drug control strategy 2014.* Washington: Executive Office of the President of the United States. www.whitehouse.gov/ondcp/national-drug-control-strategy
5. Drug Policy Alliance (9 July 2014) White House releases 2014 National Drug Control Strategy – steps in right direction but largely kinder, more gentle drug war. Accessed 24 July 2014 at www.drugpolicy.org/news/2014/07/white-house-releases-2014-national-drug-control-strategy-steps-right-direction-largely-
6. Home Office (2010) *Drug strategy 2010 reducing demand, restricting supply, building recovery: supporting people to live a drug-free life.* London: Her Majesty's Government. www.gov.uk/government/publications/drug-strategy-2010--2
7. DrugScope and RSA (21 May 2013) *Drug and alcohol recovery payment by results (PbR) pilots – National Service Providers Summit.* London: DrugScope/RSA. Accessed 24 July 2014 at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/RSADrugScopePbRMeetingNote.pdf See also Roberts M (2011) *By their fruits… Applying payment by results to drugs recovery.* London: UK Drug Policy Commission. www.drugsandalcohol.ie/15719/
8. DrugScope and Homeless Link (January 2014) Joint submission to independent review of Jobseeker's Allowance sanctions. Accessed 24 July 2014 at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DrugScopeHLSubJSA.pdf
9. The Scottish Government (2008) *The road to recovery: a new approach to tackling Scotland's drug problem.* Edinburgh: The Scottish Government. Accessed on 24 July 2014 at www.scotland.gov.uk/Resource/Doc/224480/0060586.pdf
10. Cunningham R (2012) Recovery in Scotland – playing to strengths. *Drugs: education, prevention and policy* 19 (4): 291–293.

Legislation on new psychoactive substances

A journal article by Kavanagh and Power examines the impact of legislative and law enforcement responses to the emergence of new psychoactive substances (NPS) and so-called 'head shops' in recent years in Ireland.[1] In particular, the article considers how controls in this area have adversely impacted on academic research on NPS.

In relation to the 'legal highs' phenomenon, on 11 May 2010 the government made the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010, declaring a range of 'legal highs' to be controlled drugs. To give effect to this decision, on the same day the Minister for Health and Children signed the Misuse of Drugs (Amendment) Regulations 2010, the Misuse of Drugs (Designation) (Amendment) Order 2010, and the Misuse of Drugs (Exemption) (Amendment) Order 2010. Under these statutory instruments, approximately 200 individual 'legal high' substances, which had been on sale in 'head shops' and which included the vast majority of products of public health concern, were declared to be controlled drugs. Following on from this, the Criminal Justice (Psychoactive Substances) Act 2010 (PSA) was implemented in response to the 'head shops' selling 'legal highs'.[2]

Following the implementation of the various statutory instruments referred to above, the authors describe how the Forensic Science Laboratory (FSL), which analysed a number of head shop products obtained by means of test purchases,[3] found that in the case of cathinone derivatives, 'following the initial control of a selected range of compounds, the contents of retail products were quickly changed to alternative compounds not yet controlled' (p. 2). Consequently, the authors suggest that the head shops managed to remain open contrary to the political intention behind the amendments to the misuse of drugs legislation. In its first year, however, the PSA did result in a significant reduction in the number of head shops. The authors provide an interesting perspective on why this may have occurred:

> There was considerable societal concern about head shops and the owners, being 'business people' who saw the potential to make a quick profit, in general, complied with retail and legitimate business rules, paid taxes and preferred to operate in a licit rather than an illicit marketplace. The introduction of the PSA and public protests at legal high retail units caused unease amongst these shop operators and, along with media pressure, many shops voluntarily closed and surrendered their products for destruction. *(p. 2)*

The authors also refer to a reduction between 2010 and 2012 in post-mortem blood samples testing positive for cathinone derivatives, based on toxicological analysis conducted by the State Laboratory for the Coroner Service. Furthermore, the Drug Treatment Centre Board (DTCB), which screens methadone programme patients, reported a 25% decrease in the presence of cathinone derivatives in urine samples between 2010 and 2011.

With regard to the impact of the legislative changes on research, the authors suggest that academics involved in NPS research had to ensure that they had the appropriate licence for any substance they were investigating. As a consequence, 'Some researchers preferred to avoid projects involving, or that might involve controlled substances' (p. 1), with the result that '…with little or nothing known about their actual harm potential, numerous compounds became controlled drugs, thus discouraging academia from pursuing research due to licensing requirements' (p. 4). In hindsight, the authors suggest that 'it may have been prudent…to allow researchers to study such compounds by allowing them to hold small amounts (i.e. quantities smaller than typical single doses as reported anecdotally) in their university based laboratories' (p. 4).

Future legislative approaches in this area should, according to the authors' analysis, recognise the potential for academics and forensic service providers to work together, something that would need to be facilitated through primary legislation. For example, with regard to the testing of suspected drug seizures, 'forensic drug chemists are primarily interested in uniquely identifying controlled substances in case samples rather than impurity or by-product profiling. However, the latter is an important intelligence-gathering tool, which can be used to link batches of drugs and provide a valuable insight into manufacturing and supply trends' (p. 6). Work of this type is more research oriented and, it is suggested, 'academics have more freedom and time to think outside the box and are not shackled by accreditation protocols or the seemingly ever-increasing workloads that forensic service providers continually face' (p. 6).

In conclusion, the authors call for a review of the current legislative framework so that it can accommodate academic input and allow for more targeted research, although they acknowledge that any relationship between academics and forensic science is rendered challenging by virtue of the fact that some of the work of the latter might involve case samples that are sub judice. Notwithstanding this issue, they argue that legislation should 'provide better mechanisms for academia and forensic service providers to work together and share data so that more informed policy decisions can be made' (p. 6).

(Johnny Connolly)

1. Kavanagh P and Power J D (2014) New psychoactive substances legislation in Ireland – perspectives from academia. *Drug testing and analysis* 6 (7–8): 884–891.
2. For reviews of these legislative initiatives, see Long J (2010) Further update on psychoactive substances sold in head shops and on line. *Drugnet Ireland* (35): 15–16, and Connolly J (2012) Impact of legislation to control head shops. *Drugnet Ireland* (40): 29.
3. The Garda National Drug Unit contains a Test Purchasing unit, which regularly conducts drug purchases with street-level dealers in order to secure evidence against the drug dealer for the purpose of prosecution. The Garda members' true identity is disguised or concealed.

Illegal drugs activity to be included in national accounts

National accounts are compiled in the EU according to the European System of National and Regional Accounts (ESA) framework. This year the new ESA 2010 framework has replaced the previous ESA 95 version and all EU member states have had to adopt ESA 2010. In response to a query from the Health Research Board, the Central Statistics Office stated:

> *There has been a requirement to include illegal activities in the National Accounts since the ESA 95 version of the national accounting standards were introduced but a lack of detailed and comprehensive data sources for these activities have been the cause of significant measurement difficulties for all EU member states. The European statistical agency, Eurostat, has agreed recommendations on the estimation and recording of these activities in recent years and now requires each member state to include estimates for illegal activities in their National Accounts before September 2014.*[1]

The National Income and Expenditure Annual Estimates 2013 for Ireland have been released based on the ESA 2010 framework. The percentages of gross domestic product (GDP)[2] in respect of illegal activities back to 2010 include estimates for economic activity associated with the smuggling and production of drugs as well as the smuggling of fuel, cigarettes and prostitution. After contributing 0.73% of GDP in 2010, the contribution from illegal economic activities dipped to 0.72% in 2011 and 0.70% in 2012, but recovered to contribute to 0.72% in 2013.[3] It is not possible at present to clarify either the proportion of the total in the category 'Illegal economic activities' associated with the illicit drugs market or how precisely this figure was calculated.

(Johnny Connolly)

1. Central Statistics Office, personal communication, 1 August 2014.
2. GDP represents total expenditure on the output of goods and services produced in Ireland and valued at the prices at which the expenditure is incurred.
3. Central Statistics Office (3 July 2014) Implementing new international standards for national accounts and balance of payments statistics. Press release. Downloaded 14 August 2014 http://www.cso.ie

Table 1: Ireland's GDP on an ESA 2010 basis at current market prices, showing contribution of illegal economic activities[3]

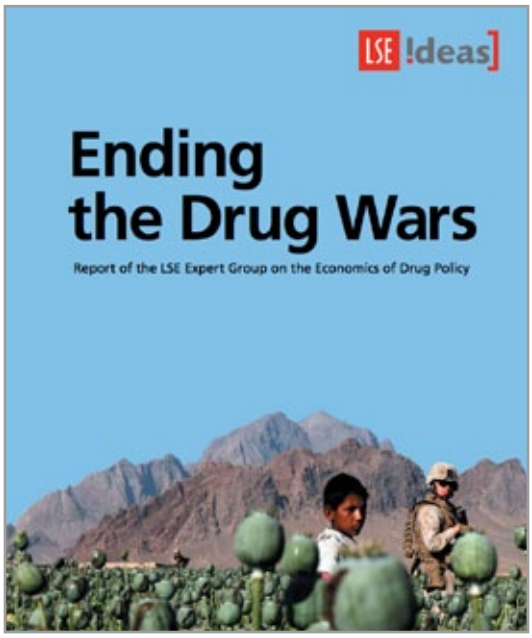
	2010	2011	2012	2013
Gross Domestic Product	€164.9bn	€171.0bn	€172.8bn	€174.8bn
Contribution of: Illegal economic activities	0.73%	0.72%	0.70%	0.72%

Towards UNGASS 2016

Launched in Issue 48, this column reports on policy initiatives, research and debates launched by UN member states and civil society organisations that are relevant to the UN General Assembly Special Session (UNGASS) on the world drug problem, due to be held in 2016 (A/RES/67/193).

The **LSE (London School of Economics) IDEAS International Drug Policy Project** is a large-scale multidisciplinary and cross-regional research undertaking. It was created to produce a deep strategic re-evaluation of the international drug control system through rigorous academic research and policy analysis. To date, it has published two reports.

In October 2012 ***Governing the global drug wars*** was published. Following an examination of the historical evolution of the international drug control system, the eleven authors make just two recommendations for immediate reform of the international drug control system – one focusing on human rights and one on the operation of the International Drug Control Board (INCB). Their final conclusions and recommendations read as follows:



Towards UNGASS 2016 *(continued)*

'The international drug conventions' achievement of their stated goal of contributing to human health and wellbeing would be more likely if the conventions were implemented with attention to human rights standards and with the participation of civil society. Widely accepted human rights standards for health services and health service delivery are very pertinent to drug treatment and rehabilitation and should be built into oversight of states' adherence to the conventions. Attention to human rights standards – including the right of people who use drugs to participate meaningfully in decisions related to services meant for them and the right to mechanisms of redress when rights are violated – should be part of the obligations that states take on when they ratify the drug conventions.

'There is an urgent need for the INCB as the body overseeing compliance with the conventions to take human rights seriously regarding state commitments to services for people who use drugs and the ready tendency of states to limit human rights in the name of drug control. For this to happen, a number of things must change:

- The proceedings of the INCB should be opened up to both member states and civil society organisations, as the meetings of other United Nations-supported entities are. Regular interaction with human rights organisations and member states concerned about human rights would be beneficial.
- Rules for the composition of the INCB should be amended to require that the body include reputable human rights experts among its members or that it include ex officio an expert or experts from the office of the UN High Commissioner for Human Rights. International law expertise has usually been lacking in this body of experts, though international law is at the heart of the group's mandate.
- At the very least, the INCB should make a serious effort to work into its activities the human rights guidelines recently published by UNODC. This guidance underscores the importance to drug control efforts of ensuring that policing and provision of health and social services to people who use drugs be conducted explicitly so as to protect and promote human rights.'

In May 2014 a second report ***Ending the drug wars*** was published. The LSE Expert Group on the Economics of Drug Policy which compiled the report identifies three principal changes which they believe should be made to the international drug control regime:

1. States should shift resources from enforcement-led and repressive policies to public health policies which will reduce harm and ensure access to treatment.
2. Instead of blanket interdiction and eradication policies, states should seek to minimise the impacts of illicit drug markets on producer and transit countries, and promote human security and protect fundamental human rights.
3. States should pursue rigorously monitored policies and regulatory experimentation. Examples to date include the cannabis regulation experiments that have been announced in Colorado, Washington and Uruguay, and the steps taken in New Zealand to regulate new psychoactive substances.

The expert group warns that if the UN does not review and revise the drug conventions, more individual states will push ahead on their own, and international coordination and cooperation in the drugs domain – as essential as it is in relation to other policy issues such as climate change and regional trade imbalances – will wither. The expert group argues that the role of the UN in relation to the control of drugs should be to (1) facilitate debate, discussion, experimentation with new policy options, evaluation and dissemination of results regarding policy innovations, and (2) advocate for human rights and for the dignity of drug users and all those affected by drug misuse. **www.lse.ac.uk/IDEAS/Home.aspx**

In May 2014 **ALICE RAP**[1] published its fifth policy brief, *Cannabis – from prohibition to regulation*. The brief looks at the health, social and economic impacts of current prohibitionist approaches and how legal regulatory cannabis policies could be crafted that better protect public health, wealth and well being. For most jurisdictions cannabis regulation provides a unique opportunity to replace unregulated criminal markets with legal regulatory approaches that are built and evaluated on public health principles and outcomes from the outset. Whether such legalisation is a net positive or negative for public health and safety will depend on how well regulations are formulated and implemented. By removing political and institutional obstacles, by freeing up resources for research and evidence-based public health and social interventions, legal regulation can potentially create a more conducive environment for achieving improved drug policy outcomes, with reduced social and health harms, in the longer term. **www.alicerap.eu/**

In July 2014 the **World Health Organization** published its *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. The document calls on countries to work towards (1) developing policies and laws that decriminalise injection and other use of drugs and, thereby, reduce incarceration, (2) developing policies and laws that decriminalise the use of clean needles and syringes (and that permit NSPs [needle and syringe programmes]) and that legalise opioid substitution therapy (OST) for people who are opioid-dependent, and (3) banning compulsory treatment for people who use and/or inject drugs. **www.who.int**

(Compiled by Brigid Pike)

1. ALICE RAP (Addictions and Lifestyles in Contemporary Europe – Reframing Addictions Project) is the first major Europe-wide project studying addictions as a whole and their influence on health and wealth.

Polydrug use in Ireland: 2010/11 survey results


Drug use in Ireland and Northern Ireland

Bulletin 5

2010/11 Drug Prevalence Survey: Polydrug Use Results

This bulletin presents key findings regarding polydrug use (the use of more than one substance within a specific time period) in Ireland. These are based on the drug prevalence survey of households in Ireland and Northern Ireland. A representative sample of adults aged between 15 and 64 years was sampled during late 2010 and early 2011. The bulletin presents prevalence rates for combinations of both legal and illegal drug use for the Republic of Ireland and also examines gender and age differences and the relationship between the use of a particular substance and the use of another substance. The survey was carried out according to standards set by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

Key findings

It should be noted that the key findings are presented according to the order of the bulletin contents and are not intended to be indicative of the relative importance of the findings. It should also be noted that the figures presented for prevalence are for that specific combination only and do not provide information on individual substances unless specified.

- Twenty percent of all adults aged 15-64 in Ireland had not used any substance (legal or illegal) within the last month.
- Alcohol and tobacco use was the most common combination of substance use reported among all adults (16%).
- Four percent of all adults had used tobacco only within the last month.
- Among all adults, the last month prevalence of polydrug use which included any illegal drug was 3%.
- Females (23%) were more likely than males (16%) not to have used any substance (legal or illegal) during the last month.
- Last month prevalence of alcohol and tobacco use was higher among men (20%) than women (15%) and among young adults than older adults (18% vs. 15% respectively).
- Last month prevalence of alcohol, tobacco, and any illegal drug was higher among men (5%) than women (0.4%) and among young adults (5%) than older adults (1%).
- Older adults were more likely than younger adults to use the combination of alcohol and anti-depressants.
- There were statistically significant differences in prevalence rates of polydrug use among men and women and among young and older adults.
- Of those who had smoked tobacco, 78% had also used alcohol in the last month.
- Of those who had used cannabis 85% had also used alcohol and 77% had also smoked tobacco in the last month.
- Since 2006/7 there have been statistically significant decreases in the use of tobacco among users of alcohol, the use of tobacco among users of cannabis and the use of alcohol among users of tobacco. Findings were similar for men and young adults.
- Users of cannabis, users of amphetamine-type stimulants and users of cocaine were likely to have used other legal as well as illegal substances in the last month.
- Users of sedatives or tranquillisers and users of anti-depressants were likely to have used other legal substances.
- Among users of alcohol males were more likely than females to have also used cannabis.
- Among users of alcohol females were more likely than males to have also used anti-depressants.
- There were statistically significant differences in the use of another substance among young and older adult users of alcohol.
- Among young and older adults who smoked tobacco there were statistically significant differences in their use of another substance as well.

National Advisory Committee on Drugs and Alcohol 2014 1

In June 2014 the National Advisory Committee on Drugs and Alcohol published Bulletin 5 in a series of reports on the 2010/11 survey on drug use in the general population.[1] The bulletin focused on polydrug use in the adult population (15–64 years). Polydrug use was defined as concurrent substance use, where a person uses at least two substances within a one-month period. The final achieved sample was 5,134 in the Republic of Ireland. This represented a response rate of 60%.

Twenty per cent of all adults had not used any substance within the last month. Women were more likely than men not to have used any substance (23% vs 19%). The most common combination of substances used was alcohol and tobacco (16%), followed by alcohol and other legal drugs (7%), alcohol, tobacco and other legal drugs (2%), and alcohol, tobacco and any illegal drug (2%). Last month prevalence rates for alcohol, tobacco plus any illegal drug were higher among men (3%) than women (0.4%), and higher among young adults aged 15 to 34 (3%) than among older adults aged 35 to 64(1%). However, older adults were more likely than younger adults to have used a combination of alcohol and anti-depressants. The last-month prevalence of polydrug use including any illegal substance was 3%.

Patterns of association between use of one substance and a range of other substances are outlined in Table 1. Association between use of alcohol and tobacco was high. Users of cannabis, amphetamine-type stimulants and cocaine were highly likely to have used other legal and illegal substances. Of those who used cannabis within the last month, 85% used alcohol and 77% tobacco. Of those who used cocaine within the last month, all reported having used alcohol, 77% smoked tobacco, 41% used cannabis, 14% used amphetamine-type stimulants and 12% used anti-depressants.

Since 2006/7 there has been a statistically significant reduction in the prevalence of tobacco and amphetamine-type stimulant use among cannabis users. There has also been a statistically significant reduction in the use of sedatives or tranquillisers among anti-depressant users. But there has been a statistically significant increase in the prevalence of anti-depressant use among alcohol users and amphetamine-type stimulant users.

(Margaret Curtin)

1. National Advisory Committee on Drugs and Alcohol (2014) *Drug use in Ireland and Northern Ireland 2010/11 drug prevalence survey: polydrug use results.* Bulletin 5. Dublin: National Advisory Committee on Drugs and Alcohol. www.drugsandalcohol.ie/22171

Table 1: Total number of users of one substance by users of another substance and related percentages, all adults (aged 15–64 years), 2006/07 and 2010/11

	Last month prevalance		Users of alcohol		Users of tobacco		Users of cannabis		Users of ATS		Users of cocaine		Users of ST		Users of anti-depressants	
	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11
Total weighted N	4967	5126	3653	3621	1619	1451	128	143	19	5	25	26	147	142	154	209
Alcohol	73.4	70.6			81.2	78.3*	90.06	84.5	100	100	100	100	65.3	65.2	62.1	63.5
Tobacco	32.6	28.3	36.1	31.4*			88.3	76.7*	84.2	88.3	80	77.2	45.6	46.1	50	43.5
Cannabis	2.6	2.8	3.2	3.3	7	7.6			78.9	62.4	60	40.9	4.7	9	5.8	6.1
ATS	0.4	0.1	0.5	0.1	1	0.3*	11.7	2.2*			25	14.1	0.7	0.4	0.6	1.2
Cocaine	0.5	0.5	0.7	0.7	1.2	1.4	11.7	7.4	33.3	74.1			0.7	2.1	0	1.5
ST	3	2.8	2.6	3.7	4.8	6.3	5.5	9	5.3	11.7	4	11.4			38.3	26.2*
Anti-Depressants	3.1	4.1	2.6	3.7*	4.8	6.3	7	8.9	5.3	52.9*	0	12.4	40.1	38.5		

All figures are based on weighted data, are rounded to the nearest decimal place and based on valid responses.
* Denotes a statistically significant change between 2006/7 and 2010/11
ATS – Amphetamine-type stimulants (ecstasy and amphetamines)
ST – Sedatives or Tranquillisers

Suicide and self-harm among Irish adolescents

Suicide is a major cause of death among adolescents and those who self-harm are at increased risk of suicide. In a recently published study of suicide, hospital-treated self-harm and self-harm in the community among Irish adolescents, the 'iceberg' analogy was used to illustrate the relative incidence of adolescent suicide (highly visible), hospital-treated self-harm (less visible) and self-harm in the community (largely hidden).[1]

The study population consisted of adolescents (aged 15 to 17 years) in counties Cork and Kerry in Ireland. Annual suicide rates were calculated using data from the Central Statistics Office (based on figures from 1997 to 2011). Data on hospital-treated self-harm (between 2003 and 2011) were obtained from the National Registry of Deliberate Self-Harm which collects data on self-harm presentations in all 40 hospital emergency departments in the Republic of Ireland. Data on self-harm in the community were collected as part of the Child and Adolescent Self-Harm in Europe (CASE) study through a cross-sectional survey of 3,881 adolescents in the area in Cork and Kerry (conducted between 2003 and 2004).

The annual suicide rate among adolescents aged 15, 16 or 17 in the selected area was 10/100,000. The rate among boys was 16.5/100,000, among girls 2.7/100,000. The incidence ratio of male to female was 6:1. The incidence of hospital-treated self-harm cases was 344.4/100,000. For boys the rate was 256.2/100,000, for girls 438.1/100,000, giving an incidence ratio of male to female of 1:1.7.

Of the respondents to the CASE survey, 8.9% of girls and 2.4% of boys reported self-harm within the past year. The rate of self-harm was 5,551/100,000. The rate among boys was 2,400/100,000, among girls 8,900/100,000. The incidence ratio of male to female was 1:3.7.

Based on these incidence rates, the frequency of suicide and self-harm were calculated. For every adolescent suicide there were 34 hospital presentations with self-harm and 555 adolescents reported having self-harmed. Among boys, for every suicide there were 16 cases of hospital-treated self-harm and 146 self-reports of self-harm. Among girls, for every suicide there were 162 cases of hospital-treated self-harm and 3,296 self-reports of self-harm.

Of the 37 suicides among adolescents aged between 15 and 17 years between 1997 and 2011, four were by overdose, 31 by hanging, one by drowning and one by other methods. Of the 775 cases of hospital-treated self-harm in the same age group between 2003 and 2011, 509 (66%) were overdoses, 146 (18.8%) self-cutting, 66 (8.5%) other methods and 27 (3.5%) overdose combined with self-cutting. Of the 207 cases of adolescents reporting self-harm in the community in 2003/04, 55 (27%) were overdoses, 121 (58.5%) self-cutting and 20 (7%) overdose combined with self-cutting.

The study concluded that there are large gender differences in the incidence of self-harm and suicide among adolescents, with boys who have a history of self-harm at particular risk of suicide. However, the majority of self-harm was unreported. The need for interventions to promote awareness of mental health issues and enhance help-seeking behaviours among adolescents was highlighted.

(Margaret Curtin)

1. McMahon EM, Keeley H et al. (2014) The iceberg of suicide and self-harm in Irish adolescents: a population-based study. *Social psychiatry and psychiatric epidemiology. Early online.* www.drugsandalcohol.ie/22193

Self-cutting and intentional overdose

A recent study used data from the Irish National Registry of Deliberate Self-Harm to compare hospital-treated self-cutting patients and those presenting with intentional overdose, looking in particular at gender differences, patients' characteristics and the outcomes associated with each method of deliberate self-harm.[1] The definition of self-harm used was that of the WHO/EURO Multicentre Study, which includes all intentionally-initiated drug overdoses, poisoning or self-injurious behaviour regardless of suicidal intent.

The study examined data on 42,585 persons who presented to emergency departments in Ireland between 1 January 2003 and 31 December 2009 with a first self-harm episode resulting from self-cutting, intentional overdose or a combination of both. Of these, 24,775 (58.2%) were women. The highest number of presentations were as a result of overdose only (34,445), followed by self-cutting only (6,398) and finally a combination of overdose and self-cutting (1,742).

Significant differences were found between presentations with overdose only and those with self-cutting only. Gender was significantly associated with method of self-harm: 21% of male presentations were for self-cutting compared to 10% of female presentations. Place of residence was also significant, with males and females living in cities being over-represented among presentations involving self-cutting. Living circumstances were also significant, with those of no fixed abode being over-represented among self-cutting presentations.

Among those presenting with combined self-cutting and overdose, males and females were more evenly represented (4.5% vs 3.8%). Males and females living in cities were also both over-represented among presentations involving self-cutting and overdose. Use of alcohol was significantly associated with overdose by both males and females. Presentations for self-cutting combined with overdose were less likely between 9am and 5pm, and more likely at weekends than cases of overdose only. Repetition was also significantly more likely among those presenting with self-cutting.

Multinomial logistic regression was used to identify factors independently associated with method of self-harm. When compared with overdose only, factors independently associated with self-cutting among both males and females included living in a city, being of no fixed abode or living in an inpatient or custodial setting, presenting outside the hours of 9am to 5pm or at weekends, no alcohol

Self-cutting and intentional overdose *(continued)*

involvement and repetition within 12 months. In addition, being aged over 45 years for men and over 55 years for women was significant. Factors independently associated with combined overdose and self-cutting for men were being aged over 35 years, living in a city, presenting at the weekend and repeating within 30 days; for women, significant factors were being over 45 years of age, residing in a city, alcohol involvement and repeating within 12 months.

The article concluded that the demographic and clinical differences between those presenting with different methods of self-harm have implications for choice of intervention. In particular, the association between self-cutting and repetition means that adequate follow-up and support need to be put in place. Moreover, services need to be available outside regular working hours.

(Margaret Curtin)

1. Arensman E, Larkin C et al. (2014) Factors associated with self-cutting as a method of self-harm: findings from the Irish National Registry of Deliberate Self-Harm. *European Journal of Public Health* 24(2): 292–297. www.drugsandalcohol.ie/21823

Young people's access to drugs

A Flash Eurobarometer survey on young people and drugs was undertaken in June 2014. Some 13,128 respondents aged 15–24 in the 28 EU member states from different social and demographic groups were interviewed via telephone. Five hundred young people from Ireland participated in the survey. Part of the survey dealt with perceived availability of drugs. Around a quarter of respondents across the EU believed it would be easy to obtain cocaine, new substances that imitate the effects of illicit drugs and ecstasy, and over half believed it would be easy to obtain cannabis.

The proportion of Irish respondents who responded that it was 'very easy' to obtain certain substances was above the proportion across all member states for all substances, except tobacco. Of the Irish respondents 40% said cannabis was 'very easy' to obtain compared to 29% of all respondents. Ecstasy was regarded as very easy to obtain by 19% of Irish respondents compared to 7% across all member states. Perceived availability of heroin was broadly similar across all member states at 4–5%.

Ireland is sometimes regarded as a sub-market of the UK for certain drugs. However, the survey also revealed that perceived availability of all substances except new substances that imitate the effects of illicit drugs was higher among Irish respondents than their UK counterparts. In relation to 'new substances', 13% of UK respondents perceived them to be 'very easy' to obtain compared to 9% of Irish respondents and 7% across the EU.

In response to a question about the supply of 'new substances that imitate the effects of illicit drugs' during the previous 12 months, most respondents across the EU reported receiving them from a friend. The second main supply source was a 'drug dealer', with Ireland below the EU average (24%/ vs 27%) but the UK, at 39%, was 12% higher than the EU average. Only 3% of respondents reported buying new substances via the internet; in Ireland, the figure was 5%.

(Johnny Connolly)

1. TNS Political and Social (2014) *Flash Eurobarometer 401. Young people and drugs.* Luxembourg: European Commission.

Gambling in Europe and Ireland

The Addictions and Lifestyles in Contemporary Europe – Reframing Addictions Project (ALICE-RAP) is the first major Europe-wide project studying addictions as a whole and their influence on wealth, health and stealth. Their recent policy paper discusses the nature and extent of gambling in EU member states.[1] In addition, a recently published discussion paper, 'Gambling: an Irish perspective', gives a detailed insight into gambling in Ireland.[2] The following account is based on these two papers.

Prevalence

The prevalence of gambling in both Ireland and Europe is mainly unknown. While some EU member states have included gambling in population surveys, many are missing critical data. An EU-wide standardised survey has yet to be established for gambling, meaning the opportunity to compare gambling data across Europe is lost. Available data suggest that 40–80% of adults across Europe engage in gambling annually. In Ireland in 2012 an estimated 64% of adults played the National Lottery, and according to the Institute of Public Health, up to 1% of the Irish population have gambling problems. At the request of the Department of Justice and Equality, the National Advisory Committee on Drugs and Alcohol (NACDA) will include a series of epidemiological questions about personal gambling in the next general population prevalence survey on drugs. This baseline data will enable the Irish government to measure the nature and extent of gambling in Ireland and to monitor the negative health effects in the future (personal communication Dr Jean Long, Health Research Board).

Gambling market

Within the EU, the gambling market is rapidly expanding, and has an estimated annual revenue of €80.3 billion. Owing to the lack of regulation of the Irish gambling market, it is not possible to measure the financial impact of gambling on the Irish economy. The Irish National Lottery, the only reliable available data source, has reported annual sales of €12.8 billion since being established in 1987. Gambling sites operated outside the EU may be accessed by EU residents, but are not controlled by EU or national regulation. Moreover, interactive gamblers may access gambling sites in other EU member states where more lenient restrictions apply. These on-line providers are well positioned to monitor on-line gambling habits and to contribute to public health initiatives protecting gamblers.

Gambling in Europe and Ireland *(continued)*

Co-morbid conditions and risk factors for gambling

Mental health disorders including depression and anxiety are closely linked with gambling. According to the Irish discussion paper, the British Gambling Prevalence Survey 2010 revealed that a common profile among the gambling population was young males who are cigarette smokers and have parents with a gambling problem. An Australian study identified the risk factors for gambling as access to legalised gambling, being less than 25 years old, living in an urban area, being socially disadvantaged, separated or divorced, and unemployed.

Gambling disorder

The proposed Irish Gambling Control Bill favours the definition of a gambling disorder used in the World Health Organization's DSM-5 diagnostic tool: 'Persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress with the following symptoms (examples):

- preoccupation with gambling,
- increasing amounts of money needed to achieve the desired excitement,
- unsuccessful efforts to control gambling,
- repeated gambling after losses ('chasing'), and
- lying to conceal the extent of involvement with gambling.'

Treatment

In Ireland, treatment for gambling disorders is publicly funded, but places are limited, with the majority of clients seeking treatment in private hospitals and treatment centres. The literature review reported in the Irish discussion paper shows that pharmacological treatments for gambling are mainly ineffective, although they may provide benefit if used to treat co-morbid mental health disorders. Non-pharmacological therapies such as cognitive behavioural therapy, family therapy, psychodynamic psychotherapy, social skills retraining, problem-solving and relapse prevention have been successfully used in the management of gambling disorders.

Proposed changes to Irish gambling legislation

Regulation of gambling in Ireland is governed by the Betting Act 1931 and Gambling and Lotteries Act 1956.

Under current legislation the maximum stake allowed in a licensed amusement hall or funfair is 6d. a player and the maximum prize is ten shillings, rendering this law unenforceable. In 2010 the Department of Justice and Law Reform published *Options for regulating gambling.* This document discussed the need for change to the existing laws and potential dangers of gambling, but also recognised the financial benefits of a well-regulated gambling industry.

The following measures are proposed for inclusion in the forthcoming Gambling Control Bill:

- The number of casinos in Ireland will be limited to 40, with a maximum capacity of 15 tables. This will rule out 'super casinos'.
- The new Bill will treat bingo and lotteries separately.
- A complete ban on fixed-odds betting terminals, commonly seen in betting shops in the form of roulette, bingo and simulated horse-racing. These mechanical devices allow a person to bet a minimum amount with fixed odds of winning and there is always a ceiling on the amount the person can win.
- The National Lottery will continue to be regulated under Section 42 of the National Lottery Act 2013.
- Provision for sponsorship of events by the gambling industry.
- Age restrictions for gambling and employment within the industry.
- Establishment of the Office for Gambling Control – Ireland (OGCI). This office will be answerable to the Minister for Justice and Equality and will be supervised by a Socially Responsible Gambling Committee, which will include people from outside the gambling industry. The OGCI will be the regulating body for issuing licences and enforcing the legislation.

(Simone Walsh)

1. ALICE RAP Policy Paper Series, Policy Brief 2. *Gambling – two sides of the same coin: recreational activity and public health problem.* Available at http://www.alicerap.eu/
2. Subramanian N (2014) Gambling: an Irish perspective. *Irish Journal of Psychological Medicine* 31(3):153–158.

Drug-related intimidation

The issue of drug-related intimidation, much of it related to drug debt, has emerged as a major concern for many communities in Ireland in recent years.[1] It has also been identified as a key issue in the National Drugs Strategy 2009–2016 (NDS), in which Action 5 aims 'to develop a framework to provide an appropriate response to the issue of drug related intimidation in the community'.[2]

A survey on the issue was completed by the North Dublin Inner-City Drugs Task Force in October 2013. The survey *Trends and behaviour survey – violence, intimidation and threats* involved an online survey of individuals and groups engaging with community-based projects in the north inner city.[3] The survey was issued to 20 local projects and there was a 70% response rate (14 projects). Of the projects that responded, 11 worked primarily with adults, one mainly with youth (aged 12 to 23) and their families, and two with children and their families. The following are some of the key survey findings:

- There is a significant level of engagement around violence, intimidation or threats in the area. Eighteen per cent of the service users involved with 13 projects (501/2,752) had expressed concern about these issues in the last 12 months.
- Violence, intimidation or threats are most often directed at the individual reporting the issue (32%) or a family member (54%).

Drug-related intimidation *(continued)*

- Those most commonly affected are aged between 26 and 35 years.
- The violence, intimidation or threats take place mostly on the street (17%) and at home (17%), although 14% take place over the phone and 9% via the internet.
- The most often cited reason for violence, intimidation or threats is drug-related (28%).
- The issues affect individuals in a variety of ways, with financial problems the most significant single effect cited (13%).
- About 50% of those affected sometimes/often/always report the issue confidentially to the Garda Síochána.
- Two thirds (64%) of respondents said they were concerned at least some of the time about their own and a colleague's safety when supporting individuals/groups with issues relating to violence, intimidation or threats.
- Almost 72% of the projects that responded had a working policy to support staff when dealing with issues of violence, intimidation or threats.

The CityWide Drugs Crisis Campaign, in association with the Health Research Board, is currently conducting a national audit of drug-related intimidation and community violence in task force areas throughout the state.[4] The purpose of this project is to develop an evidence-base in order to establish sustainable locally-based responses to the issue.

(Johnny Connolly)

1. Connolly J (2011) CityWide conference discusses drug-related intimidation. *Drugnet Ireland* (36): 24–25.
2. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy* (interim) 2009–2016. Dublin: Department of Community, Rural and Gaeltacht Affairs.
3. North Inner-City Drugs Task Force (2013) *North Inner City Drugs Task Force trends and behaviours online survey. Violence, intimidation and threats.* Dublin: North Inner City Drugs Task Force.
4. For further information contact the author at jconnolly@hrb.ie

Drug-facilitated sexual assault

A recent journal article provides an Irish perspective on drug-facilitated sexual assault (DFSA).[1] It discusses the various ways in which DFSA is defined, the limitations associated with establishing its prevalence in Irish society, the various substances that have been found to be associated with it in other jurisdictions, and the complex evidential issues that can arise in trying to establish its basis in law.

DFSA is defined by the authors as 'sexual assault that is facilitated by alcohol, drugs or other intoxicating agents where consent cannot be obtained due to lack of capacity of the victim' (p. 190). Rape that is facilitated by alcohol, drugs or other intoxicants has often been confused with so-called 'date rape'. However, the authors explain that 'date rape' is just one specific form of DFSA 'where the victim is on a date with the perpetrator' and that there are 'many other situations where drugs and alcohol may be used to facilitate a sexual assault'. The authors explain further that the terms such as 'date rape drugs' have been used to describe drugs that can be specific biological effects that 'facilitate sexual assault' (p. 189). Rape is generally defined in legislation as 'unlawful sexual intercourse or certain sexual activity perpetrated on an individual where consent is not present, or where consent is not valid due to lack of capacity of that individual to consent....due to intoxication'. The article identifies three separate circumstances where DFSA can occur: (i) there is an involuntary ingestion of an intoxicating substance by the victim, (ii) there is both voluntary and involuntary ingestion of an intoxicating substance by the victim, or (iii) there is voluntary ingestion of an intoxicating substance by the victim (p. 190).

With regard to the prevalence of DFSA in Ireland the authors highlight the general under-reporting of rape and sexual assault to the Garda Síochána. In particular, they note a report of the Rape Crisis Centre (RCC) to the effect that less than one in five of victims of rape reported the offence to the Gardaí. Furthermore, from an analysis of 10,155 phone calls to the RCC in 2007, 2.3% related to drug rape. This figure, according to the authors, is misleading and relates to a confusion between date rape, drug rape and DFSA. The substance most commonly involved in DFSA is alcohol, and this is not included in figures presented for 'drug rape'. In Ireland, according to the study, 'alcohol is involved in about half of all adult sexual assaults' (p. 191). Consequently, the offence of DFSA is 'hugely underestimated' in Ireland. From a brief analysis of UK case law regarding consent in rape cases where the complainant/victim is self-intoxicated with alcohol, the courts generally hold that 'drunken consent is still considered consent' (p. 192).

One of the major challenges in legally establishing DFSA, however, is the failure to test for the presence of specific substances in victims. In particular, samples need to be taken from victims in a timely manner, while the drugs or alcohol are still detectable. This, according to the authors, is 'especially relevant with drugs such as GHB and ethanol, which clear rapidly from the body'. The study includes a table showing the length of time different drugs generally associated with DFSA remain detectable in urine samples, and this can vary from 7–12 hours in the case of alcohol to 30 days for long-acting benzodiazepines.

The authors conclude their analysis by highlighting the under-reporting of crimes of sexual violence in Ireland. DFSA is, they suggest, an issue that cuts across various disciplines including forensic science, medicine and law. Further education of frontline service providers, facilitating a greater awareness of the legal and forensics issues involved, might, the authors suggest, be a positive step towards addressing the general under-reporting of offences in this area.

(Johnny Connolly)

1. McBrierty D, Wilkinson A et al. (2013) A review of drug-facilitated sexual assault evidence: an Irish perspective. *Journal of Forensic and Legal Medicine* 20(4): 189–197.

SPHE and substance use education

The Department of Education and Skills (DES) recently launched the report of the working group set up to examine how education on substance use is provided in post-primary schools in the context of Social, Personal and Health Education (SPHE).[1] This work arose from a commitment in the 2011 Programme for Government to 'update the out-dated drugs awareness programme in schools to reflect current attitudes and the reality of recreational drug use among teens'.[2]

The working group reviewed a selection of international and national literature and concluded that '…multi-element programmes which have whole-school, parent and community support strands, coupled with a harm reduction approach, appear to offer considerable advantages as regards effective substance use education programmes for young people…' (p. 40). In recognising the potential benefits of including harm reduction components in school-based substance use education, the working group cited evidence from an evaluation by McKay and colleagues of an adapted version of the Schools Alcohol Harm Reduction Programme (SHAHRP), conducted in Belfast.[3]

McKay and colleagues undertook a controlled non-randomised trial with post-primary school students aged 13–16 years: eight schools received SHAHRP delivered by teachers, twelve schools received SHAHRP delivered by external alcohol and drug education workers and nine schools, the control arm of the trial, received the standard curriculum on alcohol education. The researchers found that, in contrast to participants in the control group, participants receiving the SHAHRP intervention were significantly more likely to report increased levels of knowledge about alcohol and its effects, safer alcohol-related attitudes, fewer alcohol-related harms (both personal and from others) and lower alcohol consumption. These effects were maintained over the 11-month period in which none of the students received any intervention. The researchers concluded that 'the adapted SHAHRP intervention is a promising means to address one of the major health and social challenges facing young people [alcohol consumption]' (p. 118). They also acknowledged that harm reduction interventions targeting young people can be controversial; however, as in the case of students receiving SHAHRP in Belfast, such interventions do not necessarily promote or produce alcohol-friendly attitudes and/or behaviours among target groups.

The working group addressed the sometimes contentious nature of the term harm reduction, particularly when considered in the context of school-based substance use education. They acknowledged that the term may have negative connotations, but they went on to say that 'taking care of oneself or looking after one's own safety, topics already covered in On My Own Two Feet is effectively a harm reduction strategy…' (p. 44). This interpretation is in line with the aims of the education provided in Belfast through the SHAHRP intervention. The key messages included in the SHAHRP intervention include advice on staying close to trusted friends when consuming alcohol, knowing basic first-aid, organising group transport home, having mobile phones available, not making decisions while drunk, being able to identify when friends are getting drunk, being on the alert for drink spiking and mixing alcohol with other drugs and avoiding arguments and aggressive behaviour by self and others. A full description of the evaluation of SHAHRP is provided in an earlier issue of *Drugnet Ireland*.[4]

After considering the evidence and the arguments for and against harm reduction, the working group recommended that '…teaching and learning resources used in schools and centres for education be aimed at reducing, postponing and/or eliminating substance use, as appropriate, in recognition of the reality that a proportion of students are using legal and illegal substances…' (p. 8).

The working group also undertook a wide-ranging consultation with academics, researchers, public health experts, school management and teacher unions. The group also visited eight schools and three Youthreach centres and consulted with staff and students in both settings. Arising from these consultations and consideration of relevant documents and literature, the working group concluded that '…quality substance use education is dependent on the quality of standard of delivery, which is supported through the use of relevant educational resources…' (p. 7).

The working group is of the view that updating the current On My Own Two Feet resource (implicit in the 2011 Programme for Government commitment) is not an adequate response. The group set out recommendations to assist teaching staff, schools and centres for education to deliver SPHE. These include providing continuous personal development (CPD) for SPHE teachers, and adopting a whole-school approach to student well-being in which providing SPHE is the central strategy. These and a number of other recommendations primarily relate to supporting teachers and schools and embedding SPHE in the school curriculum. These recommendations and the principles underpinning them are in line with actions 20–21 in the current National Drugs Strategy, which relate to the implementation of SPHE in schools.[5]

Finally, the working group noted the large number of textbooks and resource materials for SPHE that have become available since the early 1990s. They cautioned that '…it is possible that teachers could become over-reliant on text-book material and so diminish the experiential, interactive approach, which is regarded as an essential part of SPHE delivery…' (p. 55). There is consensus in the evidence base that non-interactive programmes are not effective; such programmes include information provision alone, emotional education alone, transmission of values and decision-making alone and DARE-type programmes (delivered didactically by police officers in the United States).[6]

(Martin Keane)

1. Working Group on educational materials for use in SPHE in post-primary schools and centres for education (2014) *Report of the Working Group on educational materials for use in SPHE in post-primary schools and centres for education with particular reference to substance use education in the context of SPHE.* Dublin: Department of Education and Skills. http://www.drugsandalcohol.ie/22264/
2. Fine Gael, Labour Party (2011) *Towards recovery: programme for a National Government 2011–2016.* Dublin: Fine Gael and Labour Party. http://www.drugsandalcohol.ie/14795/
3. McKay M, McBride N, Sumnall H and Cole J (2012) Reducing the harm from adolescent alcohol consumption: results from an adapted version of SHAHRP in Northern Ireland. *Journal of Substance Use* 17(2): 98–121. http://www.drugsandalcohol.ie/17020/

SPHE and substance use education *(continued)*

4. Keane M (2012) Reducing alcohol-related harm: evaluation of a SHAHRP intervention. *Drugnet Ireland* (42): 14. http://www.drugsandalcohol.ie/17691/
5. Keane M (2013) Substance use prevention education in schools: an update on actions in the drugs strategy. *Drugnet Ireland* (48): 17. http://www.drugsandalcohol.ie/21215/
6. Bühler A and Kröger C (2008) *EMCDDA Insights: Prevention of substance abuse.* Luxembourg: Office for Official Publications of the European Communities. http://www.drugsandalcohol.ie/11625/

Promoting participation by seldom heard young people

Kelleher and colleagues undertook a review of national and international literature on the participation of 'seldom heard young people'.[1] The purpose of the review was to identify best practice around participation, overcoming barriers, and approaches to improve the inclusion and experience of seldom heard young people.

There is general consensus in the literature that 'seldom heard young people' are groups of people who do not have a collective voice and are often under-represented in consultation or participation activities; they are as the reviewers suggest, '…young people whose voices are not heard in decisions that affect them…' (p. 1). These groups rarely form a homogeneous collective and, according to the reviewers, '…the heterogeneity of the seldom heard population requires diverse responses to meet their needs within the participative process…' (p. 28). The key for practitioners is to understand why the voices of certain groups are not heard in the decision-making that affects them and to make available and accessible ways of including their voice.

Barriers and challenges to participation

The reviewers define participation as '…the process by which young people have active involvement and real influence in decision-making on matters affecting their lives, both directly and indirectly…' (p. 29). They also acknowledge that formal participation structures, e.g. Dáil na nÓg (youth parliament) and school/student councils, may not be accessible to disadvantaged and/or socially excluded young people. The review signals that there appears to be a reinforcing loop of exclusion between the adults who operate these formal participative structures and the groups of seldom heard young people: the adults assume that the seldom heard young people such as homeless youth are so chaotic as to be incapable of articulating a rational and strategic view, the young people internalise this adult view, and their exclusion is reinforced. Another barrier identified in the literature is that the issues that concern seldom heard young people are particularly challenging formal participatory structures. Thus, issues such as poverty, social exclusion and stigma are primarily driven by systemic and structural forces and forums such as youth parliaments and school councils may be unable or unwilling to accommodate such issues on their agenda.

Improving the experience of participation

Meaningful participation must extend beyond 'having a voice' to 'making a difference'. This is the message given by the reviewers. They summarise the views of marginalised young people who want the focus of participation to be relevant to their everyday lives and for participation to be an opportunity where they can make a difference by giving something back to their communities. According to the reviewers, '…for participation to be meaningful, it should reflect the most salient issues for young people at that time, and not the agendas of the organisations and services involved' (p. 43). This observation leads to consideration of different levels of participation and the type of influence seldom heard young people can bring to the decision-making process. The reviewers highlight one model with three levels of participation, which distinguishes between consultative and active participation:

- *Consultative participation:* An adult-led activity where information is exchanged, and/or the views of youth are sought on specific issues but are not necessarily incorporated into decisions and subsequent actions.
- *Collaborative participation:* Youth share responsibility to varying degrees with adults at any or all stages of decision-making and can influence both process and outcome.
- *Children/youth led participation:* Youth are supported to pursue their own agendas and make decisions autonomously. Adults may provide information and support.

The reviewers distinguish between the 'youth development' and 'youth involvement' approaches documented in the literature. The first approach helps young people to effect personal change, whereas the second empowers young people to be active in social change: '…the emphasis in a youth involvement approach extends beyond individual change in young people themselves and argues that through participation young people are able to change policy-making, organisations and society…' (p. 44). The reviewers point out that youth involvement approaches offer the best opportunity to provide effective opportunities for seldom heard young people to participate meaningfully in formal decision-making structures that affect their lives. Reflecting the heterogeneity of seldom heard young people, the reviewers suggest that methods to engage these youth must be related to their needs and preferences and, in parallel, practitioners need to reflect on current methods of engagement which may exclude rather than include young people.

Reflecting the view expressed in the literature, the authors contend that '…overall, it is important to highlight that young people are seldom heard, not as a consequence of an inherent characteristic that precludes them from participating, but rather due to the absence of appropriate participation structures and supports to facilitate their voices being heard…' (pp. 53–54). They recommend that organisations wishing to include seldom heard young people in the decision-making process could begin by examining four key components of their work:

- *Structure:* Does the organisation have an adequate level of planning, development and resourcing for participation?

Promoting participation by seldom heard young people *(continued)*

- *Culture:* Is the organisational ethos committed to participation?
- *Practice:* Does the organisation have the skills and knowledge to engage young people?
- *Review:* Does the organisation have a system to monitor and evaluate participation activity?

These four components, when combined, comprise what is termed in the literature a whole-systems approach. It is essential that they are implemented together to enable organisations to provide meaningful opportunities for participation. According to the reviewers, in organisations that do not implement these components '…the likelihood of creating opportunities for effective and meaningful participation [for seldom heard young people] are greatly reduced…' (p. 65).

(Martin Keane)

1. Kelleher C, Seymour M and Halpenny AM (2014) *Promoting the participation of seldom heard young people: a review of the literature on best practice principles*. Dublin: Centre for Social & Educational Research, Dublin Institute of Technology. http://www.drugsandalcohol.ie/21452/

Youth mental health and substance misuse disorders in deprived urban areas

A recent qualitative study of the experience of young people living with mental health and substance misuse disorders in two deprived urban areas in Ireland highlighted how early intervention in a primary care setting could potentially prevent the escalation of symptoms.[1] Semi-structured interviews were conducted with 20 young adults (aged 16 to 25 years) attending health-care settings in areas of extreme social deprivation in the cities of Limerick and Dublin. The aim of the study was to examine the manifestation and experience of mental health and substance misuse disorders among the young people.

Respondents described initial feelings of anxiety, depression and worthlessness which they recognised as problematic but for which they did not seek help. These symptoms progressed to a point where they became debilitating, and as the young people developed additional issues. Substance abuse was a common issue, with some becoming addicted. Self-harm was another coping mechanism.

Despite the exacerbation of their symptoms, the young people described a reluctance either to seek help or to accept help when it was offered. This was particularly the case for those dealing with addiction. Deteriorating life circumstances such as homelessness were often the factor that motivated an individual to seek treatment.

The young people felt themselves losing control as addiction became a full-time occupation, as relationships broke down and as negative feelings and thoughts became overwhelming. Nearly half of all respondents had serious suicidal ideation. Many felt it would be impossible to get better, particularly when they had gone for a long time without treatment or support. They needed to be convinced to seek help and to keep living.

Respondents described feelings of shame, embarrassment and isolation. The majority had left school early and some had legal issues. Many were dependent on social welfare and struggling to engage with society. As a result of living in an area of urban deprivation, the norm for many included a troubled family, stressful life circumstances and a drug-taking culture. This made it more difficult for them to cope with their mental health and substance misuse issues.

The findings from this study outlined progressively deteriorating symptoms, social isolation and stigmatisation among the young people interviewed. It highlighted the need for interventions which enhance early identification and treatment of mental health and substance use disorders in young people living in urban deprived areas. These interventions need to be delivered in an environment that is accessible and acceptable. General practice was identified as a less stigmatising environment than others owing to its availability to and familiarity with disadvantaged young people, and its ability to provide young people who present with physical problems with support around their mental health and substance misuse issues.

(Margaret Curtin)

1. Schaffalitzky E, Leahy D et al. (2014) 'Nobody really gets it': a qualitative exploration of youth mental health in deprived urban areas. *Early Intervention in Psychiatry.* Early online. http://www.drugsandalcohol.ie/22191

Supporting children in families experiencing mental health difficulties

In June 2014 Barnardos published a report outlining the experiences of children of parents with mental health difficulties, reviewing current levels of support and making recommendations for enhancing services.[1] The report reviews the relevant literature and draws on discussions with parents, carers and professionals in the mental health area.

The report emphasises that parental mental health difficulties alone present little risk of harm to children but that a lack of appropriate supports can compromise a child's ability to cope. However, parental mental health difficulties are often associated with other risk factors such as poverty or addiction, which can have a huge impact on family life. As a

Children in families experiencing mental health difficulties *(continued)*

result, a child's social, emotional and cognitive development can be adversely affected. Children are affected by their parents' mood and can become anxious and unsettled, particularly if the situation has not been explained to them by a supportive adult in an age-appropriate way. Moreover, many children take on an unrecognised caring role in the family.

Entrenched societal attitudes and discrimination mean that parents are often reluctant to ask for help as they fear that their capacity to parent their children will be questioned. Moreover, the current, predominantly medical, approach to mental health leads to a reliance on medication and does not adequately address broader family support needs. As a result, parents and children can feel isolated and the root cause of the distress can be overlooked. Side-effects of medication can further compound problems, for example when parents who are taking benzodiazepines or other medication experience drowsiness and slowed reactions which compromise their ability to respond to their children's needs.

The report calls for a holistic approach to supporting families facing complex challenges, whereby each family member is heard and their needs considered. Barnardos believe that the present family, health and child support systems need to move from a traditional approach of working in isolation to an integrated inter-agency working model which recognises patients as parents and sees parents and children in a family context, i.e. a family model approach. Key recommendations include:

- challenge mental health prejudice and discrimination,
- adopt a family model approach,
- talk to children,
- expedite the roll-out of community-based services, and
- consult with parents affected by poor mental health.

(Margaret Curtin)

1. Barnardos (2014) *Patients. parents. people. Towards integrated supports and services for families experiencing mental health difficulties.* Dublin: Barnardos. www.drugsandalcohol.ie/22129

Therapeutic communities in Europe

The EMCDDA has recently published a report on therapeutic communities (TCs) in Europe.[1] TCs are represented in most European countries but the majority of the 1,200 TCs identified in the study were reported from Italy. Typically, TCs have a small number of residents (between 15 and 25) and length of treatment ranges from 6 to 12 months. In response to changing needs many TCs in Europe have adapted, offering shorter programmes often tailored for a specific group, e.g. prison-based TCs. However, across Europe many TCs have been negatively affected by funding reductions (with the exception of France).

The study reviewed the available literature from both Europe and North America. While there are limitations due to the methodologies, in general European studies have reported positive findings, often linked to retention in, and completion of, treatment. The American studies reported widely varying levels of retention in TC treatment, and in general the results from that region showed that TCs are overall less effective in relation to retention in treatment than other types of interventions. Both European and North American studies of individuals who had participated in prison-based TCs showed lower levels of recidivism. The authors of the EMCDDA report conclude that the evidence base for TCs needs to be improved, with, for example, more robust research methodologies such as randomised controlled trials. The authors also suggest studying outcomes for those TCs who include residents who are also on opiate substitution treatment.

Another focus of the report is service standards and quality assurance related to the implementation of evidence-based guidelines. Complying with set standards is acknowledged as challenging for TCs, given the complex and changing TC environment. However, several countries have developed their own general guidelines and three international instruments are also available. The authors believe that TCs are open to this process but recommend that knowledge and best practice be shared between countries to assist those countries with fewer resources. This would also help to reduce the amount of heterogeneity between TC programmes in different countries. The authors conclude that this quality process is vital in determining the future of TC programmes in Europe.

(Suzi Lyons)

1. Vanderplasschen W, Vandevelde S, Broekaert E (2014) *Therapeutic communities for treating addictions in Europe: Evidence, current practices and future challenges.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction. www.drugsandalcohol.ie/21770

Pharmacist–patient structured methadone detoxification in Mountjoy Prison

A recently completed review analyses the outcome of pharmacist–patient structured methadone detoxification in Mountjoy Prison between June 2010 and May 2014.

Drug treatment pharmacists were introduced in Mountjoy Prison in 2008, primarily to ensure the safe, accurate and efficient dispensing of methadone. The pharmacists currently dispense in 13 different locations in the Mountjoy complex. While the safe dispensing of methadone remains the priority, since 2010 pharmacists have also been supervising and managing pharmacist–patient structured methadone detoxification, otherwise known as self-directed detoxification (SDD).

Unlike other detoxification regimes, which are prescribed and have a fixed regime, SDD allows prisoners to opt to detoxify at times when they feel they are ready for and capable of change. The pharmacists offer SDD in 12 locations within the Mountjoy Prison Complex (excluding Dochas Women's Prison). All SDDs must be requested 24 hours in advance by the prisoner in order to eliminate impulsive decisions. SDD may be undertaken if it is deemed clinically appropriate and is provided within certain parameters, i.e. up to a maximum amount, which reduces each week, and is communicated to the addiction specialist doctor. The addiction specialist writes up the prescription weekly. If, at a later date, the prisoner chooses to return to their previous dose (increase their consumption), they must see the addiction specialist. The prisoner is supervised on a daily basis by the pharmacist so any changes in demeanour and behaviour can be easily observed by a professional familiar with them and interventions can be made where appropriate.

Anecdotally this system has proved successful. However, it was decided to conduct the review in order to determine the exact number of prisoners involved in SDD and assess the outcomes. This review analysed the outcome of pharmacist–patient structured methadone detoxification in Mountjoy Prison between June 2010 and May 2014.

Methods

Three different cohorts of prisoners were chosen for the purposes of the review:

1. Those on methadone maintenance therapy (MMT) who reduced their maintenance dose by over 20mls (or 50% of their dose) between their committal to Mountjoy and their final movement out of Mountjoy. This cohort included those who returned to the community or were transferred to another prison.
2. Those on MMT who detoxified completely and came off methadone while in custody in Mountjoy. For the purposes of the review, a prisoner on MMT was considered detoxified when sequentially reduced to a prescribed dose of 7mls or under. At this dosage, a prisoner will often stop their methadone completely but get prescribed lofexidine or another drug to aid with any symptoms of withdrawal.
3. Those receiving lofexidine therapy as an adjunct to SDD.

The review excluded two cohorts of prisoners:

- Prisoners who were in receipt of MMT but who were in custody in Mountjoy for only a short period of time (less than 60 days consecutive days).
- Prisoners who were prescribed a '21-day standard detoxification'. This group were not in receipt of any MMT prescription but tested positive for opiates and/or methadone and did not have an MMT clinic place externally. The prison can only offer a '21-day standard detoxification' until a clinic place is confirmed for when they are released to continue their care. This regime consists of 20mls methadone for two days, 30mls for four days, and then a 5mls dose reduction every three days to zero. As such their dose reductions cannot be considered an SDD.

Data pertaining to all methadone and lofexidine prescriptions in Mountjoy Prison during the period June 2010 to May 2014 were examined. The number of prisoners eligible for inclusion in the study were as follows:

Methadone – 13,698 prescriptions, of which:

- 572 prescriptions were for '21-day standard detoxifications'. This equated to 390 prisoners who were excluded from the review.
- 13,126 prescriptions were for 1,207 prisoners on MMT. Of these, 405 were excluded as they had not been in custody in Mountjoy for 60 or more consecutive days.
- In total, 805 prisoners were included in the review.

Lofexidine – 138 prescriptions.

Results

Of the 805 prisoners on MMT included in the review, 416 (52%) chose to undertake SDD. Of these, 202 (49%) reduced their MMT dose by a significant amount of 20mls or more, and 214 (51%) detoxified off MMT completely while in Mountjoy. Of the 214 who detoxified off methadone completely:

- 134 (63%) used lofexidine to complete their SDD. Four prisoners had two courses of lofexidine but have also completed SDD successfully.
- 80 (37%) did not use lofexidine to complete their detoxification but did the programme to completion with the support of the pharmacists.
- 27 (13%) either relapsed temporarily or went back on MMT.

Pharmacist–patient structured methadone detoxification *(continued)*

Conclusions

- The practice of SDD through the pharmacists is routine in Mountjoy prison.
- Over half of all prisoners prescribed methadone (for 60 or more consecutive days) in Mountjoy were able to reduce their methadone dose significantly using SDD.
- Half the prisoners who undertook SDD were able to detoxify completely off methadone while in Mountjoy.
- Lofexidine as an adjunct to MMT, to treat withdrawal symptoms, was used by 63% of those who chose to undertake SDD to complete their detoxification.
- Over a third of those who undertook SDD chose to complete their detoxification without lofexidine and completed it in the main prison with the support of the drug treatment pharmacists.
- At least 13% of prisoners who underwent SDD and detoxified completely relapsed, some only temporarily.
- Information on what happened to the prisoners on release from Mountjoy is not known, e.g. did they relapse or return to treatment? It would be important to investigate this in order to gauge the overall success of the programme. This would require a further study using the HSE's Central Treatment List.

The review was done by Brian Cronin BSc (Pharm), MPSI, and Gordon Ryan BSc (Pharm), MPSI, both of whom work as Drug Treatment Pharmacists in Mountjoy Prison, with assistance from Suzi Lyons, Health Research Board.

Women in prison

A position paper by the Irish Penal Reform Trust (IPRT)[1] calls for a non-custodial approach to be adopted for women offenders and, in the few cases where prison is necessary, for the negative impact of imprisonment on women, and those they care for, to be minimised.[2]

The position paper begins with a review of recent trends in the imprisonment of women in Ireland. In the past decade, the number of women imprisoned has doubled while community-based alternatives remain under-explored. The number of women imprisoned has increased from 1,459 in 2009, representing 11.8% of the prison population, to 2,151 in 2012, representing 15.1% of the total prison population. Most women are committed to prison for defaulting on fines, with the bulk of the remainder imprisoned for non-violent offences against property or for theft or road traffic offences. According to the position paper, 'in 2012, out of 2,071 female committals under sentence, 1,687 were for non-payment of court-ordered fines' (p. 4).

As a consequence of the high rates of female imprisonment, female prisons are over-crowded. In January 2011, for example, the Dóchas Centre, opened in Dublin in 1999 as a model women's prison, was operating at 64% over capacity. A more recent report on the Dóchas Centre by the Inspector of Prisons states: 'On the 19th June 2013 there were 141 prisoners in the centre, when the maximum should have been 105' (p. 9). [3] According to the position paper, the other female prison in Ireland, based in Limerick, is also overcrowded, 'with doubling up taking place in up to 10 of the 24 cells' (p. 5), cells which are designed and only suitable for single occupancy.

The report goes on to examine the complex needs of many women convicted of offences and the excessive use of remand for such offenders. Furthermore, many of the women are caring for children and other dependent relatives. The range of needs is summarised as follows:

> *Women offenders tend to come from a background of social disadvantage and poverty, and often suffer from mental health problems, substance dependency, accommodation problems and poor family relationships. These issues can make it difficult for women to adhere to bail conditions, which has led to an overuse of remand for women offenders. This in turn has negative implications for children of women who are imprisoned on remand and the employment prospects of these women….*
>
> *A high proportion of women in prison have children. Women also play an important role in caring for dependent relatives. Women who are imprisoned can no longer fulfil their caring responsibilities and the consequences of this can be significant. This is particularly an issue for mothers with babies due to the absence of a mother and baby unit.* (pp. 11–12)

Problems associated with substance misuse among women offenders are not related just to drug dependency. The Inspector's report on the Dóchas Centre highlights the 'serious problems of drugs in the centre'. The IPRT position paper outlines a number of challenges faced by women leaving prison, particularly related to housing, accommodation and stability, with women ex-prisoners 'at high risk of reoffending'.

The IPRT position paper reviews some emerging models of good practice in other jurisdictions, focusing in particular on community-based approaches to women offenders. It also considers models recently developed in Ireland. It concludes with two recommendations:

1. In relation to adopting a non-custodial approach for women offenders, future policy and legislative development should be informed by a number of principles, including the following:
   - Where a woman is accused of a minor, non-violent offence, the default position should be that she will have a non-custodial sanction imposed…such as community service orders, gender-specific diversion programmes, and holistic support services in the community.
   - If a person convicted of an offence is the primary carer of young children, an issue that affects more female than male offenders, the best interests of the children should always be taken into account as a key consideration in determining an appropriate sentence.
2. In order to minimise the negative effects of imprisonment on 'the small number of cases where prison is necessary for women who have been convicted of an offence', and their families, a number of reforms are needed, including:
   - establishing a truly open prison for women,
   - addressing overcrowding in both female prisons,
   - introducing mother and baby units at Limerick prison, and

Women in prison *(continued)*

- ensuring visiting facilities are non-threatening, child-friendly and permit physical contact and play.

On foot of the IPRT position paper, in early 2014 the Probation Service and the Irish Prison Service published a joint strategy entitled *An effective response to women who offend.*[4] This strategy commits both services to developing a 'range of options which provide an effective alternative to custody, enhance reintegration and reduce re-offending' and to promote 'awareness and confidence amongst key stakeholders of the significant role of community sanctions in the reduction of re-offending by women' (p. 7).

(Johnny Connolly)

1. The IPRT is a non-governmental organisation campaigning for the rights of people in the penal system in Ireland, with prison as the last resort. www.iprt.ie
2. Irish Penal Reform Trust (2013) Women in the criminal justice system: towards a non-custodial approach. Dublin: Irish Penal Reform Trust. http://www.drugsandalcohol.ie/21019/
3. Reilly M (2013) Interim report on the Dóchas Centre by the Inspector of Prisons. Dublin: Department of Justice and Equality. http://www.drugsandalcohol.ie/21006/
4. Probation Service and Irish Prison Service (2014) Joint Probation Service – Irish Prison Service strategy 2014–2016: an effective response to women who offend. Dublin: Probation Service and Irish Prison Service. http://www.drugsandalcohol.ie/21496/

Effective team-working in mental health services

Twomey and colleagues[1] undertook a brief and selective review to identify how effective team-working can be achieved within Community Mental Health Teams (CMHTs), in the context of recovery-focused care. They reviewed relevant Irish policy documents and other papers available within the Irish context.

The review is contextualised within a number of recent policy pronouncements from the Mental Health Commission, the Department of Health and the Health Service Executive, which have called on practitioners to implement recovery-focused care in mental health services in order to empower service users to take control of their own recovery. Central to this approach is the understanding that service users will outline their needs to service providers and the latter will work to implement an effective response to these needs and identify and implement additional supports when appropriate. The authors undertook the review based on the belief that effective team-working within CMHTs is an integral part of delivering recovery-focused care.

The authors identify four factors which they suggest need to be considered when seeking to provide an effective team-working group: team development, team environment, team structure and team process (see Table 1). They see these factors as evolving over time.

(Martin Keane)

1. Twomey C, Byrne M and Leahy T (2014) Steps towards effective team-working in Community Mental Health Teams. *Irish Journal of Psychological Medicine* 31 (1): 51–59. http://www.drugsandalcohol.ie/21419/

Table 1: Factors to consider in implementing effective team-working in mental health services

Team development	Team environment (Develop a flexible recovery model that)	Team structure	Team process
Forming: getting to know each other	Contains relevant interventions	The level of service user involvement	Referral pathways
Storming: resolving differences and scoping degrees of consensus	Empowers service users	Governance structures	Cycle of work
Norming: focusing on current agreed aims and objectives.	Defines recovery as personal to service users	Clinical responsibility	Workload distribution
Performing: implementing agreed programme of work.	Allows for holistic interventions	Team skills mix	Communication
	Values the voice and expertise of service users	Team leadership style	Supervision
			Staff training
			Evaluating teamwork

Source: Adapted from Twomey et al. (2014) [1]

Recent Publications

Journal Articles

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

Pregabalin abuse for enhancing sexual performance: case discussion and literature review

Osman, M and Casey, P, *Irish Journal of Psychological Medicine*, 2014, Early online

http://www.drugsandalcohol.ie/22563/

Pregabalin is a aminobutyric acid analogue that is primarily prescribed in psychiatry for management of generalised anxiety disorder. The belief in its low potential for abuse has placed it in a superior position to other anxiolytic agents. However, more recently, concerns have been raised about the addictive potential of pregabalin. This problem has not received much attention nor has the mechanism of its development. There is also a lack of understanding of the difference in the experience of abusing pregabalin in contrast to abusing other illicit drugs. The authors report the case of a 55-year-old patient with a background history of multiple psychoactive substances misuse who elaborated on his own personal experience of pregabalin abuse. He consumed a month's supply of this medication over two days and realised an enhancement in sexual desire and excitement. This effect should be considered when prescribing pregabalin.

Support for a tobacco endgame strategy in 18 European countries

Gallus, Silvano et al. *Preventive Medicine*, 2014, Early online

http://www.drugsandalcohol.ie/22548/

The feasibility of a tobacco endgame strategy, aiming to bring smoking prevalence to near-zero levels, is currently under debate. The authors provide information on public support for such a strategy in Europe. Overall, 34.9% of adults (32.8% of men and 37.0% of women; p<0.001) supported a complete-ban strategy on use or sale of tobacco, 41.2% of never, 29.4% of ex- and 25.6% of current smokers. The highest support was observed in southern Europe (42.5%), followed by eastern (39.1%), northern (27.5%) and western Europe (23.0%; p<0.001). A significant inverse trend was observed with both age and education. Approximately one in three adults (and one in four smokers) supports a comprehensive tobacco endgame intervention. This first study in Europe provides a baseline for evaluating future trends in public support for extreme propositions to end or drastically cut smoking.

Impact of smoking on response to systemic treatment in patients with psoriasis: a retrospective case-control study

Kinahen, CE, Mazloom, S and Fernandez, AP, *British Journal of Dermatology*, 2014, Early online

http://www.drugsandalcohol.ie/22547/

Smoking is a well-established risk factor for developing psoriasis and is associated with development of more severe disease. Smoking cessation does not appear to result in clinical improvement of psoriasis. Whether smoking in psoriatic patients impacts response to systemic therapy is unknown.

Use of addiction treatment services by Irish youth: does place of residence matter?

Murphy, KD et al. *Rural and Remote Health*, 2014 (14): 27–35.

http://www.drugsandalcohol.ie/22461/

This study examined data from a substance abuse treatment centre that treats both urban and rural attendees to investigate if there are differences in usage patterns between attendee groups. A cross-sectional study was done of 436 service-users attending a treatment centre: patient characteristics, treatment referral details and substance history of the attendees from urban and rural areas were compared. Descriptive analysis of the service-user population was performed and recent substance use was investigated. Inferential tests examined for differences between urban and rural service-users. This is the first Irish study comparing service-users from urban and rural settings. Rural service-users developed more problematic alcohol use, while more urban service-users were referred for benzodiazepine use. Prevention strategies should acknowledge the differences and similarities in urban and rural young people.

Urban overdose hotspots: a 12-month prospective study in Dublin ambulance services

Klimas, Jan et al. *The American Journal of Emergency Medicine*, accepted manuscript. 2014 (In Press)

http://www.drugsandalcohol.ie/22440/

Opioid overdose is the primary cause of death among drug users globally. Personal and social determinants of overdose have been studied before, but the environmental factors lacked research attention. Area deprivation or presence of addiction clinics may contribute to overdose. This study examines the baseline incidence of all new opioid overdoses in an ambulance service, and their relationship with urban deprivation and presence of addiction services. The identified clusters of increased incidence – urban overdose hotspots – suggest a link between environment characteristics and overdoses. This highlights a need to establish overdose education and naloxone distribution in the overdose hotspots.

Oral health behaviours amongst homeless people attending rehabilitation services in Ireland.

Van Hout, Marie Claire and Hearne, Evelyn, *Dental Association*, (2014) 60 (3). pp. 144-149.

http://www.drugsandalcohol.ie/22431/

Research on oral health behaviours and dental care service uptake of drug users and those in recovery remains scant. The research aimed to explore and describe perspectives of drug users on their oral health behaviours, awareness of oral health complications caused by alcohol, cigarette and drug use, dental service uptake and opinions on improved dental service for active and recovering addicts. Participants described barriers to access and uptake, poor levels of preventative dental care, DIY dentistry in the event of dental emergencies, substance use to self-medicate for dental pain, mixed awareness of the effects of sugary products and substance use on oral health and cancers, and emphasised the importance of preventative dental care and dental aesthetics when in recovery. The findings illustrate a profile of oral health behaviours in Irish drug users, with information

useful for private and public practice, and in the further development of street, community and treatment setting oral health interventions.

Does social disadvantage over the life-course account for alcohol and tobacco use in Irish people? Birth cohort study

Das-Munshi, Jayati et al. *European Journal of Public Health*, 2014, 24 (4).

http://www.drugsandalcohol.ie/22385/

Few studies have examined how the settlement experiences of migrant parents might impact on the downstream adult health of second-generation minority ethnic children. We used prospective data to establish if childhood adversity relating to the settlement experiences of Irish-born parents might account for downstream adverse health-related behaviours in second-generation Irish respondents in adulthood. Design, setting and participants: Cohort data from the National Child Development Study, comprising 17,000 births from a single week in 1958, from Britain, were analysed. Respondents were followed to mid-life. Dependent variables were alcohol and tobacco use. The contribution of life-course experiences in accounting for health-related behaviours was examined.

Relative to the rest of the cohort, the prevalence of harmful/hazardous alcohol use was elevated in early adulthood for second-generation men and women, although it reduced by age 42. Second-generation Irish men were more likely to report binge alcohol use (odds ratio 1.45; 95% confidence interval 0.99, 2.11; P = 0.05), and second-generation Irish women were more likely to smoke (odds ratio 1.67; 95% confidence interval 1.23, 2.23; P = 0.001), at mid-life. Childhood disadvantage partially mediated associations between second-generation Irish status and mid-life alcohol and tobacco use, although these were modest for associations with smoking in Irish women. The findings suggest mechanisms for the intergenerational 'transmission' of health disadvantage in migrant groups, across generations. More attention needs to focus on the public health legacy of inequalities transferring from one migrant generation to the next.

Alcohol consumption in pregnancy: results from the general practice setting

Ni Shuilleabhain, A et al. *Irish Journal of Medical Science*, 2014, 183 (2). pp. 231-240.

http://www.drugsandalcohol.ie/20464/

There is no established safe level of alcohol consumption in pregnancy. Studies from Ireland have consistently shown lower abstention and higher binge drinking rates in pregnancy than other countries, indicating a high potential for foetal alcohol-related disorders. There has been little research on alcohol in pregnancy in primary care. The aim of study was to determine the prevalence of alcohol consumption amongst pregnant women attending their GP for antenatal care, and to compare this to use in the year prior to conception. Prospective cross-sectional study was carried out in fifteen teaching practices in the greater Dublin area. Women were recruited at their antenatal visits. Data were gathered by self-completed questionnaire in the practice, or researcher-administered telephone questionnaire. The questionnaire was based on the AUDIT, a WHO-validated data collection instrument designed for use in primary care.

Two hundred and forty valid questionnaires were returned (80% recruitment rate). Alcohol intake and binge drinking levels were much lower during pregnancy compared to the year prior to pregnancy ($p < 0.001$). There was a marked reduction in the prevalence of alcohol use in pregnancy compared to previous research. Over 97% drink no more than once a week, including almost two-thirds of women who abstain totally from alcohol in pregnancy. Non-pregnant Irish women drink alcohol more frequently, and with higher rates of binge drinking, than women of other nationalities. Primary care is a suitable setting to research alcohol use in pregnancy. Alcohol use in pregnancy in Ireland has decreased markedly compared to previous research from this jurisdiction.

Children's awareness of alcohol sponsorship of sport in Ireland: Munster Rugby and the 2008 European Rugby Cup

Houghton, Frank et al. *International Journal of Public Health*, 2014, Early online

http://www.drugsandalcohol.ie/22057/

This study examined children's awareness of sport sponsorship in Ireland, focussing on the 2008 European Rugby Cup win by Munster Rugby. Following the Munster Rugby win in 2008, a cross-sectional sample of 1,175 children (7–13 years) in 11 National Schools in Ireland were asked which company sponsored "the cup that Munster won" and were then asked to name the product made by that company. The study found significantly higher level of awareness of the sponsor by children in Munster (69.9%) to those outside Munster (21.5%). No significant difference in the level of awareness of their product (alcohol) by location (inside Munster 75.9%, outside Munster 83.6%).

Upcoming Events

14 October 2014
Let's Talk: social inclusion week event
Venue: DLR County Council Assembly Hall

Web: http://www.activelink.ie/content/community-exchange/events/17165

Let's Talk are hosting a flagship event during Social Inclusion week on Tues 14th Oct in the DLR County Council Assembly Hall. During this all day event, many local and national organisations will be hosting stands and displaying posters and brochures outlining the services they provide. This event is aimed at parents and carers of teenagers and will cover a broad range of topics, like bullying/cyberbullying, drugs/alcohol, mental health, teenage behaviour, sport and body image.

17 October 2014
ACJRD conference "Youth justice transformation"
Venue: Camden Court Hotel, Dublin 2

Email: danelle.hannan@acjrd.ie

Web: http://www.acjrd.ie/

This one day conference will see international and national experts address "Youth Justice Transformation" in a number of plenary and workshop sessions. Opportunities will be provided throughout the day for delegates to share information, exchange views and network with colleagues who engage in similar or complementary areas of expertise. Chatham House Rules will apply for this conference, and it is therefore a 'closed' event.

This conference will appeal to policy makers, those working in government agencies, professionals, practitioners, academics and those involved in community and civil society groups from a wide range of disciplines within the Criminal Justice System. Non-members of ACJRD Ltd, are welcome to attend the Annual Conference.

11 November 2014
Alcohol Action Ireland conference 2014
Venue: Westin Hotel, Dublin 2

Web: http://alcoholireland.ie/

Girls, women and alcohol will be the focus of Alcohol Action Ireland's annual conference.

During the conference, expert speakers will examine the factors influencing alcohol consumption and drinking patterns among Irish girls and women, the health risks involved, as well as what we need to do to bring about a positive change to the current situation. Women will also share their personal experiences of alcohol with conference attendees.

03 December 2014
National Substance Misuse Conference 2014
Venue: Royal Marine Hotel, Dun Laoghaire

Web: http://www.cmgevents.ie/events/national-substance-misuse-conference-2014

This event will be looking at current and future drug policy in Ireland, which will give those working in the field a better understanding of what is happening in drug and alcohol services in Ireland. Challenges and potential innovations in service delivery will be discussed. Issues surrounding comorbidity of mental health, addiction and physical health will also be addressed, giving those working on the ground an understanding of the different options available to them and what current good practice is. The role of family members in addiction services will also be discussed on the day, with presentations on hidden harm and the five step method, looking at the professional responsibility of healthcare providers and how to determine best practise.