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Alcohol and Drug Research Newsletter

Comparing European drugs strategies

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Drug-related deaths & deaths among drug users, 2012

Dr Suzi Lyons and Ena Lyn of the Health Research Board at the launch of Drug-related deaths and deaths among drug users in Ireland 2012 in December.

The latest figures on drug-related deaths and deaths among drug users in Ireland, up to 2012, have been published.[1] The number of deaths has decreased slightly from 645 in 2011 to 633 in 2012. Of the total number of deaths in 2012, 350 people died as a result of poisoning (i.e. toxic effect of drug[s] in the body), and 283 were drug users who died as a result of trauma, such as hanging, or from a medical cause, for example liver disease. It is important to note that the figures in this update supersede all previously published figures. Similarly, figures for 2012 will be revised when data relating to new cases become available, i.e. as more inquest cases close. For example, in January 2014 the number of drug-related deaths for 2011 was 607, but over the past 11 months this has risen to the 645 figure we now have recorded.

In the nine-year period 2004–2012, a total of 5,289 deaths by drug poisoning and deaths among drug users met the criteria for inclusion in the National Drug-Related Deaths Index (NDRDI) database. Of these deaths, 3,112 were due to poisoning and 2,177 were deaths among drug users (non-poisoning) (Table 1). Deaths due to polydrug use have increased by 60% over the reporting period, from 118 in 2004 to 189 in 2012.

Poisoning deaths, 2012

The annual number of poisoning deaths decreased from 387 in 2011 to 350 in 2012 (Table 1). As in previous years, the majority (74%) in 2012 were male; the median age of those who died was 40 years, again similar to previous years.

In 2012, alcohol was, once again, the drug most commonly involved in poisoning deaths (36%). Prescription drugs played a significant part in poisoning deaths, with over a third (35%) of these deaths involving benzodiazepines. Methadone was implicated in a quarter of deaths, with the majority (87%) involving polydrugs. Antidepressants were implicated in a quarter (25%) of deaths, with females accounting for almost half (46%) of these deaths.

Joan Moore

Joan Moore, former content editor of *Drugnet Ireland*, died in January 2015. Joan had been one of the longest serving members of HRB staff and had spent most of the last 10 years working with the drug and alcohol research team. We greatly admired Joan's erudition and intellectual gifts and her skilful management of much of the HRB's published output and we know from her family that she brought the same enthusiasm and enjoyment of work to the practical tasks in her home. So, it is poignant that she never got to use her retirement present, a workbench on which she had planned to hone her carpentry skills with the same diligence as she used to keep abreast of developments in editing and scientific communication.

Joan loved language and writing and was drawn to the silly and absurd and great story telling of every kind from *The loved one* and *Scoop*, an obvious favourite for an editor, to the wonderful *Yon lion's et our Albert*. We lost her technical gifts when she retired but it is her wit and wisdom that we now remember most. She was genuinely interested in and concerned with the minutiae of her workmates' lives and willingly shared the joys and concerns of her own beloved family. To them, Paul her husband, Tim her son and our good friend Katie, her daughter, we express our deepest sympathies.

Brian Galvin

Contents

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Drug-related deaths 2012 *(continued)*

	2004	2005	2006	2007	2008	2009	2010	2011	2012
All deaths	432	505	561	626	626	656	605	645	633
Poisonings (3,112)	267	300	325	382	386	374	341	387	350
Non-poisoning (2,177)	165	205	236	244	240	282	264	258	283

Table 1: Number of deaths, NDRDI 2004–2012 (n=5,289)

The number of poisoning deaths in which heroin was implicated continues to decline, falling by 47% to 61 in 2012, compared to a peak of 115 in 2009.

Over half (54%) of all poisoning deaths in 2012 involved more than one drug (polydrug use). Over a third (37%) of those who died from poisoning in 2012 had a history of mental illness.

Non-poisoning deaths, 2012

The number of non-poisoning deaths recorded among drug users increased to 283, compared to 258 in 2011 (Table 1). Where the specific cause of death is known, these deaths are categorised as being due to either trauma or medical causes (Figure 1).

Deaths due to trauma

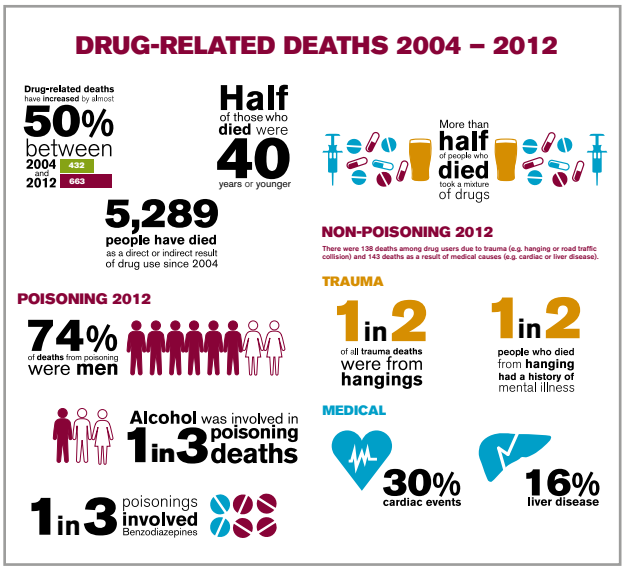
The number of deaths due to trauma increased in 2012 to 138 deaths from 124 in 2011, an increase of 11% (Figure 1). The majority (72%) of those who died were aged under 39 years. The median age was 29 years. As in previous years, the majority (82%) were male. The most common causes of death due to trauma were hanging (52%) and drowning (14%). Of note is the increasing number of deaths due to hanging, from 53 deaths in 2010 to 72 in 2012. Over half (52%) of those who died from traumatic causes in 2012 had a history of mental illness.

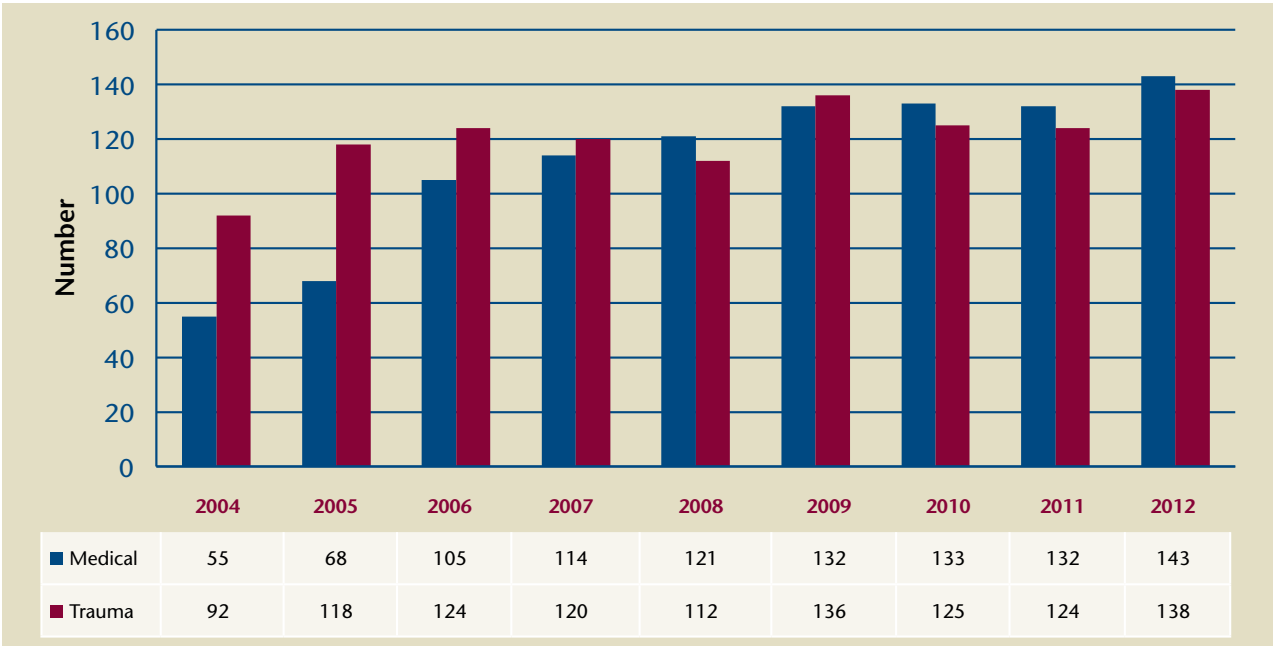
Deaths due to medical causes

The number of deaths due to medical causes increased by 8% in 2012 to 143 deaths, from 132 in 2011 (Figure 1). The majority of those who died (67%) were aged between 35 and 59 years. The median age was 46 years. Males accounted for 70% of those who died due to medical causes. The most common medical causes of death were cardiac events (31%) and liver diseases (16%).

(Ena Lynn)

1. Health Research Board (2014) *Drug-related deaths and deaths among drug users in Ireland: 2012 figures from the National Drug-Related Deaths Index.* http://www.drugsandalcohol.ie/23003





	2004	2005	2006	2007	2008	2009	2010	2011	2012
Medical	55	68	105	114	121	132	133	132	143
Trauma	92	118	124	120	112	136	125	124	138

Figure 1: Non-poisoning deaths among drug users, NDRDI 2004–2012 (n=2,092)

16th annual Service of Commemoration and Hope

On Sunday 1 February 2015 the National Family Support Network (NFSN) held its 16th annual Service of Commemoration and Hope in remembrance of loved ones lost to substance misuse and related causes. Its purpose is to publicly support and offer hope to families living with the devastation that substance misuse causes.

Those in attendance included the Lord Mayor of Dublin, Christy Burke; Commander Kieran Carey, aide-de-camp to the Taoiseach; Garda Commissioner Noirín O'Sullivan; Bishop Éamonn Walsh, Auxiliary Bishop of Dublin, and other religious representatives; and family members, friends, and many people working in the drugs area. Music was provided by the soprano Linda Allen and the North Dublin Community Gospel Choir.

In her address to the gathering, Sadie Grace of the NFSN spoke about the latest report from the National Drug-Related Deaths (NDRDI). For the period 2004 to 2012 a total of 5,289 deaths were recorded by the NDRDI. Of these deaths, 3,112 were due to poisoning and 2,177 were deaths among drug users. She spoke about the increase in deaths due to polydrug use and the fact that the majority of those who died were young men.

Sadie Grace also spoke about the compounding factors affecting bereaved families, such as media coverage, increased financial difficulties and single parents or grandparents taking on caring responsibilities for young children. She mentioned the role of naloxone in preventing deaths from opiate overdose and the NFSN's support for the HSE naloxone demonstration project. She stressed the importance of expanding the availability of naloxone nationwide. The NFSN will be presenting Minister for Health Leo Varadkar with a petition requesting nationwide availability of naloxone.

In his reflection, Fr Edmond Grace SJ talked about the pain families have gone through and the need to acknowledge the loss but also to build on the strength of hope. Sandra Hill, a member of the NFSN Bereavement Support Group, gave a moving testimony about her positive experience as part of this group in dealing with the death of her brother. She sincerely acknowledged the tremendous work of the NFSN Bereavement Support Group and encouraged family members looking for help to contact the NFSN.

Poet and playwright Paula Meehan recited her poem 'Pray for the children of longing'. Susan Scally of the Drugs Policy Unit read a message on behalf of Pope Francis. Kenny Hartnett, chair of SURF (Service Users' Representative Forum), gave an honest and emotional speech about his experience as a drug user. In his address on behalf of Archbishop Diarmuid Martin, Bishop Éamonn Walsh spoke about the importance of acknowledging and never losing sight of the dignity of every person. Daniella Jurj of the New Communities Partnership recited a poem of hope, 'Seasons of Grief'. Sister Geraldine Byrne of The Oasis Centre,a professional counselling and therapy service in Dublin, spoke about how every bereavement is a very personal and individual experience. She encouraged people affected by bereavement to seek support.

(Ena Lynn)

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How does Ireland's drugs policy compare with others?

Two studies comparing the drug policies of different European countries, including Ireland, have recently been published. One compares the 'governance' of addictions across the member states of the EU and Norway, and the other examines the 'coherency' of policies on psychoactive substances (illicit drugs, alcohol and tobacco) across seven member states of the Council of Europe.

The governance of addictions

This comparative assessment was undertaken by ALICE RAP (Addictions and Lifestyles in Contemporary Europe – Reframing Addictions Project), a European research project, co-financed by the European Commission.[1] ALICE RAP's assessment was premised on the argument that addictions inflict an excessive burden not only on individuals but also on societies as a whole. Moreover, in the 21st century, Western societies are being forced to adjust their policies to new realities which include a growing diversity of consumption scenarios, their progressive normalisation in some contexts and even their trivialisation in others. The comparative assessment sought to discover, to what extent do the policies of different member states respond to the new and emerging circumstances.

The authors used 'strategy' and 'structure' to analyse similarities and differences (the degree of 'convergence') between member states' addiction policies. They asked a question in relation to each of these two dimensions of governance, linking them to the content of the policy and the extent to which individual member states are pursuing a 'traditional' as opposed to more innovative approaches.

- *Strategy*: To what extent does the strategy adopt a 'safety-and-disease' focus or display a wider interest in 'relational management of well-being' across society as a whole?
- *Structure*: What substances are included in the strategy, and does it expand beyond misuse of addictive substances to encompass addictive activities such as gambling?

Comparing national drugs policies *(continued)*

Table 1: Models of governance of addictions in Europe

Model	Characteristics	Countries
Trend-setters in illicit substances	Combine a well-being and relational management strategy with a comprehensive structure. Focus on illicit substances through harm reduction. Low rankers on legal policy scales.	Belgium, Czech Republic, Germany, Italy, Luxemburg, Netherlands, Portugal and Spain
Regulation of legal substances	Combine a well-being and rational management structure. Focus on legal substances (tobacco and alcohol). No decriminalisation of possession.	Finland, France, Ireland, Norway, Sweden and UK
Transitioning model	Countries transitioning, mostly from the traditional model to a more comprehensive one, but still with a substance separation approach. Do not decriminalise possession.	Austria, Bulgaria, Cyprus, Denmark, Poland and Slovenia
Traditional approach	These countries embrace an individualistic and safety- and disease-based approach, combined with and organisational structure based on approaching substances separately.	Estonia, Greece, Hungary, Latvia, Lithuania, Malta, Romania and Slovakia

Source: Table 8.1 in Ysa *et al.*[1]

The authors identified four clusters of countries, reflecting four different models of 'governance of addictions'. Ireland is deemed to be in a handy enough position but is not among Europe's 'trend-setters' (see Table 1).

The authors see the first model – 'Trend-setters in illicit substances' – as the model towards which all countries might consider aspiring. This model is characterised mainly by its strategy for illicit substances, giving considerable importance to harm reduction policies such as needle exchanges and injection rooms. Another distinguishing characteristic is that all eight countries linked with this model decriminalise possession of illicit substances.

With regard to the six countries linked to the second model, including Ireland, the authors see these countries as having developed 'a regulatory approach to licit substances and loose measures to combat illicit substances'. They attribute these two separate trajectories to the heavy consumption of alcohol in these jurisdictions. The authors also note that these are the six countries in the sample that use evidence-based regulation on alcohol and tobacco, but that only the United Kingdom consistently implements best-practice interventions. Moreover, the countries associated with model 2 do not implement as many innovative policies as the countries associated with model 1, and neither are they as proactive.

With regard to 'structure', the countries linked with model 2 are all classified as having a comprehensive policy-making structure, tending to combine legal and illicit substances, involving non-profit organisations in decision-making, having an *ad hoc* co-ordinating body, decentralising implementation, and having a long history of legislating for illicit substances. The authors conclude that these countries, including Ireland, could build on their comprehensive structure and their well-being and relational management approach, by extending it towards illicit substances (see Figure 1).

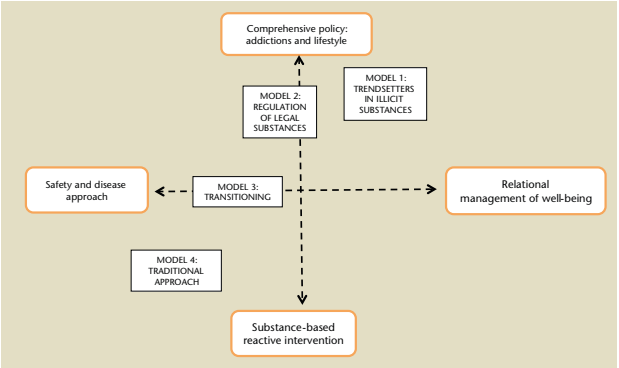


Figure 1: Governance of addictions: European models and visions

Source: after Figure 8.2 in Ysa *et al.* 2014[1]

Coherency of policies on psychoactive substances

The second comparative assessment, undertaken by the Council of Europe's Pompidou Group, whose mission is to contribute to the development of multidisciplinary, innovative, effective and evidence-based drug policies in member states, similarly found that Ireland is in a handy enough position, but is not at the forefront, in relation to the coherency of its policies on different psychoactive substances, namely illicit drugs, alcohol and tobacco.[2] The assessment comprises a series of case studies; the authors of each case study assessed the coherency of the policies in their country in relation to the World Health Organization's overarching population-based health goal – 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

The case study on Ireland shows that, of the three national policies on psychoactive substances, tobacco is the one most consistently aligned with a population-based approach to health. Two initiatives that will shift alcohol policy in Ireland closer to a population-based approach are noted: (1) in 2012 the National Substance Misuse Strategy Steering Committee published its report, calling for a population-based approach to alcohol misuse, and (2) in 2013 the first public health bill in Ireland to focus on alcohol measures was being drafted. At the time of going to press, however, neither initiative had been fully implemented. The case study reports a population-based approach in the planned response to problematic drug use. However, because of the criminal activity, public disorder, anti-social behaviour and violence that may be associated with illicit drugs, criminal justice responses have been adopted as well. While these latter measures may achieve the desired criminal justice outcomes, the report observes that they undermine the move towards a population-based approach to health by criminalising and/or stigmatising problem drug users.

The case study on Ireland concludes:

> *This continuing lack of coherence among policies on various psychoactive substances, particularly alcohol and illicit drugs, in relation to an over-arching population-health objective, may be expected to hinder the realisation of 'a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity' among the Irish population.* (p. 189)

(Brigid Pike)

1. Ysa T, Colom J, Albareda A, Ramon A, Carrion M and Segura L (2014) *Governance of addictions: European public policies*. Oxford: Oxford University Press. For more information on ALICE RAP, visit http://www.alicerap.eu.
2. Muscat R, Pike B and members of the Coherent Policy Expert Group (2014) *Coherence policy markers for psychoactive substances*. Strasbourg: Council of Europe Publishing. http://www.coe.int/T/DG3/Pompidou/default_en.asp

Women and non-medical use of prescription drugs (NMUPD)

Understanding the gender dimension of drug use and drug use disorders is a critical requirement in developing effective policy and practice. A ground-breaking study by the Council of Europe's Pompidou Group investigates women's use of prescription drugs for non-medical reasons, i.e. women who have been prescribed a medication by a doctor but are continuing to use it without the doctor's approval, OR they have obtained the medication from somebody else, not an authorised prescriber.[1]

The aims of the study are to:

- explore gender differences in NMUPD in Europe and the Mediterranean region through a documentation of secondary sources, with the aim of constructing a snapshot of the current scenario;
- identify gaps in the data available; and
- make recommendations for further research, for policy development and practice.

Following a literature review, a survey questionnaire was developed and administered to respondents in 17 countries: Cyprus, Czech Republic, Egypt, France, Germany, Greece, Ireland, Israel, Italy, Lebanon, Lithuania, Malta, Morocco, Serbia, The Netherlands, Tunisia and Wales (see map).

Findings

The literature review shows that women are a high-risk category for non-medical use of prescription drugs, and that the pattern of use is different among men and women; the pattern of use and non-medical use varies according to the category of prescription medication; and trauma and interpersonal violence may be causal factors leading to non-medical use of prescription drugs among women.

The data submitted by the 17 countries show that, in the general population, the use of prescription drugs is higher among females than among males. Prescription drug use increases with age: the report highlights the Irish data which shows that the 30s are the highest risk period.

Only six of the 17 countries could report on non-medical use of prescription drugs, and Ireland is not one of them. As a result, the full extent of NMUPD across all jurisdictions cannot be known and gender differences cannot be detected.

Recommendations

A selection of the recommendations made on foot of the investigation to the Permanent Correspondents of the Pompidou Group, including the Irish Permanent Correspondent, are noted below.

Monitoring and research

- Recommend to researchers that in addition to the use of 'sedatives and tranquillisers', the use of other categories of prescription medication be included as items in the general population survey.
- Ask researchers to ensure that the item on the source of the prescription medication be included in the general population survey as a core item.
- Ask researchers to develop mechanisms for the monitoring of emergency department visits and admissions. Currently in Ireland only emergency hospital admissions owing to misuse of prescription medications are recorded and not visits to emergency departments. As a result, the morbidity, as distinct from mortality, associated with use and non-medical use of prescription medications, is under-recorded.
- Ask the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) to include, in the common core general population survey, items relating to the use of prescription medication and to the non-medical use of prescription medication, and that the defining and reporting on the extent of NMUPD become a priority.
- Ask the EMCDDA to develop a clear method of distinguishing the monitoring of both prescription practices and NMUPD.
- Ask the ESPAD to expand the categories of prescription drugs monitored and to consider including 'prescription drug use' and not just 'use without a prescription'.

Practice (prevention and treatment)

- Offer differentiated responses to meet different needs of women in relation to prevention, harm reduction and treatment.
- Develop educational programmes for patients on safe use and disposal of prescribed medicines.
- Develop guidelines for prescribing practices that reduce unnecessary prescriptions and the potential for diversion.
- Train doctors to identify those at risk of dependence in order to hinder their movement along the addictive career path.

Policy

- Develop coherent policies that address the use and misuse of prescription medications and make specific reference to gender.
- Commission studies dedicated exclusively to NMUPD and address specific issues such as the initiation, escalation, physical and psychosocial consequences in relation to women as an 'at risk' category.

Women & NMUPD *(continued)*

- Develop state-level prescription drug monitoring programmes.
- Develop educational programmes targeted towards patients on how to safely use, store and dispose of prescribed medicines.

Violence against women and NMPUD

- Having reviewed the findings of the literature review on the possible links between trauma and interpersonal violence and NMUPD among women, the Gender Equality Commission Secretariat of the Council of Europe calls on all member states to go further – to hold round-tables bringing together international organisations active in the field to present examples of their good practice, and to commission studies on the relationship between violence against women and NMPUD within their own jurisdictions.

(Brigid Pike)

1. Clark M and expert working group and participants (2014) *The gender dimension of non-medical use of prescription drugs (NMUPD) in Europe and the Mediterranean region* [P-PG/Gender (2014) 8] http://www.drugsandalcohol.ie/22964/

The challenge of controlling new psychoactive substances (NPS)

The number and diversity of new psychoactive substances (NPS) reported in Europe in recent years represent a major challenge for Europe's policymakers. In 2013, 81 NPS were notified to the EU early-warning system (EU–EWS),[1] bringing the number of substances monitored to more than 350. As part of its Perspectives on Drugs (POD) series (see separate report on POD elsewhere in this issue), the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) has published an online and interactive analysis of the policy and legal challenges posed by NPS for European legal systems.[2] This article summarises the key points arising out of this POD analysis.

The diversity of new substances and the speed with which they have been appearing provide a challenge for the criminal law which, in keeping with the fundamental principle of legal certainty,[3] must be specific when defining an offence. In practice, this means that the drug law must clearly list all substances under its control: 'The traditional response to the discovery of a new "drug", established at a time when such a discovery was a relatively rare event, was to assess the risk to public health and add it to the national list of controlled substances' (p. 1). However, the emergence of many new substances with limited evidence of health risks 'both challenges existing process and potentially stretches the credibility of control systems'. In some countries criminal laws must be agreed by parliament, and updating the law can be time consuming, and even where an NPS is identified and controlled, it is quickly replaced in the drug market.

In response to this challenge, a number of innovative legal responses have been developed throughout Europe. In general, three broad, sometimes overlapping, approaches have been adopted.

Controls using consumer safety or medicines legislation

Consumer safety laws were used in Poland and these led to 'mass "headshop" closures' (p. 2). In Italy, regulations requiring goods or food for sale to be accurately labelled as to their expected use were employed to confiscate Spice (i.e. synthetic cannabinoid) products that were not labelled in Italian. In the UK, a similar approach was used to prevent the sale of mephedrone that was labelled as bath salts and plant food. In at least eight countries, medicines laws have been used to control NPS. By classifying an NPS as a medicinal product, a national medicines agency can demand a licence for importation, marketing or distribution. This can also have the effect of avoiding the criminalisation of users.

Extending and adapting existing laws and processes

Some countries have introduced 'temporary control regimes' in order to accelerate legal processes and allow time for NPS to be investigated for possible legal control. In the UK, a procedure was introduced in 2011 allowing for the temporary control of named substances for up to one year. Similar approaches were adopted in Latvia, Slovakia and Hungary. Some countries have chosen to extend the coverage of existing drug laws by listing defined groups of substances rather than individual drugs as was done previously. A generic group system, which includes a precise definition of a family of substances, has been the approach traditionally taken in Ireland and the UK. Other countries such as Latvia and Bulgaria use a broader 'analogue' approach, which includes a more general definition of 'similarity in pharmacological activity', as well as 'similarity in chemical structure'. Group definitions are now being adopted by many countries (Luxembourg, Italy, Cyprus, Lithuania, Denmark, France and Norway). Germany is considering adopting such a group system while the Netherlands has recently rejected such an approach owing to the 'complexity of targeting some substances while not restricting others that may have legitimate uses' (p. 3).

New laws to manage the unauthorised distribution of NPS

Ireland's Criminal Justice (Psychoactive Substances) Act 2010 is an example of a new law. A similar approach has been adopted in Austria, Portugal and Romania, although precise legal definitions, the nature of the threat posed by NPS and the possible penalties that can be imposed differ between countries.

Controlling NPS *(continued)*

Common trends

Although different approaches have been adopted throughout Europe to NPS, two common trends are identifiable: '[First] there appears to be a general move towards the use of the threat of prison to deter suppliers; and, second,… countries are choosing not to use criminal sanctions for those possessing a new substance for personal use' (p. 3).

(Johnny Conolly)

1. When a new psychoactive substance is detected on the European market, EU member states ensure that information on the manufacture, traffic and use of the drug is transmitted to the EMCDDA and Europol via their national networks (the Reitox national focal points and the Europol national units). This information exchange mechanism is the EU-EWS on NPS.
2. EMCDDA (2013) *Controlling new psychoactive substances*. See online edition with interactive features at http://www.emcdda.europa.eu/topics-a-z
3. In the common law tradition, legal certainty is often explained in terms of citizens' need to be able to organise their affairs in such a way that they do not break the law.

Financing drug policy during the recession

A recent EMCDDA Paper explores how the economic recession that started in 2008 affected public spending on drug-related initiatives in EU member states, including Ireland.[1] The authors used quantitative and qualitative data provided in the annual reports of the national focal points (NFPs), including the Irish NFP based in the Health Research Board. Using this data, they examined public expenditures on health, social protection and public order and safety, as these are the areas of government activity where most drug-related activities are provided. The authors concluded:

- Austerity has led to reductions in spending in those categories of government activity that encompass most drug-related initiatives.
- Countries that experienced greater levels of austerity tended to show greater reductions in expenditure.
- Bigger cuts in public expenditure were registered in health than in public safety and social protection.

The authors divided the27 EU countries and Norway into four groups according to the severity of the impact of the economic recession in each country. Ireland falls into the fourth group of countries, along with Greece, Spain, Latvia, Lithuania, Portugal and Slovakia – Group 4 – which includes the countries hardest hit by the economic recession. In 2009, on average, the GDP of these Group 4 countries fell by close to 7% (5.5% in Ireland), and in the two subsequent years recovery was weakest among these countries: in 2011 youth unemployment was on average 35.5% (29.1% in Ireland) and total unemployment 16% (14.7% in Ireland).

Public expenditure on health, social protection and public order and safety

Among the Group 4 countries, the pattern of growth of public expenditure components that encompassed most drug-related activities changed markedly. Between 2000 and 2007, expenditure grew faster on average in Group 4 countries than in the other groups; after economies went into recession, the biggest falls in expenditure occurred in Group 4 countries. Health expenditure was particularly hard hit, declining in real terms by 7.0% in 2010 and 4.6% in 2011, on average. Expenditure on social protection also fell markedly, especially taking into account the increase observed in unemployment (down 1.1% in 2010 and 2.3% in 2011). Public order and safety expenditure managed to maintain a very modest real growth rate (0.4%) in 2010, but this was not sustained in 2011 (down 3.3%). The pattern of changes in Ireland was broadly similar (see Table 1).

	2000–2008 (average)	2009	2010	2011
Health	7.5	3.7	-4.1	-6.3
Social Protection	7.0	15.4	2.1	0.1
Public Order and Safety	5.5	-3.0	-2.2	-3.0

Table 1: Yearly growth rate in public expenditure (%) on health, social protection, and public order and safety, Ireland 2000–2011 (constant prices)

The authors conceded that drug-related expenditures represent a small proportion of these aggregates, and it cannot be inferred that public spending on drug initiatives necessarily behaved in a similar manner. However, they suggested that reductions in funding in these areas may have had an indirect impact on drug-related initiatives.

Public expenditure on drug-related initiatives

With regard to specific drug-related public spending, the authors noted that among Group 4 countries, trend analysis of labelled drug-related public expenditure was only possible for Ireland, where it was found that drug-related public expenditure increased between 2005 and 2008 but decreased after 2008, probably owing to the public austerity measures that followed the economic recession. In 2009, the need to achieve a 'prudent fiscal outturn' led to an attempt to cut labelled drug-related expenditure across all government bodies in Ireland, and between 2008 and 2013 public expenditure on drug-related programmes declined overall by 15.3% (see Table 2).

Seeking greater cost-effectiveness

Ireland is reported as one of the countries that adopted policies specifically to either limit the potential damage of austerity or take advantage of the adverse period to improve efficiency. The Reitox NFP reports on Ireland, on which the authors of this EMCDDA Paper drew, describe a number of reports completed during the recession identifying opportunities for making savings, especially administrative efficiencies.[2] The authors also noted a report by one regional drugs task force which, in anticipation of a decline in funding, commissioned a study to evaluate the effectiveness and efficiency of its 30 projects.

Drug policy during the recession *(continued)*

2008 € million	2009 € million (% change)	2010 € million (% change)	2011 € million (% change)	2012 € million (% change)	2013 € million (% change)
276.429	277.240 (0.3%)	267.792 (-3.4%)	249.839 (-6.7%)	242.342 (-3.0%)	237.147 (-2.2%)

Table 2: Public expenditure directly attributable to drugs programmes, Ireland 2008–2013

Outcomes

The authors concluded that a full analysis of the impact of the recession on drug initiatives will only be possible after some period of delay. They cited a 2014 OECD report on the impact of the economic recession:[3]

> *It is still too early to quantify the longer-term effects on people's health, but unemployment and economic difficulties are known to contribute to a range of health problems, including mental illness… Short-term savings may translate into much higher costs in the future, and governments should make funding of investment-type programmes a priority… Maintaining and strengthening support for the most vulnerable groups must remain a crucial part of any strategy for an economic and social recovery.* (pp. 11–12)

(Brigid Pike)

1. European Monitoring Centre for Drugs and Drug Addiction (2014) *Financing drug policy in Europe in the wake of the economic recession*. EMCDDA Papers. Luxembourg: Publications Office of the European Union. http://www.drugsandalcohol.ie/23115/
2. See accounts of these reports in Section 3.4 'Economic Analysis' of the Health Research Board's Reitox National Focal Point national reports to the EMCDDA for 2010 and 2012, which may be accessed respectively at http://www.drugsandalcohol.ie/14714/ and http://www.drugsandalcohol.ie/18808/
3. OECD (2014) *Society at a glance 2014: the crisis and its aftermath.* OECD Social Indicators. Paris: OECD Publishing. http://dx.doi.org/10.1787/soc_glance-2014-en

Towards UNGASS 2016

Since Issue 48, Drugnet Ireland *has carried 'Towards UNGASS 2016' as a regular column. It reports on policy initiatives, research and debates launched by UN member states and civil society organisations in the lead-up to the UN General Assembly Special Session (UNGASS) on the world drug problem, due to be held in 2016 (A/RES/67/193).*

On 30 October 2014 **Drugs: international comparators** was published by the UK government. This report describes policy and operational responses to drugs in other countries and reviews the evidence for their impact. Countries visited for the study included Canada, the Czech Republic, Denmark, Japan, New Zealand, Portugal, South Korea, Sweden, Switzerland, the USA and Uruguay. In their foreword to the report, the Home Secretary Theresa May MP and Minister of State Norman Baker MP state that while countries are dealing with similar issues and there are common elements in the responses, there are also stark differences in emphasis, often influenced by different social and legal contexts. They comment: 'What works in one country may not be appropriate in another. … [the differences] illustrate the complexity of the challenge, and demonstrate why we cannot simply adopt another country's approach wholesale.'

The report focuses on a series of responses to illicit drugs which the authors deem 'particularly innovative, widely discussed, or relevant to the UK situation'. They are:

- drug consumption rooms,
- heroin-assisted treatment,
- dissuasion commissions,
- drug courts,
- prison-based treatment
- prison-based harm reduction,
- new psychoactive substances,
- supply-side regulation of cannabis, and
- decriminalising the possession of cannabis for personal use.

https://www.gov.uk/government/publications/drugs-international-comparators

On 7 January 2015 **Measurement matters: designing new metrics for a drug policy that works** was published by the Igarapé Institute, a Brazilian-based think-and-do-tank that focuses on emerging security and development issues; the Institute serves as the Secretariat to the Global Commission on Drug Policy. This new strategic paper introduces a preliminary set of six goals, 16 targets and 86 indicators to help guide governments, law enforcement agencies, health institutions and civil society in crafting more effective and efficient drug policy. According to one of the authors, 'conventional drug policy metrics … tell us how tough we´re being, but say nothing about whether we´re successful or not'.

Under two high-level impacts – improving the health and welfare of the population, and enhancing security and safety of people – *Measurement matters* proposes six over-arching goals:

- end criminalisation and stigmatisation of drug users,
- curb drug use through public health measures,
- diminish rate of incarceration of non-violent drug-related offenders,
- target violent organised crime groups and traffickers,
- provide meaningful alternatives to illicit crop production, and
- encourage experimentation with different approaches to regulating drugs.

http://www.globalcommissionondrugs.org/measurement-matters-designing-new-metrics-for-a-drug-policy-that-works/

Towards UNGASS 2016 *(continued)*

On 21 January 2015 **Options and issues regarding marijuana legalization** was published by the US-based RAND Drug Policy Research Center. The paper reviews recent changes in marijuana policies and the decisions that confront jurisdictions considering alternatives to traditional marijuana prohibition. The objective is to provide readers with 'some tools for assessing the options and to help them appreciate the uncertainties' (p. 12).

The authors point out that marijuana policy is not a binary choice between prohibition and the for-profit commercial model. Legalisation encompasses a wide range possible regimes, determined by answering three key questions:

- Who would be allowed to supply legal marijuana?
- Would legal marijuana be taxed and, if so, how?
- How would legal marijuana be regulated?

The costs and benefits of legalising marijuana also need to be considered. The authors stress that 'the relevant policy question is not whether marijuana's current harms outweigh its benefits but whether and how legalisation might change those harms and benefits and in which direction' (p. 11). On the costs side, the authors acknowledge 'clear and acute health effects' associated with use, especially heavy use, of marijuana. However, they note some 'fundamental limitations' of the evidence: although marijuana use is *correlated* with many adverse outcomes, it is difficult to ascertain whether marijuana *causes* those outcomes; other factors confounding the conclusions to be drawn from research findings include the context of use – whether in an illegal or a legal context – and how this has influenced use, and the 'largely unmeasured amounts of cannabinoids' involved in observational data.

On the benefits side, the authors note that some benefits of no longer enforcing laws against marijuana are medical benefits, gains in personal liberties, and the benefits of reduced arrest and sanctioning of marijuana offenders. In addition, the authors comment that self-reported medical and non-medical benefits of using marijuana are 'real and that they should matter, but they are far more difficult to quantify than other benefits, and they have received far less research attention than the harms of marijuana use' (p. 11).

The authors conclude that policy decisions must be made in a 'fog of uncertainties':

> *There is no recipe for marijuana legalization, nor are there working models of established fully legal marijuana markets. It must be expected that any initial set of choices will need to be reconsidered in the light of experience, new knowledge, and changing conditions, including federal policy and the policies in neighboring states. That puts a premium on flexibility; the policy should not be frozen into its initial design.* (p. 12)

http://www.rand.org/content/dam/rand/pubs/perspectives/PE100/PE149/RAND_PE149.pdf

(*Compiled by Brigid Pike*)

Adolescents and parental substance misuse

Keeley and colleagues[1] recently published the results of their analysis of data collected in 26 schools in Cork and Kerry from a cohort of 2,716 adolescents aged 15–17 years. The data were collected using the 'Lifestyle and Coping Questionnaire' designed specifically for the Child and Adolescent Self-harm in Europe (CASE) study, which contains questions on a number of psychological domains including drug and alcohol use. Two questions were added to the standard questionnaire regarding parental substance misuse: 'Has your mother had problems with alcohol/drugs?' and 'Has your father had problems with alcohol/drugs?'

Alcohol and drug use among adolescents

Eighty-three per cent of respondents (n=2,242) reported having consumed alcohol at least once, with no significant difference between boys and girls. Fifty per cent reported consuming 1–5 alcohol drinks in a typical week; 37% reported being really drunk on 1–3 occasions in the past month and 31% recalled being really drunk 1–3 times in the past year. Interestingly, and despite the high overall lifetime prevalence of 83%, over half the cohort (56.6%) reported that they had never been really drunk in the past month and just over a third (35%) had never been really drunk in the past year.

Less than a third of the cohort (31%) reported using an illicit drug at least once; less than a quarter (23.3%) in the last month and less than a third (32.9%) in the last year. Cannabis was the illicit drug most commonly used by both boys and girls; 93% of those who had used an illicit drug in the last month reported having used cannabis.

Substance misuse by parents and by their children

The authors reported an association between parental substance misuse and adolescent substance misuse. The magnitude of the risk was marginally higher if the parent misusing substances was the mother, and higher again if both parents were misusing substances. The association between parental substance misuse and an increased risk of adolescent substance misuse remains after adjusting for a number of other variables. However, it must be noted that from a relatively large cohort of adolescents, only 3.5% reported that their mother misused substances and 1.4% reported that both parents misused substances. Indeed, almost 89.6% of the cohort reported that their parents did not misuse substances.

The authors acknowledged the limitations of the study. The two questions on parental substance misuse did not distinguish between drugs and alcohol misuse and did not establish if the misuse was on-going or not. They went on to say, 'Despite these limitations, the paper adds information on the role parental misuse might have on young people's risk of developing addiction in an Irish context…' (p. 7).

Discussion

This study showed that alcohol consumption on at least one occasion among this cohort of 15–17-year-olds was the norm. However, the frequency and level of alcohol consumption varied considerably. The study also showed that among the same cohort, the use of illicit drugs was not the norm, with over two thirds reporting not using illicit

Parental substance misuse *(continued)*

drugs. Among the third who did report using illicit drugs, the vast majority (93.8%) used cannabis.

It is important that young people are presented with data from research studies as part of prevention interventions. For example, the majority of the young people in the cohort studied by Kelley and colleagues did not use illicit drugs. Challenges to the perception that substance use is the norm among others can be delivered as part of the Social Norms programme.[3]

(Martin Keane)

1. Keeley HS, Mongwa T and Corcoran P (2015) The association between parental and adolescent substance misuse: findings from the Irish CASE study *Irish Journal of Psychological Medicine*, early online http://www.drugsandalcohol.ie/23244/
2. Murphy KD, Byrne S, Sahm LJ, Lambert S and McCarthy S (2014) Use of addiction treatment services by Irish youth: does place of residence matter? *Rural and Remote Health* (14): 2735 http://www.drugsandalcohol.ie/22461/
3. Keane M (2011) The social norms approach to tackling substance use *Drugnet Ireland* (38): 16–17 http://www.drugsandalcohol.ie/15646/

National Poisons Information Centre annual report 2013

According to its annual report,[1] the National Poisons Information Centre (NPIC) received 9,816 enquiries in 2013. Of these, 9,520 (97%) were about human poisonings. The remaining calls concerned poisonings in animals (0.7%) and non-emergency requests for information (2.3%). Calls were evenly distributed over the week, with an average of 27 calls every day and the busiest time being between 6pm and 9pm.

The most frequent enquiries were from general practitioners/primary care personnel (39.7%), hospitals (27%) and members of the public (27.8%). The other sources of enquiries were community pharmacists, nursing/care homes, ambulance and emergency services, veterinary practices and schools. Calls from members of the public in 2013 increased by 7% over the previous year.

Over half (56%) of the enquiries about cases of poisoning in humans concerned children under 10 years of age, with boys outnumbering girls. There were 2,166 (23%) enquiries about adults (aged 20 years or over), with women being the subject of just over half of all enquiries and over half the enquiries (52%) being about intentional self-poisoning or recreational abuse. Most poisonings (93%) occurred in the home or domestic setting.

Drugs (pharmaceuticals and drugs of abuse), industrial chemicals and household products were the most common agents involved in human cases of poisoning. As in previous years, the most common enquiry concerned substances containing paracetamol. The second most common agent was ibuprofen. Cannabis was the most common drug of abuse discussed with the NPIC, followed by cocaine and heroin.

Of the 191 enquiries relating to liquid detergent capsules, 93% concerned children aged less than 5 years. The NPIC liaises with the Health and Safety Authority (HSA) regarding the increasing number of poisoning incidents involving liquid laundry detergent capsules. Actions taken to decrease the incidence of accidental poisoning from liquid laundry detergent capsules in young children include changes to the packaging and labelling of liquid detergent capsule products and consumer campaigns to raise awareness about safe use and storage.

Only a small proportion of enquires (271, 2.8%) required follow-up. Although most cases recovered completely, 17 cases suffered adverse effects, a further 12 died, and the outcome of 23 cases could not be determined. Drugs were implicated in eight of the fatal cases, and five of these involved drugs of abuse.

(Ena Lynn)

1. National Poisons Information Centre of Ireland (2014) *Annual report 2013* Dublin: Poisons Information Centre of Ireland. http://www.drugsandalcohol.ie/23241/

Overdose 'hot spots' in Dublin

Globally, opioids are one of the main causes of death among problem drug users. In countries with a high prevalence of heroin use, including Ireland, opiates are implicated in the majority of overdoses. Acute opioid overdoses impose a considerable burden on frontline health services such as ambulances and emergency departments. While the impact of environmental factors (e.g. deprivation, physical characteristics of area, allocation of health services) on the incidence of overdose has not been widely studied, historical data show that overdoses and associated fatalities are more common in areas where there is increased drug use, drug dealing and other drug-related activities, and addiction services have been set up in these areas.

A recent study looked at opioid overdoses in Dublin in order to understand more fully the risk factors involved, to help reduce the associated mortality and morbidity and to improve the response to such incidents.[1] The study had two aims: to establish a baseline incidence of all new overdoses that Dublin ambulances attend, and to look at the relationship between geographical location of overdoses, deprivation and location of methadone clinics. See Table 1 for a summary of the findings with regard to the overdose cases.

There are two ambulance services in Dublin: the Dublin Fire Brigade (DFB), and the National Ambulance Service (NAS) operated by the Health Service Executive (HSE). Ambulance staff enter data on each individual that they attend on a

Overdose 'hot spots' *(continued)*

Characteristics of patients who overdosed	• 80% male • Mean age 33 years • Evidence of opiate use observed in 89% • Evidence of use of other drugs, mainly alcohol, observed in 28% • 45% of patients attended to on the street • 38% attended to in a residential location • 70% attended to during the day • 27% repeat overdoses

Data on clinical presentation of the patient	• 39% unresponsive
	• 10% in respiratory arrest
	• 12% with respiratory depression
	• 4% in cardiac arrest.
	• Mean GCS score:[2]
	  ○ pre-intervention 7.2
	  ○ post-intervention 12.3
	• 3% confirmed dead at the scene

Type of intervention provided	• 76% administered naloxone:
	  ○ 66% given naloxone intramuscularly
	  ○ mean number of doses 1.5
	• 22% given assisted ventilation
	• 60% administered oxygen
	• 89% transported to hospital

Geographic location of overdoses	• 86% Dublin city centre • 6% South Dublin • 5% Fingal • 1% Dun Laoghaire

Table 1: Profile of overdose cases attended by ambulance services, Dublin 2012–2013

patient care report (PCR). The PCR is a paper-based record of the pre-hospital care given by ambulance staff/first responders. All PCRs for a 12-month period in 2012–2013 were reviewed prospectively to identify opioid overdoses. All relevant data were extracted: clinical presentation; clinical care provided; administration of naloxone; response to naloxone; whether the patient was taken to hospital; and death, if confirmed by ambulance staff on scene. Follow-up data on patients who were taken to emergency departments were not collected for this study.

The locations of overdoses were categorised as 'street', 'residential' (house/hotel) or 'service' (homeless shelter, treatment centre, hospital, shop, pub, Garda station). DFB personnel assigned geographic co-ordinates for the location of every overdose attended. These data were not available for attendances by the NAS.

Over the study period, ambulances attended 469 opioid overdoses. This gives an overdose incidence of 4.9 cases per 1,000 cases per year.

The relationship between overdose and deprivation was examined using the Pobal-Haase-Pratschke Deprivation Index and pre-existing Small Area (SA) boundaries.[3] The Deprivation Index is a composite score 'measuring the relative affluence or disadvantage of a particular geographic area'. The score ranges from -40 (most disadvantaged) to +40 (most affluent). Each overdose was mapped to its corresponding SA. There were some statistically significant differences found between:

- the number of overdoses and level of area affluence, with a greater number of overdoses occurring in less affluent areas, and
- the locations where overdoses occurred, with overdoses occurring in residential locations having a lower deprivation score than overdoses occurring in street locations.

The study also looked at the location of methadone clinics in relation to overdoses. This showed that most overdoses occurred within a 1,000-metre radius of certain methadone clinics.

The authors identified some limitations to the study. PCR forms were not always reliable (they were hand-written under stressful circumstances and often involved difficult decisions) and data could not be validated. Geo-data were not available for NAS PCRs.

The results of the study highlight several issues which can help inform decisions about preventing overdose deaths. Dublin ambulance services attended an opioid overdose almost daily; the majority occurred in Dublin city centre, on the street, during the day and near certain methadone clinics; street overdoses were more likely to occur in the city centre and on the quays, while residential overdoses were more likely to occur in the suburbs. Clinical findings showed patients had low mean GCS scores pre-intervention, meaning that many patients were unconscious. However, the mean GCS scores post-intervention showed improvement, indicating the effectiveness of the intervention given by the ambulance staff. However, the results also showed that the GCS scores of 25% of patients did not improve after administration of naloxone.

Despite international research indicating that overdose prevention and naloxone distribution programmes can help to reduce overdose deaths, not many countries provide such programmes.[4] The authors stated that the results point to the need for such a programme, based in the community, in Ireland.

(Suzi Lyons)

1. Klimas J, O'Reilly M, Egan M, Tobin H and Bury G (2014) Urban overdose hotspots: a 12-month prospective study in Dublin ambulance services. *The American Journal of Emergency Medicine*, accepted manuscript (in press). http://www.drugsandalcohol.ie/22440/
2. The Glasgow Coma Scale (GCS) aims to provide an indication of the neurological state of a person. The scores range from 3 (worst) to 15 (best). A score of less than 8 is considered severe. The total score is the sum of the scores in three categories: eye opening, verbal response and motor response.
3. Small area (SA) boundaries are subdivisions of pre-existing electoral districts created by the Central Statistics Office. www.cso.ie/census
4. Lyons S (2014) Preventing opiate-related deaths in Ireland: the naloxone demonstration project *Drugnet Ireland* (49): 13. http://www.drugsandalcohol.ie/21677/

'Alcohol – starting the conversation and finding solutions'

On Thursday 11 December 2014 the D12 Local Drugs and Alcohol Task Force (LDATF) organised a consultation seminar on alcohol in order to begin a discussion around problem alcohol use in the area and possible solutions.[1]

The morning started with introductions by Susan Sargent (chair of the D12 LDATF) and Aoife Fitzgerald (co-ordinator of the D12 LDATF). Three guest speakers then addressed the seminar: Suzanne Costello (Alcohol Action Ireland), who gave the national perspective on alcohol; Dr Suzi Lyons (Health Research Board), who presented local alcohol data from the National Drug Treatment Reporting System (NDTRS); and Hugh Greaves (Ballymun LDATF), who spoke about the approach the Ballymun LDATF has taken to dealing with problem alcohol use.

Hugh Greaves described how Ballymun LDATF took a public health-based approach to developing their strategy, using a community mobilisation model. The process included round-table events and a large number of stakeholders.

After the presentations, the seminar participants broke into four workshops, which reached the following broad conclusions:

- *Treatment and rehabilitation*: The key priorities identified by this workshop included the need for additional training, for example SAOR (screening and brief intervention for people with hazardous/harmful alcohol use), and the need to encourage population-level interventions to reduce harmful drinking.
- *Young people and alcohol*: The need for outreach, education and alternative activities was highlighted by this workshop.
- *Education, prevention and health promotion*: This workshop stressed the importance of schools and teachers in educating young people and raising awareness, the need for greater awareness of problem alcohol use in the community, and the need to involve all stakeholders.
- *The effect of alcohol on families and children*: The importance of role models, the need for a public campaign on the impact of alcohol on children and the need for additional supports for families as a whole were all emphasised by this workshop.

On foot of the outcomes of the consultation seminar, the D12 LDATF committed to work over the following months to develop a strategy to address alcohol-related harm in the D12 area, using a community mobilisation model.[2]

(Suzi Lyons)

1. To access a copy of all the presentations and full reports from the workshops, see http://www.drugsandalcohol.ie/23377/
2. For further information on the work of the D12 LDATF and the Ballymun LDATF, visit http://www.d12ldtf.ie and/or http://www.ballymunlocaldrugstaskforce.ie respectively.

Sentencing in drug cases

A recent study conducted by the Irish Sentencing Information System (ISIS)[1] examines the sentencing practices of the Irish courts in relation to the offences of possession or importation of controlled drugs for the purpose of sale or supply.[2] There are four such offences which are covered by the study:

- possession of controlled drugs for unlawful sale or supply (s. 15 of the Misuse of Drugs Act 1977, as amended),
- possession of controlled drugs (valued at €13,000 or more) for unlawful sale or supply (s. 15A of the Misuse of Drugs Act 1977, as amended),
- importation of controlled drugs for unlawful sale or supply (several provisions found in the Customs Acts, Misuse of Drugs Acts 1977–1984, as amended, and the Misuse of Drugs Regulations 1988), and
- importation of controlled drugs (valued at €13,000 or more) for unlawful sale or supply (s. 15B of the Misuse of Drugs Act 1977, as amended).

Convictions under s.15A or s.15B of the Misuse of Drugs Act 1977 attract a 'basic presumptive sentence' of 10 years or more. A sentencing court may, however, impose a lower sentence where there are mitigating factors that amount to 'exceptional and specific circumstances', which would render the imposition of a sentence of 10 years or more 'unjust in all the circumstances'.[3]

Part I of the report analyses the legislative basis for these drug trafficking offences and the reserved judgements of the superior courts. Part II examines the application of sentencing principles in relation to the 'basic presumptive sentence' provided for in s. 15A and s. 15B. Part III examines 79 judicial decisions involving 81 offenders before the Court of Criminal Appeal between 2009 and 2012. Twenty of these judgements relate to ordinary offences and 59 to offences carrying the presumptive sentence.

The case law analysed shows that 'in the majority of s. 15A and s. 15B sentences (67% of those surveyed), the presumptive minimum sentence of 10 years imprisonment or more is not imposed by the courts despite the fact that this sentence is popularly described as a "mandatory minimum" ' (p. 6). However, this does not mean that the courts are disregarding the presumptive minimum sentencing provisions. As the author explains, 'the Court of Criminal Appeal has repeatedly emphasised that the upper parameters of these offences are properly defined by reference to the maximum penalty of life imprisonment and not, as is often the case, to the presumptive mandatory minimum of 10 years' (p. 6). This is the case at least with regard to possession for supply offences. With regard to importation offences, the author concludes that the statutory framework 'is less coherent' (p. 6). This is due to the fact that the ordinary offence exists under legislative provisions which provide different maximum penalties, 'one of which carries

a maximum penalty of 14 years imprisonment and the other carries a maximum sentence of life imprisonment' (p. 6).

This anomaly exists primarily for historical reasons that can be traced back to the emergence of the heroin 'epidemic' in Dublin in the early 1980s. Prior to the introduction of the maximum sentence of life imprisonment in 1984, the upper limit of 14 years applied to importation and possession for sale and supply offences. Such a maximum sentence was imposed in *The People (Director of Public Prosecutions) v. L.D.*, the initials standing for Larry Dunne, a leading member of the family largely credited with introducing heroin to Dublin at that time.[4] In the period between the commission of the offence, and the date of sentencing, the legislature had increased the maximum penalty. In passing sentence, McMahon J. stated that the major players involved in drug trafficking could in future expect life imprisonment. As the ISIS report shows, however, to date no convicted person has received the maximum sentence of life imprisonment. As a consequence, as the author points out, 'It is sometimes therefore popularly espoused that custodial sentences imposed are too short or that disparity exists from one sentence to the next' (p. 7). Such disparity is apparent in the following cases examined by the author of the ISIS report:

> *… one offender found with €300,500 of cannabis and cocaine was sentenced to the presumptive minimum of 10 years while another found with €329,301 of cocaine received a wholly suspended sentence; a man found with €43,000 of cocaine received a 1.5 year custodial sentence while another man found with €287,050 of cannabis received 4 years.* (p. 7)

The ISIS report finds that in supply offences involving drugs valued at €13,000 or more, the value is the most important factor in determining the sentence. However, this is not the only factor considered, as sentences differ relative to the circumstances of individual cases and individual offenders. This approach is regarded as consistent with general sentencing principles.

The analysis of cases provided in the report shows that there are four primary factors featuring in the construction of sentences for drug trafficking offences:

- quantity or value of the controlled drug or drugs,
- type of controlled drug or drugs,
- role of the offender, and
- condition of the offender (p. 7).

The Law Reform Commission (LRC), an independent statutory body established to keep the law under review and to make proposals for reform, has recently recommended that the presumptive sentencing regime for drug offences be repealed.[3]

(Johnny Connolly)

1. ISIS was established by the Board of the Courts Service as a computerised information system on sentences and other penalties imposed for offences in criminal proceedings. ISIS enables a judge, by entering relevant criteria, to access information on the range of sentences and other penalties which have been imposed for particular types of offence in previous cases. http://www.irishsentencing.ie/
2. Mackey K (2014) *Analysis of sentencing for possession or importation of drugs for sale or supply* Dublin: Irish Sentencing Information System
3. For a detailed account of the legislation and recommendations for change, see Law Reform Commission (2013) *Report: mandatory sentences*. LRC 108–2013 Dublin: Law Reform Commission
4. For an account of this period, see Flynn S and Yeates P (1985) *Smack: the criminal drugs racket in Ireland* Dublin: Gill & Macmillan

Dr Sarah Morton (centre), School of Applied Social Science, University College Dublin, Dr Laura O'Reilly and Karl O'Brien, both Ballymun Youth Action Project, authors of Boxing clever: exploring the impact of a substance use rehabilitation programme*, at the launch of the report in February. The report was prepared from an evaluation of BYAP's Boxing Clever programme in 2013/2014 which was undertaken in partnership with the UCD School of Applied Social Science Community Partnership Drugs Programme. This report will be covered in the issue 54 of* Drugnet Ireland.

Ana Liffey strategic plan 2015–2017

Mr Tony Duffin, director of ALDP, and Mr Joe Duffy at the launch of the Ana Liffey Drug Project strategic plan 2015–2017 in City Hall in December.

Unlike Ana Liffey Drug Project's (ALDP's) previous strategic plan for 2012–2014, which was developed during a recession, its new strategic plan 'resides in the more positive context of economic recovery'. So states Eddie Matthews, chair of ALDP, in his foreword to the new strategic plan for 2015–2017.[1] ALDP is now introducing creative new approaches to targeting drug-related harm in Ireland, and seeking support specifically for:

- low-threshold residential stabilisation services, and
- medically-supervised injecting centres.

Ana Liffey, which works directly with over 2,500 people affected by addiction problems in Ireland every year, is seeking support to provide a suitable premises for a 'low-threshold residential stabilisation' service. This will provide treatment for drug users with multiple and complex needs which require immediate specialist support.

Tony Duffin, director of ALDP, says that with a suitable property, Ana Liffey could accommodate up to 20 people at a time on a pilot project to help them to stabilise, to stay off the streets as well as reducing the demands on other health services. The operating costs for such a service would be approximately €1.5 million. He states that research shows that every euro spent on treatment can save countries up to €2.50 in other costs, through public health benefits and cutting crime.[2]

In addition to the stabilisation service, Ana Liffey is also seeking to establish in Dublin a medically-supervised injecting centre where an addicted person can inject themselves safely and away from the public's gaze.[3] According to Duffin, 'They [medically-supervised injecting centres] are a very successful intervention, with over 90 centres in countries throughout the world. Not only do they contribute to reducing public injecting and unsafe disposal, they also help people attending to tackle their addictions through dedicated access to treatment programmes.'

Since 1982 ALDP has provided a 'low-threshold harm reduction' service to individuals who are experiencing problematic substance use and to their families. In recent years, it has established services in the Midlands and the Mid-West and it plans to expand its services to reach as wide a client base as possible across the country. According to ALDP, an average of one person dies from overdose in Ireland every day and people are using multiple substances in every town and city in Ireland.

In 'targeting harm', ALDP's rationale is that Ireland has limited resources to deal with problem drug use and needs to target the resources it does have towards evidence-informed interventions which have been shown to reduce the harm drug use causes to individuals, families and communities. Duffin comments, 'Drug use has changed. There is more and more poly-drug use and an increasing number of complex cases. We need to accept, as a society, that it is not realistic to expect to be able to stop all drugs entering the country, or to be able to eliminate problem drug use.'

Noting that Ana Liffey provides valuable and helpful services to those who use drugs problematically, to their families and to the broader communities, chair Eddie Matthews sums up Ana Liffey's approach:

> [We work] *through the prism of pragmatism. We neither condone nor condemn drug use. We are non-judgmental and client-centred, believing in the potential of every individual. We believe in the value of harm reduction. Our strategic plan includes a strong focus on working with government departments, NGOs, universities and other stakeholders to develop effective programmes, necessary legislation and sufficient funding to tackle drug addiction in this country.*

1. Ana Liffey Drug Project (2014) *Targeting harm: the strategic plan of the Ana Liffey Drug Project 2015–2017*. Dublin: Ana Liffey Drug Project. http://www.drugsandalcohol.ie/23173/
2. In October 2014 Public Health England, an executive agency of the UK's Department of Health, uploaded a document on its home page entitled *Alcohol and drugs prevention, treatment and recovery: why invest?* Among the benefits of investment, the document states that every £1 spent on drug treatment saves £2.50 on costs to society, through preventing an estimated 4.9m crimes every year and an estimated £960m costs to the public, businesses, criminal justice and the NHS (p. 27). http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf The National Documentation Centre on Drug Use located this source.
3. According to a report posted on Talking Drugs (http://www.talkingdrugs.org/) on 26 February 2015, and reported on DrugScope Daily on 27 February 2015, the ALDP is working in collaboration with the Voluntary Assistance Scheme at the Bar Council of Ireland on legislation to make the opening of a medically-supervised injecting centre in Dublin possible. It is currently illegal under the Misuse of Drugs Act 1977.

HSE National Service Plan 2015

The HSE's National Service Plan 2015 (NSP), approved by the government in December 2014, sets out the HSE's priorities and targets for tackling tobacco and alcohol misuse, and drug addiction, in 2015.[1] The HSE's divisional plans, on which the NSP is based, list specific operational tasks with timeframes, and a 'balanced scorecard' of performance targets. The following account draws on both the aggregated NSP and the more detailed operational plans for the Health and Well-Being and the Primary Care divisions, which share responsibility for tobacco, alcohol misuse and addiction services.

Tobacco and alcohol misuse

The Health and Well-Being Division will focus on the 'key modifiable risk factors for chronic disease and ill-health' including tobacco and alcohol misuse.[2] The Division is preparing for the roll-out of the relevant provisions in both tobacco and alcohol legislation in consultation with the Department of Health and in line with existing resources. Key actions and performance targets for 2015 are as follows:

Tobacco Free Ireland [3]

- Implement priority actions, with a particular focus on the continued roll-out of the tobacco free campus policy in primary care (100%); mental health (100% approved centres and 25% residential services); disability and social care residential services (disability [25%] and older persons [20%]); and Tusla sites (100%).
- Reduce tobacco usage in the general population by undertaking training, intervention, surveillance, evaluation, enforcement of legislation and social marketing activities. Targets for 2015 include 1,500 frontline healthcare staff trained in brief intervention for smoking cessation; 9,000 smokers receive intensive cessation support; and 2,450 smokers who enter a cessation programme quit at one month.

Performance Target: 100% health care centres tobacco-free

National Substance Misuse Strategy[4]

- Further develop a co-ordinated approach to prevention and education interventions in alcohol between all stakeholders including 3rd-level institutions. Target is to have a national accreditation system in place in a number of 3rd-level colleges.
- Support pilot community mobilisation alcohol initiatives in five drugs task force areas (North Inner City, Tallaght, Dun Laoghaire/Rathdown, North West and South) through grant agreement with Alcohol Forum.[5] Five local alcohol action plans developed by end of year.

Community Oncology Cancer Control Programme (COCCP)

In the Primary Care Division of the HSE, the COCCP has a commitment to 'implement a national standardised algorithm for the treatment of tobacco addiction' by the end of 2015.[6]

Addiction services

In the Primary Care Division of the HSE, a key priority for the Social Inclusion Services is to 'achieve improved health outcomes for people with addiction issues'.[6] Seven key actions and associated tasks have been identified for 2015:

1. Progress the integration of drugs task force projects and developments within the wider addiction services in line with objectives in the NDS[7]

- Ensure that each local and regional drug and alcohol task force (DATF) project is governed by the HSE grant aid agreement/service arrangement for 2015.
- Additional funding of €1.023m has been notified to support measures to tackle substance misuse. This funding will support community and voluntary groups or other relevant bodies to undertake one-off prevention initiatives in line with the National Substance Misuse Strategy.
- Assist projects to participate in planning and reporting in line with the monitoring tool developed by the National Addiction Advisory Governance Group, within the Section 39 Governance Framework.
- Ensure that funded organisations:
  - support and promote the aims and objectives of the NDS to significantly reduce the harm caused to individuals and society by the misuse of drugs. Their annual plans must be linked to both the national strategic actions and local drug strategy/ implementation plans;
  - provide the HRB with data on each service user entering and existing service in compliance with the National Drug Treatment Reporting System (NDTRS);
  - engage with a Quality Standards Framework such as QuADS through the Quality Standards Support Project; and
  - implement case management process as guided by the National Drugs Rehabilitation Framework.

2. Implement priority actions from the NDS (Programme for Government Primary Care Funds €2.1m) – implement the clinical governance framework for addiction treatment and rehabilitation services

- Develop integrated drug and alcohol services in line with the NDS and the National Substance Misuse Strategy, which provide drug-free and harm reduction approaches for problem substance users, and
  - facilitate problem substance users to engage with, and avail of, such services;
  - ensure that each patient has an appointed key worker and a clearly documented care plan that is subject to a regular review and update;
  - measure transfers from HSE clinics and level-2 GPs to level-1 GPs; and
  - carry out a client satisfaction survey of all the addiction services.
- Participate in the European Union Reducing Alcohol Related Harm (RARHA) Project.
- Develop national guidelines for alcohol consumption to reduce health risks from drinking.

HSE NSP 2015 *(continued)*

- Implement a naloxone demonstration project to assess and evaluate its suitability and impact (in line with NDS Action 40).
- Develop a clinical and organisational governance framework (in line with NDS Action 45).
- Finalise, launch and maintain an on-line directory of drug and alcohol services and specialist drugs and alcohol treatment programmes (in line with the recommendations from the Working Group on Drugs Rehabilitation, Action 32).
- Screening and brief intervention (SBI):
  - Roll out SAOR (Support, Ask and Assess, Offer Assistance and Refer) screening and brief intervention training for alcohol and problem substance use within tier 1 and tier 2 services (25 SAOR training programmes to 300 staff and 3 train-the-trainer programmes will be delivered nationally) in partnership with Health Promotion and Improvement and the National Addiction Training Programme.
  - Develop and implement an SBI implementation plan to support the roll-out of national SBI protocol.
- Hidden harm:
  - Finalise a strategic statement regarding hidden harm together with Tusla and drug and alcohol services. This statement will guide two pilot sites (north-west and Midlands) to ensure early intervention.
  - Commission training on hidden harm on behalf of Tusla and drug and alcohol services staff.
  - Participate on the North-South Alcohol Policy Advisory Group.
- National Addiction Training Programme:
  - Finalise a training needs analysis and workforce development plan in line with NDS Action 47.
  - Co-ordinate the provision of training within the substance misuse framework, i.e. Addiction Training Programme, in line with NDS Action 47.

3. Implement the outstanding prioritised recommendations of the Opioid Treatment Protocol, including the development of an audit process across the full range of drug services. This will incorporate person-centred care planning through the Drug Rehabilitation Framework and increase opioid substitution treatment (OST) patient numbers

- Develop an audit process across the full range of drug services that incorporates person-centred care planning through the Rehabilitation Framework, in line with the introduction of the *Opioid Treatment Protocol* recommendation 2.3.
- Increase the maximum number of OST patients from 15 to 25 for level 1 prescribers, and in exceptional circumstances from 35 to 50 for level 2 prescribers, in line with *Opioid Treatment Protocol* recommendations 3.4 and 3.5.
- Performance targets:
  - No. of clients in receipt of OST (outside prisons): 9,400
  - No. of clients in receipt of OST (in prisons): 490
  - % of substance misusers over 18 years for whom treatment has commenced within one calendar month of assessment: 100%
  - % of substance misusers under 18 years for whom treatment has commenced within one week of assessment: 100%

4. Implement referral and assessment for residential services using a shared assessment tool agreed between the HSE and service providers in line with the Drug Rehabilitation Framework

- Develop a shared assessment tool between HSE and Tier 4 service providers in line with the Drugs Rehabilitation Framework and National Protocols and Common Assessment Tools.

5. Implement the findings of the evaluation of the Pharmacy Needle Exchange Programme (PNEX)

- Increase the level of knowledge of pharmacies in relation to harm reduction as per the PNEX.
- Provide training for PNEX staff to reflect the wider range of service provision.
- Strengthen integrated care pathways and referral pathways for patients.
- Enhance advice and information giving on sexual health including appropriate referral for BBV testing and increased condom distribution.
- Performance target:
  - Number of unique individuals attending pharmacy needle exchange: 1,200

6. Implement prioritised recommendations of the Tier 4 Report (Residential Addiction Services)

- Develop a Clinical Audit team and draw up an approved list of residential services based upon adherence to best practice quality standards in relation to staff competencies and clinical operations.

7. Develop joint protocols for integrated care planning between mental health services and drug and alcohol services

- Develop joint protocols between mental health and drug and alcohol services for patients with severe mental illness and substance misuse problems, in line with National Substance Misuse Strategy 2011, Recommendation 10, and NDS Action 33).

Monitoring progress

Each month the HSE issues a Performance Assurance Report (PAR), analysing key performance data year-to-date against the performance targets set in the annual NSP. It is based on metadata, which are also published by the HSE. These reports are available at http://www.hse.ie/eng/services/publications/corporate/performanceassurancereports/

1. Health Service Executive (2014) *National service plan 2015*. http://www.drugsandalcohol.ie/23052/
2. Health Service Executive (2014) *Health and well-being operational plan 2015*. Dublin: HSE. http://www.drugsandalcohol.ie/23275/
3. Tobacco Policy Review Group (2013) *Tobacco free Ireland*. Dublin: Department of Health. http://www.drugsandalcohol.ie/20655/

HSE NSP 2015 *(continued)*

4. Department of Health (2012) *Steering group report on a national substance misuse strategy*. Department of Health, Dublin. http://www.drugsandalcohol.ie/16908/
5. North West Alcohol Forum Ltd (NWAF) is an NGO established to work in partnership with all sectors to reduce hazardous drinking and its consequences to the individual, the family and the community.
6. Health Service Executive (2014) *Primary care divisional operational plan 2015*. Dublin: HSE. http://www.drugsandalcohol.ie/23193/
7. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy* (interim) *2009-2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. http://www.drugsandalcohol.ie/12388/

Youth programmes reviewed

The Department of Children and Youth Affairs (DCYA) has published its review of three youth programmes: the Special Projects for Youth (SPY), the Young People's Facilities and Services Fund (YPFSF) and the Local Drugs Task Force (LDTF) projects.[1] The review was undertaken as a value-for-money and policy review (VFMPR) to examine the efficiency and effectiveness of the three programmes. This article summarises the key messages from the review.

Review method and rationale

The reviewers collected data via site-based interviews with front-line staff and young people, interviews with the Youth Affairs Unit of the DCYA, a survey of all youth programme providers, an analysis of high-level statistical data, a review of administrative data and a literature review.

The three programmes under review target 'at-risk' young people who are disadvantaged in different ways, with some experiencing multiple disadvantages. The programmes generally target 10–21-year-olds in areas characterised by problem drug use, educational disadvantage, criminal activity, unemployment and homelessness. The review notes that there are indications in the available national data that, overall, drug use, youth crime and youth homelessness have declined while unemployment and poverty rates among young people of working age have increased. The review points out that students attending 'DEIS schools'[2] continue to experience higher levels of non-attendance, suspensions and expulsions compared to students in non-DEIS schools and the gap is widening. Furthermore, the review notes that young people with lower levels of education are more likely to be unemployed. Based on these factors and the expected increase in the overall youth population, the review suggests that '…there remains a valid rationale for the provision of youth programmes for young people who are disadvantaged…' (p. 67).

Governance arrangements

Based on an analysis of the data collected, the authors of the review question the capacity of the current governance arrangements to adequately fulfil their purpose which is defined as the '…means to effectively and efficiently implement intended policy objectives within established rules...' (p. 51). In particular, the review highlights the poor quality of data submitted by programme providers, which made it difficult for those with governance responsibilities to make judgements regarding the efficiency and effectiveness of the programmes.

Efficiency

The review notes that efforts to undertake a comprehensive analysis of the efficiency of the programmes were hampered by reliance on a small sample of service providers to estimate salary costs, staff numbers, average daily and annual participant numbers and unit costs. The review reports that total expenditure on the programmes declined by approximately 16% between 2010 and 2012.

Effectiveness

One of the terms of reference of the review was to examine the extent to which the youth programmes' objectives had been achieved and to comment on their effectiveness. From the review of the international literature, seven 'potent programme outcomes' were identified:

- communication skills,
- confidence and agency,
- planning and problem-solving,
- relationships,
- creativity and imagination,
- resilience and determination, and
- emotional intelligence.

The evidence suggests that these outcomes are associated with improvements for the young people targeted by the programmes, e.g. getting a job, completing college or giving up using drugs.

These seven outcomes were used to retrospectively examine local practice in 13 sample sites, with data being collected via the survey to programme providers, interviews with front-line staff and young people and a review of administrative data related to the programmes.

The review found 'evidence of "presence" of these seven mechanisms that were (a) intentionally and consciously applied by professionals in pursuit of beneficial outcomes, and (b) experienced by young people' (p. 111). However, the authors comment that this evidence from selected sites fell far short of confirming that outcome-focused practice is being routinely adopted.

Continued relevance

The review reports that there is a 'fit' between the three targeted youth programmes and current DYCA strategy. The authors conclude that 'these programmes can make a difference [and] can provide a significant contribution to improving outcomes for the young people involved and should be considered for public funding…' (p. 126). However, they go on to say that the 'programmes and performance governance arrangements require significant reform… [relating] to the development of a robust performance evaluation framework to inform the way

Youth programmes *(continued)*

that the DCYA offers incentives for high programme performance and issues sanctions for poor programme performance' (p. 126).

(Martin Keane)

1. Department of Children and Youth Affairs (2014) *Value for money and policy review of the youth programmes that target disadvantaged young people*. Dublin: Government Publications. http://www.drugsandalcohol.ie/23242/
2. The DEIS (Delivering Equality of Opportunity in Schools) programme is the Department of Education and Skills' policy instrument to address educational disadvantage. Currently 849 schools are included in the DEIS programme.

It's 'Talk Time – what women want'

Participants in the forum organised by SAOL and UISCE in the Sheriff Street Football Club on 4 March 2015.

For the third year in a row, women from all over Ireland have come together to discuss issues relating to their experiences as 'women in addiction and in addiction services'. The themes in the previous two years were My Story in Recovery, and Ten Tips for Professionals Working with Women in Addiction (see box). This year women were asked to work on 'a message for the Minister'.

Organised by SAOL, a community-based recovery project for women in Dublin's north inner city, and UISCE (Union for Improved Services Communication and Education), a drug users forum based in Dublin's north inner city, the forum was held in the Sheriff Street Football Club on 4 March 2015.[1] Some 100 women, including women from Cork and Belfast, attended the forum and local TDs Maureen O'Sullivan and Mary-Lou MacDonald spoke to the group. O'Sullivan talked about the importance of prevention in tackling the drug problem and the need also to tackle the housing and homelessness problems. MacDonald stressed that communities as a whole have a responsibility to tackle the drug problem and invited service users to let their communities, including their TDS, know what their needs and issues are.

In breakout groups the women addressed three open-ended questions:

1. What is the number one thing that you think should be provided in services, which are presently not available?
2. If you could change one thing to positively change the drug scene in Ireland, what would it be?
3. What responses do women need from the government to help the unhealthy relationship with alcohol?

The breakout groups reported back on the outcomes of their discussions. These report-backs will be written up in a draft document outlining how to improve addiction services for women. Once peers from SAOL have checked the contents of the draft document with as many of the projects that attended Talktime 3 as possible, the report will be finalised and sent to the Minister for the National Drugs Strategy, to the north inner-city local drugs and alcohol task force and to Citywide. It will also be published in Brass Munkie and on SAOL's website.

(Brigid Pike)

1. For more information on SAOL and UISCE visit www.saolproject.ie and www.nicdtf.ie/PROJECTS/PROJECTS/UISCE.html

Top Ten Tips for Professionals Working with Women in Addiction*

1. Don't be rushing us, because real recovery takes time. Smaller, women-only groups, will help.
2. Don't judge us; get rid of the negative attitude; no discrimination. Women in recovery have enough shame already, we don't need more.
3. We want real empathy with practical support – not small talk with no action from you. If we didn't need some practical help, we wouldn't be at your services.
4. We need more women key-workers for women service users; then let us choose.
5. Work with us in partnership. We don't need you to make decisions for us.
6. Make appointment times more flexible as there are more barriers for women when accessing services.
7. We need more residential options for mothers and babies. There's often no point sending us to places when we have to leave our children behind.
8. Childcare services and resources are essential. We need more.
9. We need more social events for women as it is often harder for us to socialise and make friends when recovery gets under way.
10. We need practical help (including funding) with housing, general health and back to education.

**Source*: 'It's talk time 2', SAOL 2014

EMCDDA Perspectives on Drugs

The Perspective on Drugs (PODs) series was initiated by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) in 2013 as an accompaniment to its annual European Drug Report. The PODs provide online interactive analyses and a deeper perspective on a selection of important issues. Individual PODs are updated as new developments occur. The PODs introduced to date are summarised below and can be found at **http://www.emcdda.europa.eu/topics-a-z**

Mass media campaigns for the prevention of drug use in young people

The use of mass media campaigns in drug prevention is both relatively common and not without controversy. Both policymakers and practitioners have hotly debated the effectiveness of such campaigns. This POD reviews available evidence on the topic.

Hepatitis C treatment for injecting drug users

Transmitted through the sharing of needles, syringes and other injecting equipment, hepatitis C is the most common infectious disease among injecting drug users in Europe today. This analysis looks at some of the positive advances in treating the disease, including a new generation of medicines.

Preventing overdose deaths in Europe

It is estimated that over 70,000 lives were lost to drug overdoses in Europe in the first decade of the 21st century. Reducing drug-related deaths, therefore, remains a major challenge for public health policy. This POD describes some of the factors that increase the risk of fatal and non-fatal overdoses and a number of interventions developed to prevent these events.

Treatment for cocaine dependence

The EMCDDA has carried out a meta-analysis of six reviews examining the effectiveness of medications used in treating cocaine problems. The original reviews, undertaken by the Cochrane Drugs and Alcohol Group, involved 92 studies (85 in the US) and over 7,000 participants. This POD shows how some medications can reduce specific symptoms, but no single pharmacological solution has been found for cocaine dependence *per se*.

Emergency health consequences of cocaine use in Europe

Several thousand cocaine-related emergencies are reported in Europe every year. This POD studies the type of cocaine-related problems reported and the potential of using hospital emergency data for monitoring acute problems associated with this drug.

Trends in heroin use in Europe: what do treatment demand data tell us?

Understanding heroin use trends in Europe is crucial on account of the considerable public health impact of this drug. Treatment demand data are analysed in this POD to assess changes over time in the number of first-time entrants to treatment who report heroin as their main problem drug.

Characteristics of frequent and high-risk cannabis users

Cannabis is Europe's most commonly used illicit drug, with around 20 million adults (15–64 years) having used it in the last year, and around 3 million on a daily, or almost daily, basis. This POD explores the characteristics of frequent and high-risk cannabis users and reflects on how examination of this group can help design tailored interventions for those most at risk.

Models for the legal supply of cannabis

The three UN Conventions provide the international legal framework on drug control, instructing countries to limit drug supply and use to medical and scientific purposes. Yet, debate continues on the decriminalisation, or even legalisation, of drugs, particularly cannabis. Models under development for the legal supply of cannabis are described in this POD, as well as some of the questions they raise.

New developments in Europe's cannabis market

Europe has long been one of the world's largest consumer markets for cannabis, particularly resin imported mainly from Morocco. In this analysis, the EMCDDA reports how Europe's consumer market for cannabis is increasingly dominated by herbal products, with domestic herbal production supplying national markets. It also describes how imported cannabis resin appears to be getting stronger.

Synthetic cannabinoids in Europe

Synthetic cannabinoids represent the largest group of compounds currently monitored in Europe by the EU early-warning system on new psychoactive substances. Current knowledge on these substances, as well as trends in production, availability and use, are presented in this analysis.

Synthetic drug production in Europe

Synthetic drugs have been produced illicitly in Europe for over 40 years and, by global standards, Europe is a significant producer. Described in this POD are current trends in illicit synthetic drug production

Injection of synthetic cathinones

Over 50 synthetic cathinone derivatives were detected via the EU early-warning system between 2005 and 2013. This POD explores worrying new localised and national outbreaks of injecting these substances and recommends close monitoring of the issue as a public health priority.

Health and social responses to methamphetamine use

Methamphetamine is an established stimulant drug in many parts of the world (e.g. south-east Asia and the US), where it has long caused major public health problems. While methamphetamine use in Europe has historically been confined to the Czech Republic and Slovakia, new pockets and patterns of use are now emerging elsewhere in the EU, in diverse populations. In this analysis, the EMCDDA looks at challenges for the provision of health and social responses to this drug.

Internet-based drug treatment

Over the past 10 years the Internet has become recognised as a credible vehicle for delivering drug and alcohol education, prevention and treatment programmes. This POD charts developments in Internet-based drug treatment and explores some of the benefits it can offer.

Wastewater analysis and drugs

The findings of the largest European project to date in the emerging science of wastewater analysis are described in this POD. The project in question analysed wastewater in over 40 European cities (21 countries) to explore the drug-taking habits of those who live in them. The results reveal marked geographical variations.

From *Drugnet Europe*

High-risk drug use and treatment

Cited from *Drugnet Europe* No 88, October–December 2014

'Continuity and change: high-risk drug use and drug treatment in Europe' was the focus of a series of events held at the EMCDDA in September 2014. Two parallel expert meetings, dedicated to the agency's treatment demand key indicator (TDI) and to the problem drug use indicator (PDU), preceded a broader, common event open to specialists from outside the two expert groups.

While the two key indicator expert meetings explored important technical issues related to the implementation of these tools, the conference-style meeting focused on data- and multi-indicator analyses and monitoring drug treatment (as an epidemiological data source and a response to the drugs problem). Issues debated included trends and developments in high-risk opioid use; ageing drug users; vulnerable populations; high-risk use of stimulants, benzodiazepines and cannabis; treatment outcomes; and evaluating best practice.

Drug-related harms and responses

Cited from *Drugnet Europe* No 88, October–December 2014

Latest evidence in the area of drug overdose and HCV and HIV infections among drug users was among the topics discussed during a week of events organised by the EMCDDA in October 2014. Two EMCDDA expert meetings, dedicated to the agency's drug-related deaths and mortality key indicator (DRD) and the drug-related infectious diseases key indicator (DRID), were preceded by a satellite event focusing on the role of take-home naloxone in reducing opioid-related fatalities.

Epidemiologists, clinicians, public health practitioners and representatives of civil society shared perspectives with the Reitox national focal points and international organisations. Among the issues highlighted was Europe's hepatitis C virus (HCV) epidemic among people who inject drugs and the need for scaling up treatment. Treatment coverage for HCV is very low in Europe, compared to levels stipulated in current guidelines. But the potential to tackle the problem exists: effective HCV treatments have been available for some years and new treatments are being released. These, together with harm reduction measures, can contribute to the prevention of new infections and help control the epidemic.

Also raised at the meetings were the resurgence in heroin-related deaths in some European countries and new HIV infections related to the injection of stimulants.

Four new drugs to be placed under control

Cited from *Drugnet Europe* No 88, October–December 2014

On 25 September 2014, EU Ministers adopted a European Commission proposal to control four new psychoactive substances (NPS) currently raising health concerns in Europe. With the decision, the substances 25I-NBOMe, AH-7921, MDPV and methoxetamine will be subject to control measures and criminal penalties throughout the EU.

In April 2014, the extended EMCDDA Scientific Committee examined the four drugs and submitted its risk-assessment reports to the European Commission and the Council of the EU. On the basis of these, the Commission recommended to the Council on 16 June that the drugs be submitted to control measures, given that severe toxicity has been associated with their use.

The final decision entered into force the day after its publication in the *Official Journal of the European Union* on 1 October 2014. Member states now have one year to take the necessary measures to subject those substances to control measures and criminal penalties, as provided for under their legislation (complying with their obligations under the 1971 United Nations Convention on Psychotropic Substances).

Two other new psychoactive substances causing health concerns in Europe were risk-assessed by the EMCDDA extended Scientific Committee on 16 September 2014. The first of these is 4,4′ -DMAR, a derivative of aminorex with psychostimulant properties, which has been available on the drug market since at least December 2012. The second is MT-45, a synthetic opioid investigated in the 1970s for its analgesic properties and detected for the first time on the European drug market in October 2013. Respectively, a total of 31 and 28 deaths have been associated with these drugs and, in all cases, the presence of the substance in biological samples was analytically confirmed.

Pregnancy and opioid use: strategies for treatment

Cited from *Drugnet Europe* No 88, October–December 2014

Illicit opioid consumption during pregnancy brings with it the risk of an increase in obstetric complications for the mother as well as a range of potential dangers for the child, both before and immediately after birth. The primary goal when treating opioid dependence in pregnant women is to stabilise the patient. Psychosocially-assisted opioid substitution treatment is the preferred first-line therapy for this group and several combinations of substitution medicines and psychosocial approaches are available. A newly-published EMCDDA Paper reviews methadone, buprenorphine and slow-release oral morphine, used in a range of combinations with cognitive behaviour approaches and contingency management, and identifies the strengths of each medicine and method.

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

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

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

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

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

Recent publications

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

Hazardous alcohol consumption among university students in Ireland: a cross-sectional study

Davoren MP, Shiely F, Byrne M and Perry IJ *BMJ Open* (2015) 5 (e006045)

http://bmjopen.bmj.com/content/5/1/e006045.full.pd...

http://www.drugsandalcohol.ie/23350/

There is considerable evidence of a cultural shift towards heavier alcohol consumption among university students, especially women. This study aims to investigate the prevalence and correlates of hazardous alcohol consumption (HAC) among university students with particular reference to gender and to compare different modes of data collection in this population.

Description and outcome evaluation of Jigsaw: an emergent Irish mental health early intervention programme for young people

O'Keeffe L, O'Reilly A, O'Brien G, Buckley R and Illback RJ *Irish Journal of Psychological Medicine* (2015) early online

http://www.drugsandalcohol.ie/23291/

Jigsaw is an early intervention mental health service developed by Headstrong which provides support to young people, aged 12–25 years, in 10 communities across Ireland. This study aimed to profile young people who availed of Jigsaw, in one calendar year, and to provide evidence that Jigsaw's model facilitates the reduction of psychological distress.

How social context impacts on the development, identification and treatment of mental and substance use disorders among young people – a qualitative study of health care workers

Leahy D, Schaffalitzky E, Armstrong C, Latham L, McNicholas F, Meagher D, Nathan Y, O'Connor R, O'Keane V, Ryan P, Smyth B, Swan D and Cullen W *Irish Journal of Psychological Medicine* (2015) early online

http://www.drugsandalcohol.ie/23277/

Social context has a major influence on the detection and treatment of youth mental and substance use disorders in socio-economically disadvantaged urban areas, particularly where gang culture, community violence, normalisation of drug use and repetitive maladaptive family structures prevail. This paper aims to examine how social context influences the development, identification and treatment of youth mental and substance use disorders in socio-economically disadvantaged urban areas from the perspectives of health care workers.

'Causes of causes': ethnicity and social position as determinants of health inequality in Irish Traveller men

Hodgins M and Fox F *Health Promotion International* (2014) 29(2): 223–234

http://www.drugsandalcohol.ie/23272/

This study sought to engage Traveller men in a discussion about their lives, their health and key determinants of their health, with a view to engaging Traveller men in health promotion initiatives. Irish Travellers are an indigenous ethnic minority, constituting 0.8% of the population. As a marginalised group, they experience significantly poorer health status than their counterparts in the settled community. Traveller men have 3.7 times the mortality of the males in the general population. Travellers are identified as a hard-to-reach group and Traveller men particularly so. Traveller men have rarely participated in the research studies on health and health service utilization, and the results of this study, in which Traveller men participated in three focus groups, are therefore of particular interest. The Traveller men, in discussing health, related it to the absence of specific illnesses and conditions, expressing a negative and a physical concept of health. The results of the study provide evidence for the role of social constructions of masculinity in determining the health and help-seeking behaviour of Traveller men, but also the influence of wider social determinants such as ethnicity and social status. The futility of approaches to health promotion that comprise simplistic health information/education interventions is outlined in this context. The study presents a challenge to address both hegemonic versions of masculinity and discrimination based on ethnic status, and rather than challenge the behaviour of men or of health services that they come into contact with, to changing the conditions of Traveller men's lives.

The association between parental and adolescent substance misuse: findings from the Irish CASE study

Keeley HS, Mongwa T and Corcoran P *Irish Journal of Psychological Medicine* (2015) early online

http://www.drugsandalcohol.ie/23244/

This article is described more fully in a report 'Adolescents and parental substance abuse' elsewhere in this issue of *Drugnet Ireland*.

Hospital-treated deliberate self-harm in the western area of Northern Ireland

Corcoran P, Griffin E, O'Carroll A, Cassidy L and Bonner B *Crisis* (2015) early online

http://www.drugsandalcohol.ie/23287/

This study aims to establish the incidence of hospital-treated deliberate self-harm in the western area of Northern Ireland, and to explore the profile of such presentations. Deliberate self-harm presentations made to the three hospital emergency departments operating in the area during the period 2007–2012 were recorded.

There were 8,175 deliberate self-harm presentations by 4,733 individuals. Respectively, the total male and female age-standardised incidence rate was 342, 320, and 366 per 100,000 population. City council residents had a far higher self-harm rate. The peak rate for women was among 15–19-year-olds (837 per 100,000), and for men among 20–24-year-olds (809 per 100,000). Risk of repetition was higher in 35–44-year-old patients if self-cutting was involved, but was most strongly associated with the number of previous self-harm presentations.

The incidence of hospital-treated self-harm in Northern Ireland is far higher than in the Republic of Ireland and more comparable to that in England.

Recent publications *(continued)*

Parental rules, parent and peer attachment, and adolescent drinking behaviors

McKay MT *Substance Use & Misuse* (2015) 50(2): 184–188

http://www.drugsandalcohol.ie/22795/

Family factors have been widely implicated in the development of adolescent drinking behaviours. These include parental attachment and parental rules concerning drinking behaviours. Moreover, throughout adolescence attachment to parents gives way to attachment to peers, and parental rules about alcohol use become less strict. The present study examined the relationship between parental and peer attachment, parental rules on drinking and alcohol use in a large sample (n=1,724) of adolescents in the United Kingdom. Controlling for school grade (proxy for age), sex and the non-independence of respondents (clustering at school level), results showed that scores on a parental rules on drinking questionnaire were a significant statistical predictor when comparing moderate drinkers and abstainers, as well as moderate drinkers and problematic drinkers. Scores on both attachment scales were also significant, but only in the comparison between moderate and problematic drinkers, with lower attachment to parents and higher attachment to peers associated with problematic drinking.

Modeling the impact of place on individual methadone treatment outcomes in a national longitudinal cohort study

Murphy E and Comiskey CM *Substance Use & Misuse* (2015) 50(1): 99–105

http://www.drugsandalcohol.ie/22782/

Little has been published on the effect of geography on methadone treatment outcomes. This study aims to measure the effect of place on longitudinal outcomes. From 2003 to 2006, 215 clients were recruited to a cohort study of methadone treatment. Participants had their address and clinic geocoded. Treatment outcomes were measured at intake, at one and three years post-treatment, using the Maudsley Addiction Profile instrument. Spider diagrams and buffer rings were used to visually map clinics and clients. Regression models were used to measure the effect of place.

Clients' accommodation and social and criminal problems in the region had a medium to large effect on heroin use. Analysis of buffer rings revealed that clients located within a 10-km radius of a major clinic demonstrated poorer outcomes in terms of heroin use. Findings illustrated the relevance of geography on drug treatment outcomes and the planning of services.

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

Osman M and Casey P *Irish Journal of Psychological Medicine* (2014) 3(4): 281–286

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

Pregabalin is a γ-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 recent 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.

We 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.

Cigarette smoking impairs human pulmonary immunity to mycobacterium tuberculosis

O'Leary SM, Coleman MM, Chew WM, Morrow C, McLaughlin AM, Gleeson LE, O'Sullivan MP and Keane J *American Journal of Respiratory and Critical Care Medicine* (2014) 190(12): 1430–1436

http://www.drugsandalcohol.ie/22976/

Cigarette smoking is linked to important aspects of tuberculosis, such as susceptibility to infection, disease reactivation, mortality, transmission and persistent infectiousness. The mechanistic basis for this remains poorly understood. This study aims to compare the functional impairment, seen in human alveolar macrophages (AM) from non-smokers, smokers and ex-smokers, after infection with Mycobacterium tuberculosis (Mtb).

Sexually transmitted infection incidence among adolescents in Ireland

Davoren MP, Kevin H, Horgan M and Shiely F *The Journal of Family Planning and Reproductive Health Care* (2014) 40 (4): 276–282

URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC417401...

http://www.drugsandalcohol.ie/23124/

The burden of sexually transmitted infections (STIs) rests with young people, yet in Ireland there has been very little research into this population. The purpose of this study was to determine the incidence rate and establish risk factors that predict STI occurrence among adolescents in Ireland.

drugnet
IRELAND

European Monitoring Centre
for Drugs and Drug Addiction

New psychoactive substances in Europe

The market

Legal highs
Marketed in bright and attractive packaging. Sold openly in head/smart shops and online. Aimed at recreational users.

Research chemicals
Sold under the guise of being used for scientific research. Aimed at 'psychonauts' who explore the effects of psychoactive substances. Sold openly online.

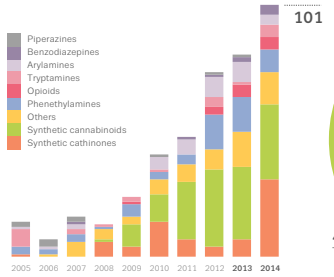
Food supplements
Sold under the guise of being food or dietary supplements. Aimed at people wanting to enhance their body and mind. Sold openly in fitness shops and online.

Designer drugs
Passed off as drugs such as MDMA and heroin. Produced in clandestine labs by organised crime. Sold on illicit drug market by drug dealers.

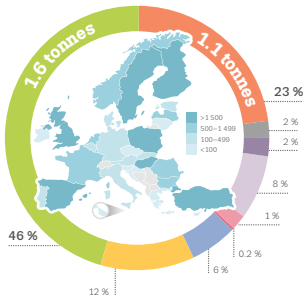
Medicines
Medicines that are diverted from patients or illegally imported into Europe. Sold on illicit drug market by drug dealers.

New psychoactive substances (NPS) — at a glance

Number of NPS reported to the EU Early Warning System, 2005–14



Number of NPS seizures and proportion of seizures by category of substance, 2013

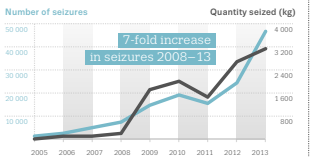


101 NPS reported for the first time in 2014

>450 NPS currently monitored

46 730 seizures amounting to more than 3.1 tonnes in Europe

Number of NPS seizures and quantity seized, 2005–13



From synthesis to consumer

Chemical companies based in China and India synthesise NPS in bulk quantity

Shipped by air or sea to Europe

Processed and packaged into legal highs, research chemicals and food supplements

Sold openly in head/smart shops and online

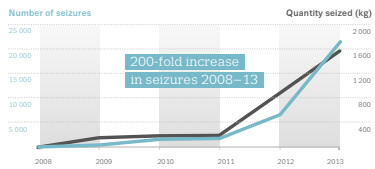
8 % of young adults have used NPS in their life (Eurobarometer)

Synthetic cannabinoids

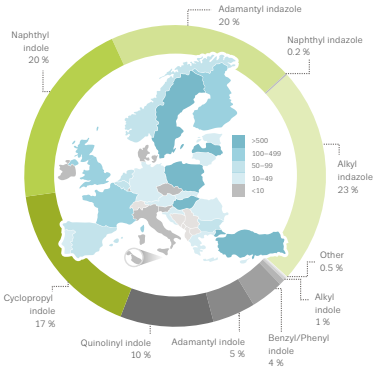
Sold as 'legal' replacements for cannabis

21 495 seizures amounting to almost 1.6 tonnes in 2013

Number of synthetic cannabinoid seizures and quantity seized, 2008–13



Number of synthetic cannabinoid seizures and proportion of seizures by sub-category, 2013



EU Early Warning System

Since 1997, the EMCDDA has played a central role in Europe's **response to new psychoactive substances**. Its main responsibilities in this field are to operate the EU Early Warning System, with its partner Europol, and to undertake risk assessments of new substances when necessary. The EU Early Warning System works by collecting information on the appearance of new substances from the **28 EU Member States**, **Turkey** and **Norway**, and then monitoring them for signals of harm, allowing the EU to respond rapidly to emerging threats.

Synthetic cannabinoids (left panel) and **synthetic cathinones** (right) make up the largest groups of new psychoactive substances monitored by the EMCDDA and, respectively, reflect the demand for cannabis and stimulants in Europe. However, the EMCDDA also monitors many new substances that come from a range of other groups, including **phenethylamines**, **opioids**, **tryptamines**, **benzodiazepines**, **arylalkylamines** and **piperazines**. All these substances require monitoring in order to identify signals of serious harms as early as possible. Opioids, for example, are of special concern for public health because they pose a very high risk of overdose and death. During 2014, serious harms that required urgent attention led to **16 public health alerts** being issued by the EMCDDA, while **6 new substances** — 25I-NBOMe, AH-7921, methoxetamine, MDPV, 4,4'-DMAR and MT-45 — **required risk assessment** by the EMCDDA's Scientific Committee.

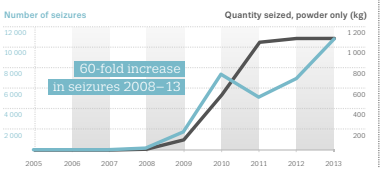
Read the full report at
emcdda.europa.eu/publications/2015/new-psychoactive-substances

Synthetic cathinones

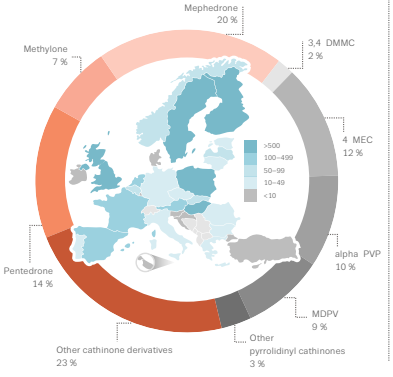
Sold as 'legal' replacements for stimulants

10 657 seizures amounting to more than 1.1 tonnes in 2013

Number of synthetic cathinone seizures and quantity seized, 2005–13



Number of synthetic cathinone seizures and proportion of seizures by substance, 2013



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