

**Suicide prevention:
the evidence base**
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New report reveals the latest drug trends in Europe

In June 2015 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published the *European drug report 2015: trends and developments*, summarising the latest trends across the 28 EU member states, and Norway and Turkey.¹ The European drug report highlights changing dynamics in the heroin market, with an overall stagnation in the demand for heroin in Europe. The report warns, however, that an increase in production in most of the countries supplying Europe with heroin could result in more of the drug becoming available in European drug markets. Other changes in market dynamics, including processing of heroin inside Europe, the emergence of alternative trafficking routes and diversification of products from opioid-producing countries in Asia, need to be monitored carefully. As the age profile of heroin users increases, providing appropriate treatment and care to long-term users is a growing challenge for drug treatment and social services.

Cannabis continues to dominate reports on all drug law offences. Around 80% of all drug seizures are of cannabis, two thirds of which are herbal cannabis, demonstrating the importance of domestically produced herbal cannabis in the European drug market. Cannabis use is around five times more prevalent than use of other substances and the drug is now, for the first time, the most frequently cited reason for entering drug treatment in Europe.

Responding to the report, Dimitris Avramopoulos, European Commissioner for Migration, Home Affairs and Citizenship, said: 'The report shows that we are confronted with a rapidly changing, globalised drug market and, therefore, we need to be united, swift and determined in our response to the drugs threat.' He continued: 'I am particularly concerned that the Internet is increasingly becoming a new source of



Aodhán Ó Ríordáin TD, Minister of State for the National Drugs Strategy, with Dr Graham Love, Chief Executive of the Health Research Board, during a visit to the HRB

European drug report (continued)

supply, for both controlled and uncontrolled psychoactive substances. 101 new uncontrolled psychoactive substances were reported in 2014, challenging our existing control mechanisms. I look forward to the forthcoming EU legislation in this area, which is currently under negotiation.

This will further strengthen our responses and equip us with better instruments to deal with these substances more rapidly and more effectively.'

The situation described in the report is presented below under a series of headings. The European drug reports use the most recent data available to provide aggregate figures. While data on some indicators, such as treatment demand, are supplied annually, the year of the most recent prevalence data can vary.

Cannabis

- The EMCDDA estimates that around 14.6 million young Europeans (11.7% of this age group, aged 15–34) used cannabis in the last year, and 8.8 million of these were aged 15–24 (15.2% of this age group).
- The use of cannabis in Europe has stabilised or is declining, especially among younger age groups. The situation varies between countries. Of the 14 countries who have conducted new surveys since 2012, four reported lower estimates, two were stable and eight reported higher estimates than in previous comparable surveys.
- Among the 3% of European adults (18–64 years) who used cannabis in the last month, about one quarter used cannabis on a daily, or almost daily, basis.



EMCDDA select new director

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has selected Alexis Goosdeel (Belgium) as the agency's new Director, starting on 1 January 2016. Mr Goosdeel, a psychologist with a background in public health, has been head of the EMCDDA's Reitox and international relations unit since 2005. This work involves coordinating a network of 30 national drug monitoring centres and preparing EU candidate and potential candidate countries for membership of the EMCDDA.

The EMCDDA is a special Lisbon-based EU agency. Its aim is to provide the EU and its member states with 'factual, objective, reliable and comparable information at European level concerning drug addiction and their consequences'. The EMCDDA was formally established in 1993 and has been operational since 1995.

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Drugnet Ireland is published by:
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European drug report (continued)

- The use of cannabis by school students aged 15–16 years varied considerably, from 5% in Norway to 42% in the Czech Republic.
- Cannabis was the most frequently reported main problem drug among those entering treatment for the first time in 2013. Between 2006 and 2013 the number of such clients increased from 45,000 to 61,000. For all clients entering treatment, cannabis was the second most frequently reported main problem drug, after heroin.
- In 2013 there were 431,000 seizures of herbal cannabis, 240,000 seizures of cannabis resin, 30,000 seizures of cannabis plants and 10,000 seizures of synthetic cannabinoids
- While the number of seizures of herbal cannabis has exceeded those for cannabis resin every year since 2009, the quantity of resin seized in 2013 is still much higher (460 tonnes compared to 130 tonnes).

Opioids (mainly heroin)

- The average prevalence of problem opioid use among European adults (aged 15–64) in 2012 is estimated at around 0.4%. This is the equivalent of 1.3 million problem opioid users in Europe.
- In Europe 41% (175,000) of all clients who entered treatment in 2013 were users of opioids (mainly heroin).
- The number entering specialist drug treatment for the first time for heroin use fell from a peak of 59,000 in 2007 to 31,000 in 2013, accounting for 20% of all clients entering treatment for the first time.
- In 11 European countries more than 10% of first-time opioid clients entering specialised treatment in 2013 were misusing opioids other than heroin. In some countries, these drugs now represent the most common form of opioid use.
- Misused methadone was the most commonly reported of the drugs being misused by opioid clients entering specialised treatment in 2013 whose main problem drug was an opioid other than heroin, accounting for 60% of treatment demand by these clients.
- Between 2006 and 2013 the median age of clients entering treatment for opioid use increased by five years. Many older opioid users are susceptible to a range of chronic health problems with implications for treatment and social support services.
- Among opioid clients entering treatment in 2013, 33% reported injecting the drug.
- Injecting continues to play a major role in the transmission of blood-borne infectious diseases such as the hepatitis C virus (HCV) and, in some countries, HIV/AIDS. There were 1,458 newly reported HIV diagnoses attributed to injecting drug use in 2013, compared to 1,974 in 2012, the first time since 2010 a decrease has been recorded.
- Of the 10 countries with national data available for 2012–13, five reported a prevalence rate of more than 50% for HCV antibodies among drug users. Six countries reported an increase, with only Norway recording a fall in HCV diagnoses.
- Heroin or other opioids were present in the majority of reported fatal overdoses. Overall, around 6,100 overdose deaths were reported in 2013, slightly up from the previous year and similar to the number reported in 2011. Between 2006 and 2013, the pattern has been one of

decreasing numbers of overdose deaths among younger drug users and increasing numbers among older users.

- Heroin seizures have been declining in Europe since 2010 and the number of seizures (32,000) and quantity seized (5.6 tonnes) in 2013 were among the lowest recorded in a decade.

Cocaine

- Cocaine is the most commonly used illicit stimulant drug in Europe, although most users are found in a small number of countries. It is estimated that about 2.3 million young European adults aged 15 to 34 (1.9% of this age group) used cocaine in the last year.
- Only Spain and the United Kingdom reported last-year prevalence of cocaine use among young adults of more than 3%. Most countries with the highest prevalence rates for cocaine use among young adults over the past few years, have reported a peak in use in 2008 and a steady decline since then.
- Cocaine was the main problem drug for 55,000 clients entering specialised drug treatment in 2013, 15% of all those entering specialised treatment in that year. The number of clients entering treatment for the first time who cited cocaine as their primary drug has been decreasing in recent years, from a peak of 38,000 in 2008 to 25,000 (16%) in 2012. Spain, Italy and the United Kingdom accounted for more than 70% of all those in treatment for cocaine use.
- The United Kingdom accounted for more than half of the 6,000 clients entering treatment in 2013 who cited crack cocaine as their primary drug.
- Across the 27 countries reporting data, at least 800 deaths related to cocaine use were recorded in 2013.
- In 2013, around 78,000 seizures of cocaine were reported in the European Union, amounting to 63 tonnes. There was a significant increase in both seizures and volume between 2008 and 2010, and the situation has been relatively stable since then.

Other stimulants and new psychoactive substances

- While lifetime use of new psychoactive substances (NPS) remains at a low level among young people, the number of new NPS reported continues to grow. These data are based on notifications by member states to the EU Early Warning System (EWS). During 2014 the EWS identified 101 NPS for the first time, an increase of 25% on 2012.
- Of the NPS detected for the first time, 31 were synthetic cathinones and 30 were synthetic cannabinoids. Other substance groups monitored are substituted phenethylamines tryptamines and piperazines. Thirteen newly reported compounds do not conform to the readily recognised chemical groups (including plants and medicines).
- The EWS has identified more than 70 new cathinone derivatives. In 2013, over 10,000 seizures of synthetic cathinones were reported to the EWS, the best known being mephedrone, controlled in Europe since 2010 but becoming increasingly important in the stimulants market in some countries. Cathinones are used in similar ways to, and often interchangeably with, other stimulants such as amphetamine and MDMA.
- Around 1.3 million Europeans used amphetamines during the last year.

European drug report (continued)

- Ecstasy contains the synthetic substance MDMA. It is estimated that 1.8 million young European adults (aged 15–34), 1.4% of this age group, used ecstasy in the last year. Decreasing prevalence of ecstasy use has been reported in all countries that have sufficient data to allow exploration of trends.

Accompanying the *European drug report* are *Perspectives on drugs* (PODs), online interactive articles providing insight into specific issues in the drugs field.

The four themes in focus this year are misuse of benzodiazepines among high-risk drug users, psychosocial interventions, drug consumption rooms, and heroin trafficking routes.

(Brian Galvin)

1. European Monitoring Centre for Drugs and Drug Addiction (2015) *European drug report 2015: trends and developments*. Luxembourg: Office for Official Publications of the European Communities. <http://www.emcdda.europa.eu/>

Ireland's national suicide strategy 2015–2020, and the evidence base

On 18 June 2015 the Taoiseach, Enda Kenny TD, launched Ireland's national suicide strategy *Connecting for life*.¹ The strategy envisions an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing. This vision will be achieved through seven goals:

1. Better understanding of suicidal behaviour
2. Supporting communities to prevent and respond to suicidal behaviour
3. Targeted approaches for those vulnerable to suicide including alcohol and drug users
4. Improved access, consistency and integration of services
5. Safe and high-quality services
6. Reduced access to means
7. Better data and research

The outcomes expected by 2020 are a reduced suicide rate in the population and among specified priority population groups, and a reduced rate of presentations of self-harm in the whole population and among specified priority groups. The strategy will be implemented by a National Cross-Sectoral Steering and Implementation Group.

The most common disorders associated with suicidal behaviour are depression and alcohol and other substance use disorders which are found in 25–50% of all suicides. People with alcohol and drug problems are one of the specified priority population groups. The HSE will continue to roll out programmes aimed at early intervention and prevention of alcohol and drug misuse. Their campaigns will build a link between alcohol and/or drug misuse and suicidal behaviour in all communications.

Evidence for effectiveness of suicide prevention interventions

On the same day as *Connecting for life* was launched, the Health Research Board (HRB) published its evidence review of the effectiveness of suicide prevention interventions.² The HRB was commissioned by the National Office of Suicide Prevention (NOSP) to examine the international evidence base for suicide prevention in order to establish which interventions were successful in reducing suicidal behaviour including suicide ideation, self-harm, suicide attempts or death by suicide.

The HRB used 34 published reviews, some of which covered more than one intervention. The HRB review assessed five interventions (means restriction, media

guidelines, gatekeeper training, screening and psychosocial interventions) and four settings (telemental health, web-based interventions, emergency departments (EDs), schools and youth strategies).

Overall, the review found the body of evidence on suicide prevention interventions to be limited but some important interventions reduced suicidal behaviours. These are restricting access to means of suicide, cognitive behavioural therapy* and dialectic behavioural therapy.** Suicide prevention interventions in ED settings (for example, reviews of treatment and expectations) also show promise. Telemental health and web-based interventions have only emerged recently and there is not enough evidence to comment on their success. Table 1 summarises the findings.

The authors recommend that all these interventions should continue to be studied so that stronger evidence-based conclusions can be reached. Published evidence in relation to suicide prevention interventions is limited. This does not mean that interventions are ineffective, but rather that there is little evidence published in peer-review journals. In addition, the societal context is important and there is a need for further high-quality research that takes account of the Irish context.

The HRB welcomes the strategic approach adopted in *Connecting for life* and in particular its focus on monitoring and evaluation.

(Jean Long)

- * Cognitive behavioural therapy (CBT) is an action-oriented form of psychosocial therapy that focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behaviour and emotional state.
- ** Dialectic behavioural therapy (DBT) is a type of cognitive behavioural therapy. Its main goal is to teach a person skills to cope with stress, regulate emotions and improve relationships with others.

1. Department of Health, Health Service Executive and National Office for Suicide Prevention (2015) *Connecting for life: Ireland's national strategy to reduce suicide 2015-2020*. Dublin: Department of Health <http://www.drugsandalcohol.ie/24167/>
2. Dillon L, Guiney C, Farragher L, McCarthy A and Long J (2015) *Suicide prevention: an evidence review 2015*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/24168/>

National suicide strategy *(continued)*

Table 1: Summary of main suicide prevention interventions and settings, and evidence for their impact

Intervention and/or Setting	Description	Evidence	Comment
Means restriction	Restricts access to means of completing suicide.	4 reviews examined. Good evidence that interventions work.	The evidence shows that means restriction (in particular, barriers) can reduce the occurrence of suicide. Other international reviews report that controls on the use of chemicals and drugs have been found to successfully reduce suicide outcomes.
Media guidelines	Based on the premise that media reporting of suicides can contribute to the phenomenon of imitative suicides, some countries have introduced guidelines for reporting.	1 review examined. Some limited evidence that intervention works.	This evidence is based on Austria's experience where the media were involved in designing national guidelines and subsequently complied with them.
Gatekeeper training	Teaches people how to identify people at risk and refer them to treatment.	1 review examined. Some limited evidence that intervention works and works best if the GP is the gatekeeper.	This evidence is based on the impact of multi-faceted strategies to prevent suicide that had gatekeeper training as one of a number of interventions in place. Therefore, it is difficult to ascertain what specific role gatekeeper training played in delivering suicidal behaviour outcomes.
Screening	Uses psychometrically validated screening instrument to identify people at risk of suicide.	Three reviews examined. Evidence mixed but weak.	The evidence base for the impact of screening on suicidal behaviours is mixed but relatively weak.
Psychosocial interventions	<i>Psychotherapeutic interventions</i> cover a wide range of interventions including cognitive behavioural therapy (CBT), dialectic behavioural therapy (DBT), problem-solving therapy and family therapy. <i>Enhanced care/outreach/follow-up</i> include interventions to help people at risk of suicide to access/maintain contact with services by means such as follow-up postcards, 24-hour emergency access to psychiatric services and home visits.	13 reviews examined. Revealed a mixed picture across the various interventions.	Overall, CBT and DBT are the <i>psychotherapies</i> for which there is the best evidence of impact on reducing suicidal behaviour. Problem-solving therapy and family therapy showed evidence of promise as effective interventions, but evidence was not conclusive. Evidence across the different types of enhanced care interventions is inconclusive.
Telemental health	Uses communications networks to provide mental health care services and education from one geographical location to another.	Two reviews available. Limited evidence.	Given the current evidence base it is difficult to draw firm conclusions regarding the impact of telemental health on suicidal outcomes.
Web-based prevention	This approach is based on the premise that people vulnerable to suicide frequently access web-based resources as a source of support. Web-based strategies for suicide prevention are only emerging.	One review. Preliminary evidence that this approach could work.	Preliminary evidence in the one review available suggests that web-based intervention strategies may be beneficial in helping to reduce suicidal behaviours.
Emergency Department (ED) interventions	EDs have been identified as important settings in which to evaluate and alleviate suicide emergencies, instigate follow-up care and reduce suicide symptoms.	One review. Limited but promising evidence that interventions in this setting work.	Care that was initiated in EDs and/or continued post-ED discharge was a promising method that may be beneficial in reducing suicide.
School-based interventions	Interventions in this setting are based on the premise that providing programmes in schools, such as knowledge and awareness, gatekeeper training, curriculum-based programmes, screening, skills training and/or peer leadership, can influence whether completed suicide occurs.	Eight reviews. No evidence that these interventions reduce suicidal behaviours.	The effectiveness or ineffectiveness of school-based prevention programmes in reducing suicidal behaviours has yet to be determined.

Source: Dillon et al. (2015)

IMO targets addiction and dependency

On 11 June 2015 the Irish Medical Organisation (IMO) launched a policy paper on addiction and dependency.¹ Speaking at the launch, IMO President, Dr Ray Walley, said: 'Addiction and dependency are some of the most challenging public health policy issues of recent times and IMO doctors are advocating for sensible and workable measures that should be examined by legislators and policy-makers to loosen the grip that substance abuse and addiction has placed on large tracts of our society.'

Alcohol

Key actions called for by the IMO include:

- the implementation of the National Alcohol Strategy without delay and immediate action to ban sponsorship and promotion of sports by the alcohol industry,
- introduction of minimum unit pricing for alcohol products, and
- creation of a strategy for the development of treatment and rehabilitation services for alcohol and drug dependency.

Gambling

The IMO believes that regulatory controls to limit the exposure of young people to gambling should be instigated immediately, including controls that limit the intensity or frequency of gambling service advertisements. Given the prevalence of gambling in Ireland, and the increased access that most young people and adults have to gambling through smartphones and other portable internet-enabled devices, effective educational programmes are needed to raise awareness of problem gambling in the Social, Personal, and Health Education (SPHE) curriculum. Funding is also needed for research into the extent of problem gambling and its effects on individuals and their families in Ireland.

Treatment and rehabilitation services

The IMO urges the government to create a strategy for the development of treatment and rehabilitation services for alcohol and drug dependency to include:

- establishment of acute alcohol and illicit drugs detoxification centres for those who wish to choose detoxification as part of their recovery;
- development of appropriate acute treatment facilities for those with alcohol and benzodiazepine dependency;
- full implementation of the Farrell Report (2010)² to allow for the expansion of numbers of patients on the Opioid Treatment Protocol and thus increase access to treatment for heroin dependence throughout the country;
- pursuit of research that will assess the potential benefits and risks of using supervised injection sites as a means of reducing drug-related harm and bringing patients into contact with drug treatment services;
- development of specialist services in dual-diagnosis, comorbid substance dependency and mental health illness, with appropriate pathways of referral in and out of services and standardised protocols for care;

- appropriate training of all physicians in treatment of addiction and dual-diagnosis, both as part of the core curriculum and continuing professional development; and
- provision of state funding for the treatment of gambling addiction.

Reducing the social cost of addiction

- Introduce spent convictions legislation that will allow minor crimes to be removed from an individual's criminal record, to better enable those convicted of minor possession offences to re-enter the workforce.
- Develop an effective substance abuse and dependence intervention programme, incorporating a referral procedure, for people who have come to the attention of various State authorities, such as An Garda Síochána or officers of the Department of Social Protection.
- Establish a cross-departmental integrated approach to treatment and rehabilitation to ensure the education, housing, and social protection needs of patients and their families are met.
- Provide financial support to local and regional drugs task forces and social services to address child- and family-related drug problems.

Funding prevention and treatment

- Ensure that contributions from the alcohol and gambling industries fund the treatment and rehabilitation of those who have developed clinical dependencies on their products.
- Route proceeds acquired by the Criminal Assets Bureau relating to drug crime to investment in drug treatment programs.

Reducing supply

Finally, the IMO urges the government to restore all resources to state agencies charged with seizing and intercepting drugs shipments, thereby affecting their availability and price in a manner that will reduce consumption. Stiff penalties are also called for to deter the importation and sale of illegal drugs into Ireland. The IMO recommends that mandatory life sentences should be imposed on those found guilty of major drug trafficking crimes.

(Brigid Pike)

1. Irish Medical Organisation (2015) *IMO position paper on addiction and dependency*. Dublin: Irish Medical Organisation. <http://www.drugsandalcohol.ie/24092/>
2. Farrell M and Barry J (2010) *The introduction of the opioid treatment protocol*. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/14458/>

CityWide starts debate ahead of UNGASS 2016

Everyone knows that in a few months' time, April 2016, the UN General Assembly will be holding a two-day debate on the UN's drug prohibition policy. It is the first time that all 190-odd UN member states have debated the drugs issue since 1998, when they voted for a plan to make the world drug-free by 2008. Reviewing this plan in 2009, the member states agreed the drugs issue remained a 'serious problem', and voted in a new political declaration and plan of action to continue tackling the problem.¹

The purpose of the 2016 UNGASS debate is to review progress in implementing the 2009 political declaration and action plan, and to **assess the achievements and challenges in countering the world drug problem.**² That small clause, to assess the achievements and challenges, is causing a huge amount of discussion and debate among and within governments and civil society around the world.³

Ireland is no exception. On 4 September 2015, the CityWide Drugs Crisis Campaign hosted a public event in Dublin, which included a screening of the film *Breaking the taboo*,⁴ followed by a panel discussion and audience Q&A session on the future of the 'war on drugs'. The panel comprised Sir Richard Branson, founder of the Virgin Group and member of the Global Commission on Drug Policy, Aodhán Ó Ríordáin, Minister of State with responsibility for the National Drugs Strategy, Bernie McDonnell, Director of Services, Community Awareness of Drugs, and Fr Peter McVerry, social justice campaigner. Keelin Shanley, broadcaster and RTÉ journalist, was moderator of the discussion.

Made in 2011, *Breaking the taboo* is a film documentary about the last 40 years of the 'war on drugs', focusing on Columbia, Brazil, Mexico, the United States and Afghanistan. In Mexico and Columbia alone, over 100,000 people have been killed in recent decades owing to the operations of drug cartels and organised criminal gangs involved in the illicit drugs trade. The film ends by examining the case put forward by the Global Commission on Drug Policy, in a report published in 2011,⁵ for drug liberalisation as the best way of dealing with the drug problem: it looks at decriminalisation of drug use, provision of safe injecting facilities, and regulation of the drug market.

In the panel discussion that followed, the Minister reiterated his commitment to facilitating the piloting of a safe injecting facility in Dublin before the end of 2015, and indicated his support for the decriminalisation of cannabis use. He acknowledged that decriminalisation was unlikely to be achieved during the lifetime of the present government. The arguments for and against these two options took up much of the panel discussion and the audience Q&A session. Thus, it is apparent that Ireland has broken the taboo on talking about the challenges on the demand side of the drug problem. But by the same token, it is apparent Ireland has not broken the taboo on talking about the challenges on the supply side.

And yet it was concerns about the supply side that led South American countries Columbia, Guatemala and Mexico to call for UNGASS 2016.⁶ Writing in 2012 from

their own devastating experiences, these countries warned that 'transnational organized crime and, in particular, the violence that it spreads in the course of its criminal activities, represent a serious problem that compromises the development, security and democratic life of all nations,...'. They called for member states to intensify their efforts with regard to the prevention and punishment of crime, the provision of social programmes in education, health, leisure and employment, and the prevention and treatment of addictions so as to preserve the social fabric. On the supply side they called for a paradigm shift:

That the United Nations should exercise appropriate leadership in this effort and conduct a process of in-depth discussion in order to analyse all the available options, including regulatory or market measures, with a view to establishing a new paradigm for preventing the flow of resources to organized crime organizations;

At the CityWide event in Dublin in early September, Minister Ó Ríordáin was careful to stress that when he talked about decriminalisation, he was not talking about legalisation: decriminalising the possession of small amounts of cannabis does not mean legalising the supply of cannabis. Although the concept of regulation was examined in the course of the film *Breaking the taboo*, the word was not mentioned by the Minister or by any other contributors at the CityWide event.

'Legalisation' implies the removal of all legal restrictions on the drug market, which in turn suggests 'open slather'. 'Regulation' on the other hand, which was discussed in the film and which was explicitly mentioned by the sponsors of the UNGASS resolution, implies control – of the production, distribution, sale and consumption of drugs – in other words, control of both supply and demand.

In recent years a growing number of countries have begun experimenting with various regulatory approaches to the illicit drug market – coffee shops in the Netherlands, cannabis clubs in Spain, a strict government-controlled cannabis market in Uruguay, commercial recreational marijuana operations in various states in the USA, and the licensing for sale of psychoactive substances clinically proven to be 'low risk' in New Zealand. While regulating the illicit drug market is still largely uncharted territory, with uncertain outcomes, policy analysts argue there are compelling reasons to press ahead with such experiments,⁷ and a recent review of risks commonly associated with cannabis regulation finds that the evidence for risks is 'weak' (see Table 1).⁸

CityWide Conference

As part of the celebrations of its 20th anniversary, CityWide is holding a one-day conference on 12 November on the theme of Drug Policy Reform. See page 32 below for further details.

CityWide starts debate *(continued)*

Table 1: Common claims regarding cannabis regulation and the supporting evidence

Claim	Strength of Supporting Evidence	Bottom Line
Legalization / regulation increases the availability of cannabis	Weak	Evidence suggests that the supply of illegal cannabis has increased under a prohibition model, and that availability has remained high among youth. Evidence does not suggest that cannabis availability among youth has increased under regulatory systems.
'[I]f marijuana was legalised, the increase in users would be both large and rapid...'	Weak	Evidence suggests that the policy environment (specifically legal status and enforcement policy) has at most a marginal impact on the prevalence of drug use, thereby suggesting that regulating cannabis markets will not inevitably cause higher levels of cannabis use.
Regulation will not reduce drug crime	Weak	Given that the prohibition of cannabis has not been shown to reduce illegal supply, it is likely that cannabis regulation is more effective at minimizing criminal markets for cannabis, despite the fact that criminal markets will continue to represent a proportion of the total market.
'We are going to have a lot more people stoned on the highway and there will be consequences'	Weak	While experimental studies suggest that cannabis intoxication reduces motor skills and likely increases the risk of motor-vehicle collisions, there is not sufficient data to suggest that cannabis regulation would increase impaired driving, and thereby traffic fatalities.
Regulation promotes drug tourism	Weak	There is a great deal of uncertainty regarding cannabis regulation and so-called 'drug tourism' and it is likely that such activity will vary across different jurisdictions based on the use of different regulatory controls.
Regulation leads to a 'Big Marijuana' scenario.	Weak	Available evidence regarding 'Big Marijuana' is currently lacking, though regulatory controls can be introduced within regulatory systems to reduce the potential of profit maximisation by cannabis retailers.

Source: Werb et al. 2015: 23

While there may be good reasons to resist the arguments and the analysis supporting experiments in regulation, a preliminary paragraph in the 2009 UN Political Declaration with regard to the world drug problem nevertheless indicates that governments and civil society organisations should at least ensure a balanced consideration of the achievements and the challenges on both the supply and the demand side of the illicit drug problem:

... the world drug problem remains a common and shared responsibility that requires effective and increased international cooperation and demands an integrated, multidisciplinary, mutually reinforcing and balanced approach to supply and demand reduction strategies.¹

(Brigid Pike)

1. UN Office of Drugs and Crime (2009) *Political declaration and plan of action on international cooperation towards an integrated and balanced strategy to counter the world drug problem*. <https://www.unodc.org/documents/ungass2016/V0984963-English.pdf>
2. *Resolution adopted by the General Assembly [on the report of the Third Committee (A/67/459): International cooperation against the world drug problem*. A/RES/67/193
3. <https://www.unodc.org/ungass2016/> for background and up-to-date information on preparations for UNGASS 2016.
4. *Breaking the taboo* film viewed on 8 September 2015 at <https://www.youtube.com/watch?v=h7Cyhq8HRVE>
5. Global Commission on Drug Policy (2011) *Report of the Global Commission on Drug Policy*. Rio de Janeiro: Global Commission on Drug Policy. <http://www.drugsandalcohol.ie/15228/>
6. *Letter dated 2 October 2012 from the Permanent Representatives of Colombia, Guatemala and Mexico to the United Nations addressed to the Secretary-General*. A/67/493
7. Caulkins JP, Hawken A, Kilmer B and Kleiman MAR (2012) *Marijuana legalization: what everyone needs to know*. New York: Oxford University Press.
8. Werb D, Watson TM and Maghsoudi N (2015) *State of the evidence: cannabis use and regulation*. Toronto: International Centre for Science in Drug Policy. <http://www.drugsandalcohol.ie/24325/>

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 the 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 New York on 19–21 April 2016. www.ungass2016.org

Released early in 2015, the **E-Book of Authorities** catalogues agreed UN statements and language on a selection of topics, to show the extent of existing international support for evidence-based drug policies. The objective of the E-Book of Authorities is to help inform international drug policy discussions, debates and negotiations. The topics covered include:

- Human rights
- Harm reduction
- Death penalty
- Access to controlled substances for medical and scientific purposes
- Flexibilities of the UN drug conventions regarding alternatives to punishment for certain drug offences
- Cultivation and alternative development
- Civil society engagement.

This e-tool is maintained by a coalition of partners including the International Drug Policy Consortium, Harm Reduction International and the Transnational Institute, and is funded by the United Nations Office on Drugs and Crime and Open Society Foundations. <http://bookofauthorities.info/about/>

Between 9 and 21 March 2015 the **Commission on Narcotic Drugs (CND)**, which supervises the application of the international drug control treaties, held its 58th Session in Vienna, including a special segment on the preparation for UNGASS 2016. In the run-up to the Session, the International Narcotics Control Board and the UN Development Program published reports intended to inform the deliberations of the 53 member states that currently comprise the CND. These two reports are described below. http://www.unodc.org/unodc/en/commissions/CND/session/58_Session_2015/CND-58-Session_Index.html

In early March 2015 the **International Narcotics Control Board (INCB)** published its **Annual Report**, which provides a comprehensive survey of the drug control situation in various parts of the world. In his introduction, the chairperson of the INCB, Lochan Naidoo, states that as the goal of the United Nations legal framework on drugs is 'the safeguarding of the health and welfare of humankind ... one of the most fundamental principles underpinning the international drug control framework, enshrined in both the 1961 Convention and in the Convention on Psychotropic Substances of 1971, is the limitation of use of narcotic drugs and psychotropic substances to medical and scientific purposes. This legal obligation is absolute and leaves no room for interpretation.'

With an eye on UNGASS 2016, the INCB devotes Chapter 1 of its annual report to reiterating the need to adopt 'a comprehensive, integrated and balanced approach to

implementing the provisions of the international drug control treaties in order to respond to the world drug problem together'. The elements of such an approach comprise:

- **Availability of internationally-controlled substances for medical and scientific purposes:** Despite the progress made in some regions, the report acknowledges that approximately three quarters of the world's population live in countries with inadequate or non-existent access to medicines containing narcotic drugs and psychotropic substances, which leads to unnecessary pain and suffering.
- **Demand reduction:** The report cites articles in the drug treaties that stipulate that member states 'shall take all practicable measures for the prevention of abuse of narcotic drugs and psychotropic substances and for the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved'. The INCB recommends that member states put greater emphasis on, and provide political support and appropriate resources to, these efforts, to ensure a proper balance between demand and supply reduction.
- **Supply reduction:** Without demand reduction, the report asserts that supply reduction cannot be effective in the long run. As well as responding effectively to emerging challenges such as new psychoactive substances and changing drug supply routes, the report calls for specific efforts to focus on depriving the illicit drug economy of its commercial attractiveness and for dismantling its socio-economic basis, for example disrupting illicit financial flows connected to drug trafficking, undermining the links between illicit drugs and other forms of criminal activity, and preventing people from being recruited by drug traffickers by addressing the socio-economic conditions that contribute to their becoming involved in the first place.
- **Socio-economic aspects:** Poverty, food insecurity, economic inequality, social exclusion, deprivation owing to migration and displacement, a shortage of comprehensive educational and recreational facilities and employment prospects, poor parental engagement and guidance during childhood, and exposure to violence and abuse are all listed as factors contributing to both the supply and demand sides and affecting the interaction between the two sides.
- **Socio-cultural aspects:** Influencing or changing people's perceptions in relation to illicit drugs is seen mainly as a prevention matter. But it is also affected to a certain extent by the overall structure of drug control policy and the image it projects: imbalanced approaches to different aspects can diminish public support. The main element of sustainable success is not reactive approaches alone, according to the report, but rather the fostering of a 'preventive culture', one that is resistant to the appeal of popular culture that promotes drug use.

<http://www.incb.org/incb/en/publications/annual-reports/annual-report-2014.html>

In early March 2015 the **UN Development Program** published **Perspectives on the development dimensions of drug control policy**. While drug control policies have been justified by 'the real and potential harms associated with illicit drug production, trafficking, and use', the report points out that

UNGASS 2016 (continued)

various UN organisations have observed that these policies have had 'harmful collateral consequences: creating a criminal black market; fuelling corruption, violence, and instability; threatening public health and safety; generating large-scale human rights abuses, including abusive and inhumane punishments; and discrimination and marginalization of people who use drugs, indigenous peoples, women, and youth'. The report goes on to note that the UN Office on Drugs and Crime (UNODC) has stated that 'the UN drug conventions do not

require penalization of drug use or drug possession for personal use' and that the UNODC Executive Director, Yuri Fedotov, has encouraged UN member states to use UNGASS 2016 as an opportunity to 'discuss ways to rebalance international drug control policy responses to focus on health and respect for human rights, and address stigma and discrimination that limits access to services by people who use drugs'. http://www.unodc.org/documents/ungass2016/Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf

Judging prohibition

Given the growing international debate about the merits of the so-called war on drugs, 'So prohibition can work?' is the provocative title of a recent article which reports on a study that considered the impact of the Criminal Justice (Psychoactive Substances) Act introduced in Ireland 2010 in response to the 'headshop' phenomenon.¹ This legislation led to the closure of 90% of the headshops then in existence throughout Ireland.² The study examined the use of new psychoactive substances (NPS) by adolescents attending addiction treatment both before and after the introduction of the legislation. Included in the study were all adolescents entering assessment at one outpatient service, comparing the six months immediately prior to the legislation in May 2010 with the same six-month period the following year.

There were 94 treatment episodes included, and the patients had a mean age of 16.8 years. Problematic use of any NPS fell from 34% (14) of patients in the pre-legislation period to no patients after the introduction of the legislation. There was also a significant decline in recent use of any NPS (82% vs 28%). Recent use of cocaine and amphetamines also declined, but problematic use of these drugs was unchanged. The authors concluded that the use of NPS among adolescents attending drug and alcohol treatment was substantially reduced 6–12 months after the legislation was introduced and after most head shops had closed. Adolescents attending after the ban also showed 'significantly lower rates of both recent use and problematic use of any NPS' (p. 3).

In discussing their findings, the authors made the following observations: '...our study cannot explain why these adolescents reduced their NPS use. It seems unlikely that concerns regarding criminal sanctions acted as an important deterrent. They demonstrated ongoing use of a broad range of similarly illegal drugs after the legislative ban' (p. 3). Highlighting the main impact of the ban, the closure of the headshop outlets, the authors make the point: 'Looking beyond NPS, we know that availability is a key factor influencing use of other substances, such as cannabis and alcohol. ...In the months following legislation 93% of the headshops closed thereby curtailing easy access to these drugs' (p. 3).

In this respect, the study supports the contention of the United Nations Office on Drugs and Crime (UNODC) and other advocates of prohibition that rates of drug use and related harms would be higher but for prohibition. However, many uncertainties remain about the long-term impact of the legislative ban. A study by Kelleher and colleagues on the legislative changes predicted that 'the reduction in the supply of NPS will lead to displacement of drug consumption choice', bringing with it 'a new set of risks to customers' (p. 141).³ In recent years, online illicit

drug sales have increased and an active street market for the sale of prescription drugs, including benzodiazepines, has developed. Kelleher and colleagues also revealed a sub-group of recreational users of NPS who were not coming into contact with healthcare professionals and it is unclear how the legislation impacted on their drug consumption behaviours.

A number of commentators criticised Ireland's legislative approach to the headshop issue. Reuter, referring to a regulatory impact analysis conducted by the Department of Justice and Equality prior to the introduction of the Act,⁴ stated that the approach adopted was 'of limited conceptual sophistication' and ultimately naïve:⁵ 'The assessment makes no mention of any potential adverse effects of prohibition. It identifies the dangers of not regulating and the potential gross gains of the regulatory options. The only negative aspects of regulation that are given any attention are the costs of operating the regulation' (p. 7).

In a similar vein, Ryall and Butler argued that, from a harm reduction perspective, the policy response was as an example of 'moral panic in that media portrayals greatly exaggerated the ill effects of head shop products, in the process stoking public anger rather than encouraging rational debate' (p. 303).⁶ Although the authors acknowledged 'a degree of sophistication' on the part of the various stakeholders at the time, including headshop owners, users, law enforcement personnel, policy advisers and the minister responsible for the National Drugs Strategy, ultimately they concluded that 'the great Irish head shop controversy ended in a clear victory for traditional "war on drugs" values' (p. 310).

Current plans in the UK to introduce legislation modelled on the Irish approach look set to revive the headshop controversy. Ultimately, it may also lead to further critical examination of the consequences of prohibition in general.⁷ (Johnny Connolly)

1. Smyth BP, James P, Cullen W and Darker CD (2015) "So prohibition can work?" Changes in use of novel psychoactive substances among adolescents attending a drug and alcohol treatment service following a legislative ban *International Journal of Drug Policy*, Early online. <http://www.drugsandalcohol.ie/24190/>
2. Connolly J (2012) Impact of legislation to control head shops *Drugnet Ireland*(40): 29. <http://www.drugsandalcohol.ie/16890/>
3. Kelleher C, Christie R, Lalor K et al. (2011) *An overview of new psychoactive substances and the outlets supplying them* Dublin: National Advisory Committee on Drugs. <http://www.drugsandalcohol.ie/15390/>

Judging prohibition (continued)

4. Department of Justice and Equality (2010) *Criminal Justice (Psychoactive Substances) Bill 2010: regulatory impact analysis* Dublin: Department of Justice and Equality. <http://www.drugsandalcohol.ie/15465/>
5. Reuter P (2011) *Options for regulating new psychoactive drugs: a review of recent experiences* London: UK Drug Policy Commission. <http://www.drugsandalcohol.ie/15458/>
6. Ryall G and Butler S (2011) The great Irish head shop controversy *Drugs: education, prevention and policy* (18/4): 303–311. <http://www.drugsandalcohol.ie/15360/>
7. 'Call to halt legal highs ban based on "flawed" Irish system' <http://www.bbc.com/news/uk-33226526>. See also Parliamentary submission by the UK drug-reform charity Release 'Proposed amendments to Psychoactive Substances Bill for Committee Stage' <http://www.release.org.uk/publications/release-transforms-submission-home-affairs-select-committees-short-inquiry-psychoactive>

Misuse of Drugs (Amendment) Act 2015

The Misuse of Drugs (Amendment) Act 2015 had to be introduced as emergency legislation after a court struck down a series of regulations introduced over the past two decades banning certain drugs.¹ In what the Court of Appeal said was a 'constitutional issue of far-reaching importance', the three-judge court unanimously said a regulation making the possession of methylethcathinone illegal was invalid.² The substance is also known as 4-Mec or Snow Blow. The judgement raises a number of questions about the rationale behind the Misuse of Drugs Act 1977, the principal legislation that underlines drug prohibition in Ireland. In particular, it raises questions about the way in which concepts such as drug harm and drug misuse are defined and incorporated into the criminal law. This article presents an edited version of the judgement.

The State successfully defended the original case in a High Court hearing in March 2014. The matter was then appealed to the Court of Appeal. At issue in the case was the constitutionality of s. 2(2) of the Misuse of Drugs Act 1977. This provision states: 'The Government may by order declare any substance, product or preparation (not being a substance, product or preparation specified in the Schedule to this Act) to be a controlled drug for the purposes of this Act and so long as an order under this subsection is in force, this Act shall have effect as regards any substance, product or preparation specified in the order as if the substance, product or preparation were specified in the said Schedule.' The court held that this section, under which regulations banning numerous substances have been introduced over the past two decades, was unconstitutional because it purported to vest in the Government law-making powers which are in the exclusive authority of the Oireachtas. In doing so, the court decided that this section of the Act failed the 'principles and policies' test.³ This test is designed to prevent a Minister or administrative agency from deciding matters that are properly the concern of the Oireachtas (Parliament). Under article 15.2.1 of the Irish Constitution, the sole power of making laws in the state is vested in the Oireachtas.

The original case concerned the prosecution of a man for possession of methylethcathinone, which was among a number of substances put on the controlled drugs list in 2010. Stanislav Bederev, who denied criminal charges of having the substance for supply in 2012, brought a High Court challenge, seeking to stop his trial by claiming the regulations were unconstitutional. Lawyers for Mr Bederev argued it was not lawful to put this substance on the controlled drug list because there were no principles and policies guiding the introduction of such rules. In particular, it was argued that the decision to ban a particular drug was a matter to be considered by the Oireachtas before the relevant government minister could formally initiate the ban.

In May 2014 the High Court rejected this challenge.

On behalf of the Court of Appeal, Mr Justice Gerard Hogan said, given what had been done in relation to the substance in this case, it might also be asked whether it would be open to the Government to employ the same law to ban other types of drugs which are in everyday use and which are potentially harmful and liable to be misused such as alcohol and tobacco. The Court of Appeal considered the evidence of the then Chief Pharmacist at the Department of Health and Children before the High Court. She had explained that drug and pharmaceutical products were ever changing and new products were constantly coming on the market. In these circumstances, 'it would be cumbersome to insist that any such new drugs or drug products which were dangerous or liable to misuse could only be banned by legislation subsequently enacted by the Oireachtas' (p.13). While acknowledging this issue, Judge Hogan asked how decisions as to the dangers of drugs or misuse came to be decided. The central question in the appeal was whether the 1977 Act contained sufficient principles and policies to inform such questions (p.23).

The Court of Appeal looked to the long title of the Act for guidance. This declares the purpose and object of the 1977 Act is 'to prevent the misuse of certain dangerous or otherwise harmful drugs' (p. 23). Judge Hogan then listed a series of key questions that he ultimately would conclude were not sufficiently addressed in the Act:

- How is it to be determined which of these dangerous or harmful drugs are to be controlled and which are not?
- How can it be determined which drugs are 'dangerous', and to whom?
- Is this standard to be measured by reference to the general public? Or would it suffice that the drug in question would be dangerous if consumed or used by certain sectors of society such as children or young adults?
- By what standards are the questions of whether particular drugs are 'harmful' and liable to be 'misused' to be assessed and determined?
- What levels of 'harm' and 'misuse' need to be established before an order could properly be made (p.24)

Summing up for the Court of Appeal, Judge Hogan stated that the unavoidable conclusion was that s.2.2 purports to vest in the Government what, in the absence of appropriate principles and policies in the legislation itself, 'are in truth law-making policies' (p. 30). As a result of the judgement, all substances controlled by means of Government Orders made under s.2(2) of the Misuse of Drugs Act 1977 ceased to be controlled with immediate effect, and their possession ceased to be an offence. These substances included ecstasy,

Misuse of Drugs (Amendment) Act 2015 *(continued)*

benzodiazepines and new psychoactive substances, so-called 'headshop drugs'. Following an emergency sitting of the Oireachtas, new legislation was passed and then signed into law by the President within forty-eight hours.

(Johnny Connolly)

1. Misuse of Drugs (Amendment) Act 2015 (No 6 of 2015) Downloaded 6 October 2015 at <http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/bills/2015/2115/document1.htm>

2. Hogan, Mr Justice Gerard, Court of Appeal (2015, 10 March) *Bederev-v-Ireland*, The Attorney General and the Director of Public Prosecutions. Dublin: Courts Service. <http://www.drugsandalcohol.ie/24355/>
3. Maddox N (2004, 7 January) Legislation by delegation - the principles and policies test in Irish law *Irish Law Times* (22/293). Available at SSRN: <http://ssrn.com/abstract=1532885>

National Drugs Strategy (NDS) 2009 – 2016: progress in 2014

The progress report provides a narrative account of progress against each action in the NDS 2009–2016, for the year 2014.¹ It indicates which actions under each pillar have been completed, where work is in under way, and where actions have been delayed or abandoned (Table 1).

Supply reduction

Under this pillar, most progress has been made in relation to local supply reduction initiatives, and compliance with EU-level obligations and operations. Local initiatives included establishing and supporting appropriate drug networks and ensuring drug issues are included in the work of Joint Policing Committees, developing frameworks for tackling drug-related intimidation in the community, targeting adults in the drug trade who use children to engage in illegal drug-related activities, improving drug-related security in prisons and introducing a presumptive drug testing regime.

Work is under way in relation to several policy initiatives – legislation on drugs and driving, licensing laws to combat sale or supply of alcohol to persons under the age of 18, the Drug Court and the Forensic Science Laboratory.

Two capital projects have been put on hold owing to the difficult economic situation – developing an integrated system to track the progression of offenders with drug-related offences through the criminal justice system, and building a new Forensic Science Laboratory.

Prevention

Actions under this pillar relate to both illicit drugs and alcohol. Most progress has been made with regard to setting up education programmes and drug policies in schools, including support mechanisms in DEIS schools, and with regard to youth interventions and facilities in out-of-school settings, and developing online prevention and help services. Work is under way developing programmes targeting families experiencing difficulties owing to drug/alcohol use and the children of drug users, and also selective prevention measures to reduce under-age and binge drinking.

The adoption of the National Substance Misuse Strategy has led to a delay in the development of a framework of targeted prevention and education interventions using a tiered approach, and in the implementation of a uniform set of drugs and alcohol education standards – while the methodologies are re-assessed to ensure they are still appropriate. It has also delayed the promotion of substance misuse policies and development of brief interventions in the informal education sector, tertiary institutions, workplaces, and youth, sport and community organisations.

Treatment and rehabilitation

Treatment and rehabilitation services continue to be developed on an ongoing basis, including both expanding the range of services and the groups with specific needs being targeted, for example families of drug users, drug users in prisons, and vulnerable groups such as travellers, LGBTs, new communities and sex workers. A clinical and organisational governance framework for all treatment and rehabilitation services has been developed.

Work is reported to be well under way with regard to developing treatment guidelines for treating blood-borne viruses, and training programmes for all involved in the provision of substance misuse treatment services. Policies and procedures for referrals of under-18 service users who are showing signs of substance use, and for young people arrested by the Gardaí, are also being developed. In response to the issue of drug-related deaths, a naloxone demonstration project has been rolled out.

A statutory regulatory framework for the provision of counselling within substance misuse services has been delayed because counselling is not one of the 12 health and social care professions designated under the Health and Social Care Professionals Act 2005. A statutory consultation process is now under way on the possible designation of counsellors and psychotherapists for regulation under the 2005 Act.

Table 1: Progress in 2014 against actions in NDS 2009–2016

Pillar	Actions			
	Total number	Completed or ongoing	Under way	Delayed or abandoned
Supply reduction	17	11	4	2
Prevention	13	7	3	3
Treatment and rehabilitation	25	11	10	4
Research and information	8	2	3	3

National Drugs Strategy (*continued*)

Research and information

In line with the EU Early Warning System, a communication protocol for notification of drug use emergencies has been developed in Ireland. The five key epidemiological indicators relating to drug use (prevalence in general population, prevalence and patterns of use of specific drugs, drug treatment demand, drug-related deaths and infectious diseases) and the associated data collection systems are also all under continuous development.

Work is under way on the development of indicators for harm reduction, public expenditure and drugs and crime, and of a system for monitoring problem substance (including alcohol) use among those presenting to hospital emergency departments, and on the roll-out of unique identifiers under the Health Identifiers Act 2014.

While the National Advisory Committee on Drugs and Alcohol (NACDA) is currently overseeing a study to estimate the prevalence of children residing with substance-misusing parents, and the conduct of two drug prevalence surveys (in the general population and the prevalence of opioid use), it has been unable to conduct rehabilitation research owing to lack of a researcher and a rehabilitation research budget. Work on disseminating research findings and models of best practice has also been hampered by lack of research staff and a reduced budget. The reform of the Coroner Service has also had to follow a more gradual, cost-neutral approach owing to the difficult national economic situation.

(Bridgid Pike)

1. Department of Health (2015) *National Drugs Strategy 2009-2016: progress report to end 2014*. <http://www.drugsandalcohol.ie/23935/>

Benzodiazepine use among young people attending a treatment centre

Benzodiazepines are commonly-prescribed drugs used for a wide range of conditions and symptoms including anxiety, insomnia and epilepsy. They have short-term side-effects, e.g. impairment of perception of risk, restlessness, agitation, anxiety and delusions, and long-term use can lead to dependence. The 2010/2011 National Drug Prevalence Survey found that lifetime use of benzodiazepines among 15–34-year-olds in Ireland was 35.7%, an increase on lifetime use at the time of the previous survey.¹

The results reported here describe the characteristics of young people attending the Matt Talbot Services in Cork between January 2005 and August 2011, and their patterns of drug use, in particular benzodiazepines.² The authors retrospectively reviewed client notes and extracted data of interest from the notes. Collecting complete data for each participant on all the variables of interest was not possible, and so the denominators for many characteristics vary depending on the completeness of the data relating to the individual variables. As a result, the proportions reported in the following account vary.

The number of clients referred to the service increased over the years, from two in 2005 to 49 in 2010. A total of 198 client files were included in the study. Almost all the clients included in the study were male (98%). This is because originally the service was just for males and only started to accept females for treatment in 2010. The average age of clients was 16.4 years (range 13 to 21 years). Most clients (55/113, 49%) were referred by the Department of Justice, either through Juvenile Liaison Officers or Probation Officers.

Almost all (182/187, 99%) had ever drunk alcohol, with half starting at 13 years or younger. After alcohol, most had also used cannabis (170/181, 94%) and tobacco (153/165, 93%). The next most prevalent drug ever used was cocaine (88/162, 54%) and then benzodiazepines (80/157, 51%).

Of the 80 clients who reported ever using benzodiazepines, one third (28/80, 35%) had used them at least once a week, and half (43/77, 56%; data on time of last use were not available for three) had used them in the previous month (classified as regular users).

The average age of first use of benzodiazepines was 14.9 years.

The characteristics of regular benzodiazepine users were compared with non-regular users. Regular users were significantly more likely to be regular users of other drugs. There were also statistically significant differences between behavioural and physical symptoms. Regular users were more likely to report paranoia, loss of interest in sports or hobbies, attention-seeking behaviour, pale/white skin, and vomiting. Skin pallor is well-known to be associated with benzodiazepine withdrawal and can last several weeks.

The study has limitations. Information was missing for many of the variables because data were extracted retrospectively from client notes so the results are not comprehensive. More data on psychosocial and clinical systems, which could have been collected through a tailored questionnaire, would have helped to provide a more comprehensive understanding of the clients.

The authors note that benzodiazepines had been used by many of the young people attending the service over the period and that many of them were regular users. Regular users were more likely to suffer from known side-effects of the drug such as paranoia. The authors urge greater awareness among health professionals of the acute and chronic negative consequences associated with benzodiazepine use in young people as described in their study.

(Suzi Lyons)

1. National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB) (2011) *Drug use in Ireland and Northern Ireland: first results from the 2010/11 drug prevalence survey*. Bulletin 1. Dublin: NACD & PHIRB. <http://www.drugsandalcohol.ie/16450>
2. Murphy K, Byrne S, McCarthy S, Lambert S, and Sahlm L (2014) Benzodiazepine use among young attendees of an Irish substance treatment center. *Journal of Addiction Medicine* 8 (3): 199–204. <http://www.drugsandalcohol.ie/22656/>

Changes to the NDTRS form for 2016 data collection

In order to comply with reporting requirements for the EMCDDA,¹ the NDTRS form for 2016 has been extensively changed and updated. As part of this process the NDTRS team also took the opportunity to revise and update the remaining questions to ensure that data important at a national level are captured as well

The revised form is shown on pages 15–18.

Spotlight on selected new and revised questions

Q2b Integrated individual health identifier (IHI)

The IHI number is included in preparation for the implementation of the IHI in the future although it is not yet available.²

Q3 – Q3a Sex: self-defined gender identity and Q3b Self-defined sexual orientation

The rationale for collection of data on self-defined gender and sexuality comes from specific actions contained in the current National Drugs Strategy (NDS).³ A key theme that emerged throughout all stages of the consultation process for the NDS was the requirement to focus on the needs of specific communities and help them to access services tailored according to their needs. In addition to the needs of prisoners, Travellers, new communities and homeless people, the other key group identified was lesbian, gay, bi-sexual and transgender (LGBT) people. This new question will provide data to allow Actions 28 and 44 of the NDS to be assessed and measured in the future in relation to LGBT people.

Q6 Number of children

The revised form will allow the number of children (under and over 18 years of age) that the client has to be recorded. This new question will enable information to be collected by age bands: less than five; five to 17; 18 and older. It will also allow the living arrangements of the children to be captured for the first time. This means that in the future, the number of children living with problem drug or alcohol users can be enumerated. This will assist with estimating the number of young and older children at risk of hidden harm.⁴

Q11a, Q11b and Q11c – Ethnicity

The NDTRS form has been updated to match the ethnicity questions asked by the Central Statistics Office (CSO). Instead of nationality, country of birth will now be recorded. The terminology for the options on ethnic/cultural background have been standardised with the CSO terminology and the option of Roma has been added. A new question on the language spoken at home (other than English or Irish) has been included. Information garnered through these questions should assist with planning services for new communities.

Q13 Main reason for referral

The list of process addictions that can be recorded has been increased and now includes gambling, spending, eating disorders, sex or porn addiction, and internet/gaming.

Q25a Current problem drug(s)

Four additional problem drugs can now be recorded instead of three. This should allow better understanding of trends in polydrug use.

Q29d Number of previous alcohol detoxes

In order to understand better the harm of problem alcohol use, a new question looks to ascertain the number of alcohol detoxes a client has undergone. The need for alcohol detoxification can be an indicator of chronic harm caused by problem alcohol use.

Risk behaviour – Q30c Frequency of injecting

In line with requirements for reporting to Europe, information on the time period during which the client last injected has been expanded:

- injected in the past 30 days;
- injected in the past 12 months, but not in the past 30 days;
- injected, but not in the past 12 months;
- Service user did not wish to answer.

Risk behaviour – Q30d and Q30e Sharing of needles and syringes and/or other drug paraphernalia

In order to comply with reporting to Europe, the questions on sharing drug equipment have now been separated out: sharing of needles and syringes is to be reported separately from other drug paraphernalia, e.g. straws, pipes etc. The time period for any sharing will also now be recorded: shared in the past 30 days; shared in the past 12 months, but not in the past 30 days; shared, but not in the past 12 months; service user did not wish to answer

Q32a Treatment interventions

Services will now be able to record the start date, end date and number of sessions of key working given during a client's treatment. Detoxification from specific additional drugs can also now be recorded including 'Z' drugs. There is also space to specify other types of drugs not listed on the form, e.g. cannabis.

NDTRS data collection 2016 (continued)

Q34 Condition and progress of client at discharge or when last seen

The revised form will try to capture more meaningful information on the condition, outcomes and progress of clients when they leave the service (for whatever reason). Information about changes in drug and/or alcohol use, about progress with their care plan (if applicable), and about engagement with other services on the road to recovery can be collected. There is also an option to 'specify' other outcomes important to different services, which will be monitored over the first year of data collection. Subsequent versions of the form will be updated and revised, where possible, to reflect important emerging measures.

Phased roll-out of training

The NDTRS team will start a phased roll-out of training for the new form in the autumn of 2015. The team will contact individual services to let them know the timetable for training. However, all services will receive the new forms, along with in-depth revised protocols, in the post in December 2015 in order to start completing them from 1 January 2016.

The NDTRS team is aware of the considerable work involved in collecting these data, and we would like to take this opportunity to thank all the services for their invaluable input and cooperation. The NDTRS team would also like to thank all those who participated in the pilot of the revised form.

New on-line database 'LINK'

In parallel to the revision of the hard-copy form, the NDTRS team are redeveloping the NDTRS database. The new system, called 'LINK', will be web-based, allowing services to enter their data directly onto the on-line system, and ultimately enabling more timely and accessible data. Information about 'LINK' and its roll-out will be published in the winter edition of *Drugnet Ireland*.

If you have any queries before this time please contact the team at ndtrs@hrb.ie.

(Suzi Lyons)

1. EMCDDA (2012) *Treatment demand indicator (TDI) standard protocol 3.0: Guidelines for reporting data on people entering drug treatment in European countries*. Lisbon: EMCDDA. <http://www.emcdda.europa.eu/publications/manuals/tdi-protocol-3.0>
2. For more information on the IHI, go to <http://www.hiqa.ie/healthcare/health-information/health-identifiers>
3. 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/>
4. Health Service Executive, Child and Family Services (2014) *Hidden harm stakeholder consultation, 28 January 2014, Radisson Hotel Sligo*. <http://www.drugsandalcohol.ie/22374/>



Aodhán Ó Riordáin TD, Minister of State for the Drugs Strategy and Dr Siobhan O'Halloran, Chief Nursing Officer Department of Health with HRB staff on recent visit to the Health Research Board



A. Administrative details

PLEASE COMPLETE USING A BALL POINT PEN

Forename _____ Address _____
Surname _____ Eircode
1a. Centre
1b. Type
2a. Client number
2b. IHI

B. Demographic details

3a. Sex (circle) 1. Male 2. Female 3. Transgender
3b. Self-defined sexual orientation (circle)
1. Heterosexual 2. Homosexual 3. Bisexual
4. Did not wish to answer this question
99. Not known
4a. Date of birth
Day Month Year
4b. Age **Years**
5. Living with whom (circle)
1. Alone 2. Parents/family
3. Friends 4. Partner (alone)
5. Partner & child(ren) 6. Alone with child(ren)
8. Foster care 7. Other 9. Not known
6. Number of children
Total number of children (if none write 0)
Under 5 yrs 5 - 17 yrs 18 yrs or Over
Number living with client
Number living with other parent
Number in care
Number living elsewhere
Living status not known

7. Living where (circle)
1. Stable accommodation
3. Homeless 4. Unstable accommodation
5. Prison 6. Institution (residential care/halfway house)
9. Not known
8a. Area of residence
(See pink book or Appendix 1)
8b. CCA
(see appendices 1/2)
8c. City/county
9a. Education: highest level completed to date (circle)
0. Primary level incomplete 1. Primary level
2. Junior cert 3. Leaving cert
4. Third level 5. Never went to school
9. Not known
9b. Age left primary or secondary school for the first time
(not third level) (years, or circle code below)
01. Never went to school 88. Still at school
99. Not known

10. Employment status (circle)
1. In paid employment 2. Unemployed
3. Training course 4. Student
5. Housewife/husband 6. Retired/unable to work
8. Other (specify) _____
9. Not known
11a. Country of Birth (circle, if other please specify)
1. Ireland 2. Other 99. Not known
Country _____
11b. Ethnic / cultural background (circle)
1. Irish 2. Irish Traveller 11. Roma
3. Any other white background 4. Black African
5. Any other black background
6. Asian Chinese 7. Any other Asian background
8. Other, including mixed background
10. Do not wish to answer this question
99. Not known
11c. Language other than English or Irish at home?
(circle)
1. Yes 2. No 99. Not known
(if yes, specify) _____

C. Referral/assessment details

12. Date of referral

Day Month Year
13. Main reason for referral Circle ONLY one option
1. Alcohol
2. Drug (specify) _____
3. Concerned person
4. Other problem (specify) _____

14. Source of referral (circle)
1. Self 2. Family 3. Friends
4. Other drug treatment centre 5. General practitioner
6. Acute hospital service excluding emergency dept.
7. Social services/Community services
8. Court/probation/police 10. Outreach worker
12. School or college 13. Prison
14. Employer 16. Emergency Department (ED)
17. Mental health professional 18. Needle Exchange
99. Not known
15. Date of initial assessment

Day Month Year

16. Assessment outcome (circle one)
1. Suitable for treatment in any drug/alcohol service
2. Unsuitable for drug or alcohol treatment
4. Psychiatric assessment only
3. Referred to another site, no intervention provided in this centre
If 2, 3, 4 STOP and return form to HRB.
17. Where client is suitable for treatment (circle one)
1. Treatment offered with this centre and client **accepted**
10. Treatment offered with this centre and client **DID NOT** accept
3. Client did not fulfill criteria to commence treatment
4. Client commenced treatment with another centre
5. Service unable to contact / locate client
7. Client sent to prison 8. Client died
11. Other (specify) _____
If 1 continue form, otherwise STOP and return form to HRB.

D. Treatment details

18. Number of times started treatment in this centre this year (Jan-Dec) (Enter 1, if first time this year) Times
19. History of treatment (answer both questions, please tick)

	Never treated	Previously treated	Age first treated (years, if unknown 99)	Treatment status unknown
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

20a. Ever received any opiate substitution before (excluding this current treatment)
1. Previously received 2. Never received 99. Not known
20b. Age first received any opiate substitution (excluding this current treatment) years
If unknown, Code 99

E. Drug use

a. Current problem drug(s) including alcohol (write in words)	b. Route of administration (use code)	c. Frequency of use in last month (use code)	d. Age at first use (years, if unknown 99)
21. Main drug			
22. Drug 2			
23. Drug 3			
24. Drug 4			
25. Drug 5			

26. Age first used any drug (excluding alcohol and tobacco)
 years (if not applicable code 88)
27. Specify first drug ever used (excluding alcohol and tobacco)

28. Was it difficult to assess which was the main problem drug?
1. Yes 2. No

E. Drug use, continued

If alcohol is listed as a problem drug at Q21-Q25, please complete Q29a to Q29d, otherwise go to Q30a.

29a. Please specify the preferred types of alcohol consumed (circle all that apply)

2. Beer 3. Spirits 4. Wine 5. Fortified wine 6. Cider 7. Alcopops
8. Other specify _____

29b. How many standard drinks were consumed on a typical drinking day over the past month?

(if none write 0)

Standard drinks

29c. Please categorise the extent of the drinking problem (circle)

2. Hazardous drinker 3. Harmful drinker 4. Dependent drinker

29d. Number of previous alcohol detoxes

(if none write 0, if unknown 99)

F. Risk behaviour

30a. Ever injected (circle) 1. Yes 2. No 9. Not known

If no or unknown, go to Q30e.

30b. If yes, age first injected

If unknown, Code 99

years

30c. Frequency of injecting (circle one only)

1. Injected in the last 30 days
2. Injected in the last 12 months **but not** in the last 30 days
3. Injected but not in the last 12 months
4. Client did not wish to answer 99. Not known

30d. Ever shared needle and syringes (circle one only)

2. Never shared
1. Shared in the last 30 days
3. Shared in the last 12 months **but not** in the last 30 days
4. Shared but not in the last 12 months
5. Client did not wish to answer 99. Not known

30e. Ever shared any other drug paraphernalia (excluding needles and syringes)

(circle) (e.g. straws, foil, pipes)

2. Never shared
1. Shared in the last 30 days
3. Shared in the last 12 months **but not** in the last 30 days
4. Shared but not in the last 12 months
5. Client did not wish to answer 99. Not known

31. History of viral screening (one tick per column)

	Hepatitis C	Hepatitis B	HIV
1. Never tested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Tested in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Tested but not in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Client did not wish to answer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99. Not known	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. Activity details

32a. Treatment interventions	32b. Date started	32c. Date finished (or of last visit)	32d. Number of sessions/visits	32a. Treatment interventions	32b. Date started	32c. Date finished (or of last visit)	32d. Number of sessions/visits
Brief intervention				Methadone substitution			
Individual counselling				Buprenorphine/naloxone substitution			
Group counselling				Detox from alcohol			
Group education/awareness programme				Detox from heroin			
Individual education/awareness programme				Detox from methadone			
Medication free therapy				Detox from benzodiazepines			
Complementary therapies				Detox from "Z" drugs			
Social and/or occupational reintegration				Detox from other drug Specify: _____			
Family therapy				Community detox			
Structured after care programme				Key working			
Strengthening family programme				Case manager appointed			
Psychiatric treatment				Care plan			
Multi component model							

H. Exit details

33a. Exit details (circle)

1. Treatment completed
2. Transferred/referred to another drug/alcohol treatment service
4. Client declined further treatment
5. Client did not return for appointments (no show/DNA)
6. Premature exit for non-compliance. Specify reason (circle one)
1. Drug taking 2. Violent behaviour 3. Illegal activities
5. Alcohol taking 4. Breaking service contract
7. Released from prison but not linked to other treatment service
9. Sentenced to prison
14. Prison to prison transfer
12. No longer lives in the area
8. Died
10. Other (specify) _____

33b. Transfer or referral (circle)

1. Transferred/referred to another centre for additional/continued alcohol or drug treatment (specify centre) _____

33c. Please specify the number of family members or significant others (who were not treated for a personal addiction) involved in this treatment

Please write 0 if none

34. Condition of client at discharge or when last seen (circle all that apply)

1. Drug free 11. Engaging with care plan
2. Drug use unchanged 12. Disengaged from care plan
3. Drug use increased 13. Care plan gaps and blocks identified
4. Drug use reduced 14. Engaging with other services (e.g. housing, education)
5. Abstaining from alcohol 15. Engaging with other therapeutic services (e.g. self help groups, AA)
6. Alcohol consumption unchanged 16. Engaging in other unstructured aftercare
7. Alcohol consumption increased 17. Other (specify) _____
8. Alcohol consumption reduced 99. Not known
10. Substantially reached priority goals of care plan

35. Date of final discharge or transfer

Day Month Year

Treated problem alcohol use in Ireland, NDTRS data 2013

The most recent figures on treated problem alcohol use from the National Drug Treatment Reporting System (NDTRS) show that a total of 7,549 cases were treated for problem alcohol use in 2013, a drop of 12.3% since 2011.¹

The total number of cases has reduced for the last two consecutive years for which data are available, from a peak of 8,604 in 2011, down to 8,336 in 2012 and 7,549 in 2013 (Table 1). The number of new cases presenting for the first time for treatment also decreased, by 20.8%, from 4,520 in 2011 to 3,578 in 2013. Between 2009 and 2012, the number of cases who returned for treatment increased by 19.5% (from 3,524 cases in 2009 to a peak of 4,212 in 2012), but between 2012 and 2013, a decrease was recorded for this group, from 4,212 to 3,801, a drop of 9.8%.

No specific geographic trends were observed for 2013. Twenty-two of the 32 local health offices reported a decrease in the number of treated cases, with Cork/North Lee (6.6%), Waterford (6.4%) and Donegal (5.9%) reporting the highest proportions of cases in 2013. The incidence of treatment for problem alcohol use by county between 2009 and 2013 was highest in Waterford, Donegal, Sligo, Leitrim and Carlow (with each of these counties reporting more than 240 cases per 100,000 of the 15–64-year-old population).

As in previous years, almost one in five (18.8%) of those treated for problem alcohol use in 2013 reported problem use of at least one other drug. The most common drugs used were cannabis, followed by cocaine, benzodiazepines and ecstasy. Use of more than one drug increases the complexity of cases and can lead to poorer outcomes for the patient.

In 2013, there were no significant changes in the sociodemographic characteristics of those treated for problem alcohol use compared to 2012:

- Half of those in treatment for problem alcohol use started drinking alcohol at 15 years of age or younger.
- The median age for cases was 40 years.
- While the proportion of cases under the age of 18 remained small in 2013 (3.0%), the number of new cases in that age group fell, from 6.4% in 2010 to 5.0% in 2013.
- The majority of cases, both new (62.6%) and previously treated (64.0%), were male.
- The proportion of cases in employment increased from 19.7% in 2012 to 21.5% in 2013.
- The proportion of all cases who were homeless in 2013 was 5.7%. Previously treated cases were more likely to be homeless (7.4%) than new cases (3.8%).

Notwithstanding the increase in the number of treatment centres reporting to the NDTRS within the time period, there was a decrease in the number of cases treated between 2011 and 2013. This may reflect a true decrease in the number of cases presenting for treatment for problem alcohol use but may also reflect reduced levels of participation, or under-reporting to the NDTRS, or a combination of both.

NDTRS data for 2004 to 2013 are available on line through interactive tables located on the National Documentation Centre's website: <http://www.drugsandalcohol.ie/key-info/>

(Suzi Lyons)

1. Health Research Board (2015) *Treated problem alcohol use in Ireland: figures for 2013 from the National Drug Treatment Reporting System*. Dublin: National Health Information Systems, Health Research Board. <http://www.drugsandalcohol.ie/23564>

Table 1: Number and proportion of cases treated, by treatment status, NDTRS 2009–2013

Treatment status	2009	2010	2011	2012	2013
	Number (%)				
All cases	7816	7866	8604	8336	7549
New cases	4220 (54.0)	4178 (53.1)	4520 (52.5)	4028 (48.3)	3578 (47.4)
Previously treated cases	3524 (45.1)	3583 (45.6)	3971 (46.2)	4212 (50.5)	3801 (50.4)
Treatment status unknown	72 (0.9)	105 (1.3)	113 (1.3)	96 (1.2)	170 (2.3)

Nursing in contexts of marginalised health

The first Nursing in Contexts of Marginalised Health Conference took place in Dublin City University on 11 September 2015. This timely event, which brought together nurses from public health, addiction, academia, policy, and other sectors, coincided with the move of the Drugs Policy Unit in the Department of Health from Primary Care to the Office of the Chief Nursing Officer.

In the morning session, Susan Kent, Deputy Chief Nursing Officer, spoke about the important, though often invisible, role of nurses and midwives in shaping healthcare policy and practice. Diane Nurse, national planning specialist in the HSE's Social Inclusion Unit, provided an overview of activities within the Social Inclusion Unit, where three of six staff deal primarily with issues of homelessness and drugs. It is hoped in the future that services will not be based on specific, often marginalised, groups but on a more holistic approach, which recognises the people as individuals with particular needs. One of the challenges of those working in social inclusion is defining and demonstrating outcomes. Commissioning must be evidence- and needs-based, but outcomes tend to be long-term.



Mairéa Nelson, Mary Dunne and Brian Galvin who work in the HRB's National Drugs Library

This theme was continued in the afternoon session by Linda O'Driscoll, Drug Treatment Court Nurse Liaison. The aim of the Drug Court is to prevent recidivism. Although only a small proportion graduate from the programme, Linda sees improvements in everyone who takes part. Many have chaotic lives, so demonstrating changes in their behaviour and better management of their daily lives is a positive outcome that may not be officially recognised. The Liaison Nurse supports clients through her role as advocate and expert to the team and Judge in all aspects of treatment.

Aoife O'Driscoll, policy officer at the National Adult Literacy Agency (NALA), spoke about removing barriers in healthcare, especially the medical language used by health practitioners when speaking to clients. She advocates using plain English rather than medical 'jargon' whenever possible and ensuring that clients understand their treatment plans.



The panel discussion that closed the conference acknowledged the complexities inherent in managing concurrent marginalisations. Participants believed that poor information-sharing, large caseloads and professional isolation were having negative impacts on their nursing work. It was agreed to maintain the momentum generated at the conference by creating a website and uploading the conference presentations and setting up a forum, and it is hoped to develop a nurses group that will continue to advocate for change on behalf of the marginalised in society.

The HRB's National Drugs Library presented a poster (see image on this page) at the conference to show those working with marginalised groups that the National Drugs Library is a physical library that is open to the public and provides access to our books, journals and databases, though most people access our resources through our website www.drugsandalcohol.ie

(Mary Dunne & Mairéa Nelson)

Predicting retention in MMT in Ireland

A cross-sectional study of clients attending a large methadone clinic in Dublin was conducted in March 2012, with the aim of identifying the factors associated with relapse from methadone maintenance treatment (MMT) and the reasons for the relapse.¹

Almost two thirds (189, 63%) of the total 300 clients attending the clinic in March 2012 participated in the study. A researcher administered a questionnaire collecting data on demographic characteristics and clinical factors and asked a series of open-ended questions regarding reasons for breaking treatment. Participants were categorised into two groups: those who had had a break in their MMT (n=87, 46%) and those with no break in their MMT (n=102, 54%).

The demographic profile of both groups was relatively similar (Table 1). The majority were male and single, and there was a very high level of unemployment in both groups. A higher proportion of those with a break in MMT were homeless (7.6% versus 1.1%), and co-habiting was more common among those with a break in MMT (34.5% versus 17.6%). The median age of those with a break was 33 years, slightly younger than those with no break (36 years).

Clinical factors were also similar in both groups (Table 1), although just over half (52.3%) of those with a break in MMT were taking a methadone dose of 60mls or less compared with only 32.4% of those with no break.

Of those who ever had a break in MMT, most only reported one break (83.9%, 73). The length of break varied from less than one month to 18 months but the median duration was two months. Females were more likely to have had shorter breaks compared to males but no other factors were found to be significant in relation to duration of MMT.

Statistical analysis showed that age was the only *demographic factor* significantly associated with not having a break: older clients were less likely to have a break in MMT. Three *clinical factors* were significantly associated with not having a break: current methadone dose higher than 60 mls, longer time in treatment, and less than one year in current treatment episode. In addition, although the numbers were small, nine out of the ten clients with a prescription for anti-psychotic medicine did not report a break in treatment.

Table 1: Demographic and clinical factors of clients with or without a break in MMT

Demographic characteristics	With a break (n=87)	No break (n=102)
Gender		
Male	70.1%	70.6%
Age (median)	33 years	36 years
Marital status		
Single	58.3%	78.4%
Co-habiting	34.5%	17.6%
Married	7.1%	3.9%
Housing		
Hostel	30.4%	27.7%
Own home	26.6%	38.3%
Rented	20.3%	14.9%
Other's home	15.2%	18.1%
Homeless	7.6%	1.1%
Employment		
Unemployed	94.3%	95.1%
Employed	5.7%	4.9%
Clinical factors		
Age first used opiates (median)	18 years	17 years
Length in MMT	110 months	100 months
Length of current treatment episode	24 months	36 months
Current dose of methadone		
60mls or less	52.3%	32.4%
61 mls or more	47.7%	67.7%

Source: Adapted from Darker et al (2015)

Methadone maintenance treatment (continued)

The most common reasons for breaks in MMT reported by the study participants were:

- 21.8% – relapse to drug use
- 13.7% – ‘fed up with methadone’ and wanting to detox off
- 11.4% – imprisonment or problems with the police
- 10.3% – difficulty with travelling to the clinic or clinic times
- 8.0% – being ‘clean’
- 6.8% – being out of the country
- 6.8% – emotional events, e.g. family bereavements
- 3.4% – not wanting to take methadone while pregnant
- 3.4% – illness.

Reasons given for regular attendance were:

- 37.5% – wanting to get or stay ‘clean’
- 16.1% – wanting to avoid sickness
- 13.9% – methadone dependence
- 10.2% – level of services provided by clinic
- 5.1% – withdrawal symptoms
- 5.1% – support from family members
- 4.4% – only having to attend a few times a week.

The findings of this study in relation to older age and higher methadone dose being predictors of retention in MMT correspond with the findings of other national and international research studies. The authors state that the finding in relation to anti-psychotics was unexpected, although the numbers involved were very small. They refer to published literature suggesting that Olanzapine, an antipsychotic drug, has been found to increase retention among clients with schizophrenia and that very occasionally methadone has been used to treat psychotic symptoms. The most common reason for break in treatment reported in other studies has also been relapse to drug use.

While the study confirms that higher methadone doses may improve retention in treatment, the authors recommend that this should be balanced against the known side-effects of increasing the dosage, e.g. constipation, hypotension, drowsiness and increased dependence. The second recommendation is in relation to prescribing anti-psychotics to clients with psychotic disorders in order to improve retention. The authors also recommend that further research be carried out to explore the impact of schizophrenia on MMT and that more in-depth research be carried out on the reasons for breaks in treatment in those groups known to be at higher risk.

(Suzi Lyons)

1. Darker C, Ho J, Kelly G, Whiston, L and Barry J (2015) Demographic and clinical factors predicting retention in methadone maintenance: results from an Irish cohort. *Irish Journal of Medical Science*, Early online. <http://www.drugsandalcohol.ie/24022/>

Low-threshold residential stabilisation service (LTRSS) in Ireland

In June 2014 the Ana Liffey Drugs Project (ALDP) published a position paper proposing the provision, on a three-year demonstration basis, of a low-threshold residential stabilisation service (LTRSS). The paper outlines the concept of LTRSS and how this differs from current services as well as describing how the service would operate and the steps required to begin implementation.¹

Definition of LTRSS

The overall aim of an LTRSS is to provide a ‘genuine person-centred service, catering for those with greatest need’. The paper describes LTRSS as follows:

- low threshold – barriers to entry are kept as low as possible;
- residential – medically-led inpatient programme, with psychosocial support and follow-up care;
- stabilisation – stabilising the individual’s drug use, as well as providing detoxification (if appropriate) and referral to community or residential services;
- access to the service based on individual need, as measured by a comprehensive assessment tool; and
- time-bound (no more than a 28-day stay), but flexible to meet the client’s needs.

The proposed new service is described as differing from services currently available in Ireland in that it is open access, based on a holistic assessment of need and not determined by the individual’s drug use. There would be no cost to the client. Outcomes would not be solely clinically based but would also focus on enhanced stability.

Rationale

A number of local and national policy documents which support the development of LTRSS in Ireland are cited in the position paper. In particular, the feedback from the consultation process for the current National Drugs Strategy (2009–2016) and the strategy itself highlighted the need for services tailored to the needs of individuals and also the need to enhance all aspects of treatment, stabilisation and harm-reduction services.

While there is a general recognition of a need for expanded residential treatment options, the paper argues that services for polydrug users require particular attention. Polydrug use is a significant factor in drug-related deaths and as Ireland has one of the highest rates of drug-related deaths in Europe, there is a very strong rationale for the development of residential services which are not restricted to single drug use and which are responsive to the chaotic lifestyles of polydrug users.

Low-threshold residential stabilisation service (continued)

The paper states that polydrug users' access to the majority of existing residential stabilisation and detoxification services is restricted, and that an LTRSS would provide a more flexible treatment model adapted to the needs of this particular at-risk group.

At the same time, the paper recognises that the client's presenting needs, as opposed to the potential clinical outcome, should be the primary determinant of service provision. The paper lists patient characteristics that can help determine whether a client is likely to benefit from in-patient provision. These include:

- dependence on more than one drug,
- physical complications,
- co-morbidity,
- history of complications during previous withdrawals,
- chaotic polydrug use,
- pregnancy,
- failed outpatient withdrawal, and
- inability to cope with out-patient withdrawal owing to isolation, homelessness or lack of support.

The proposed LTRSS would target those presenting with these characteristics through a comprehensive assessment process.

Principles

The LTRSS would provide a 24-hour, seven-days-a-week programme based on the following principles:

- *Access based on the person's need at the time of presentation:* when a bed becomes available, the person with the greatest need would be offered a place; there would be no waiting list. (See next section for a fuller explanation of this principle.)
- *Limited length of stay:* maximum stay of approximately 28 days depending on need; the goal would be stabilisation with an option for detoxification.

- *Type or level of drug use not a barrier to entry:* Polydrug users and those with comorbid mental health issues will not be excluded except where the individual's mental or physical health is a barrier to their receiving the stabilisation service.

Proposed service

Clients would be able to self-refer. An initial detailed assessment would be conducted following which a case would be brought to a team meeting to determine whether a client requires admission and the level of priority they should be given. If no bed is available, the client would be asked to come back on a daily basis until a bed is available.

Prior to admission, a structured care plan would be developed with the client, setting out clear goals for the treatment episode. All clients would be seen by the service's GP prior to admission, to ensure that clinical risk is appropriately assessed, medical history is complete and any necessary adjustments have been made to the care plan.

During their stay clients would be regularly monitored to ensure they are medically stable. The service would be overseen by a GP. Discharge would usually be to a residential treatment facility. However, discharge to day programmes, family or other structured supports would also be possible.

Next steps

The ALDP is currently seeking funding and a premises to operate the service on a demonstration basis for three years beginning in 2017.

(Margaret Curtin)

1. Ana Liffey Drug Project (2015) *Ana Liffey Drug Project position paper on the provision of low threshold residential stabilisation service (LTRSS) in Ireland*. Dublin: Ana Liffey Drug Project. <http://www.drugsandalcohol.ie/24100/>

Needle exchange provision in Ireland in 2012

The Health Service Executive (HSE) recently published a review of needle exchange provision in Ireland.¹ The review was designed to assess the effectiveness of HSE-funded needle exchange services, using evidence from 2012. In particular, the study examined:

- needle exchange activity nationally,
- referral rates to health and social care,
- data collection procedures and clinical governance, and
- quality assurance and clinical governance.

Data for 2012 were collected between February and June 2013, using a questionnaire consisting of closed and open-ended questions. The data collection template was reviewed to ensure that it met the data-recording requirements

of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). All six non-statutory needle exchange services and all HSE regional offices returned questionnaires. However, of the 63 pharmacies where needle exchange services were available, only 33 had reported transactions in 2012 and of these only 16 returned questionnaires.

Models of needle exchange in Ireland

The three models of needle exchange in use in Ireland in 2012 are documented in the review. These were:

1. static – 24 sites mainly in Dublin City,
2. outreach – 14 sites mainly in counties Dublin, Kildare, Laois, Offaly, Waterford and Wicklow, and
3. pharmacy – 63 sites in regions outside Dublin, Kildare and Wicklow.

Needle exchange provision (continued)

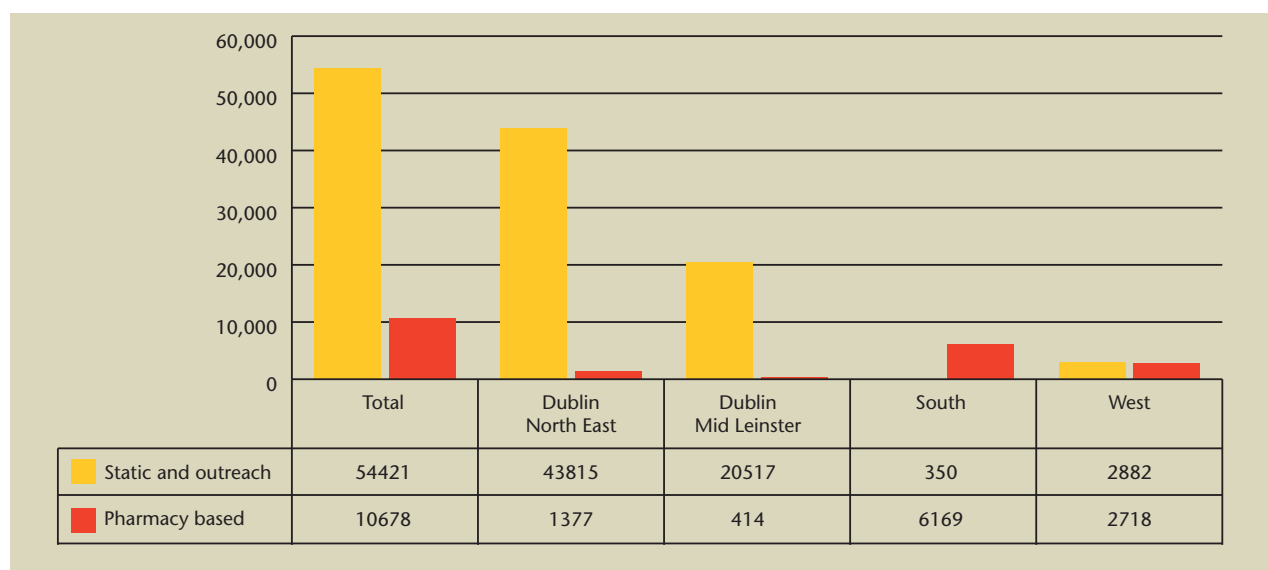


Figure 1: Number of transactions at needle exchange services, by region and model of service, 2012

Access

Pharmacy needle exchange programmes provided the greatest level of accessibility, with pharmacies typically open six days a week and providing, on average, 48 hours of service weekly. On the other hand, 15 of the 24 static services opened for less than eight hours a week, and seven opened for 25–43 hours per week. Half (seven) of the outreach services opened for less than 25 hours a week, while five opened for 25–43 hours per week and two whenever needed.

Activity

The review indicates that 13,763 individuals used the needle exchange service during 2012, of which 7,359 (80%) were men and 1,862 (20%) were women. However, as there is no unique health identifier in Ireland, the authors urge caution in the use of these totals because individual service users may have been counted more than once.

A total of 65,099 needle exchange transactions are reported to have occurred during 2012, with the majority (84%) being provided through static or outreach services in either Dublin North-East or Dublin Mid-Leinster (see Figure 1). The differences in the level of use of each exchange type is a reflection of the number of services available in each area.

Paraphernalia distributed

Detailed information on the quantity of injecting equipment distributed at all sites was made available to the reviewers, with the exception of two static sites where only partial information was available. Individual items were distributed at the static and outreach services, whereas packs of equipment were distributed at the pharmacy-based exchanges.

Static and outreach services

In total, 156,575 syringes and 135,696 needles were distributed. Almost half of all syringes (49%) were fixed needle with a unit capacity of 1ml. In addition, the following items were distributed:

Vials of 10ml water for injection	75,819
Vials of 5ml water for injection	8,377
Vials of 2ml water for injection	1,572
Spoons/filters	25,450
Citric acid	20,125
Sterile swabs	20,603
Foil (for smoking heroin)	12,031
Tourniquets	476

The review points to a discrepancy between the number of needles and quantity of other injecting equipment distributed. In particular, the fact that 67,928 more needles than vials of water were made available is highlighted. This, the authors state, may signal that some equipment was being used more than once, contrary to best practice.

Pharmacy-based needle exchanges

A total of 11,790 packs, each containing the equipment for 10 sterile injections, were distributed through pharmacy-based needle exchanges. Each pack contained 10 filter syringes (including needles), 10 stericups, 10 swabs, 10 citric acid packs, 10 vials with 5ml water for injection and one information leaflet (harm reduction and safer injecting advice).

Returns policy

All services reported that they encouraged the return of used equipment but that this was not a condition for accessing new equipment. All pharmacy-based needle exchanges kept a record of equipment returned, but across the static and outreach services the level of record-keeping varied.

Needle exchange provision (continued)

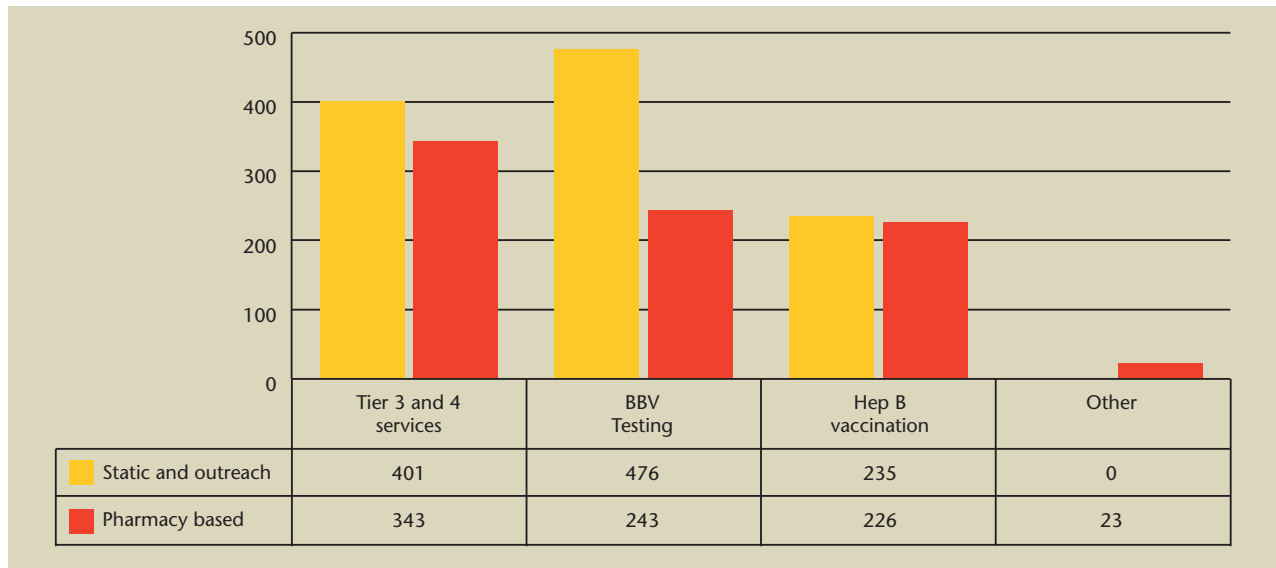


Figure 2: Number of referrals to different services, recorded by model of needle exchange, 2012

Referrals and other services

The number of referrals reported to the review team are outlined in Figure 2. The authors state that this is an under-estimation of the level of referral from the static and outreach services. The review states that all services reported providing information on blood-borne viruses (BBVs) but that recording of the numbers referred for BBV testing or for hepatitis B vaccination was inconsistent in the static and outreach services. Referrals from the pharmacy-based services were recorded and reported systematically.

All services reported providing face-to-face advice on overdose and harm reduction as well as referrals to other treatment and counselling services. Other services included referral to general practitioners, A&E, outreach and social care services as well as wound care and injection site inspection.

Quality assurance and governance

The review details the quality assurance mechanisms in place in the various needle exchange services. Governance requirements for pharmacies are set out in the Pharmacy Act 2007, which gives the Pharmaceutical Society of Ireland powers of inspection, investigation and enforcement. All static and outreach needle exchange services work within the National Drug Rehabilitation Implementation Committee (NDRIC) framework, which is designed to ensure service providers offer individuals affected by drug misuse a range of integrated options tailored to meet their needs and create for each person an individual rehabilitation pathway. These services are reported as using a range of clinical governance approaches.

Recommendations

The review recommends a standardised electronic reporting mechanism for regular monitoring and reporting of all needle exchange transactions. It also points to the need for a unique identifier for each service user to remove the risk of individuals being reported more than once in a reporting year. The need for specific data on injecting of image- and performance-enhancing drugs is also highlighted.

An examination of the potential barriers to BBV testing and vaccination is also recommended in order to improve uptake of this opportunity for testing and vaccination.

A number of recommendations are included with regard to the standards that need to be in place in order to enhance quality assurance and clinical governance.

Finally, the review recommends the provision of injecting equipment (e.g. steri-cups, filters and foil) in addition to needles and syringes, and points to the possibility of central purchasing of stock for all non-pharmacy needle exchange programme as a means of strengthening value for money.

(Margaret Curtin)

1. Bingham T, Harnedy N, O'Driscoll D and Doyle J (2015) *Review of needle exchange provision in Ireland*. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/23916/>

Releasing prisoners early – Community Return

The Community Return programme represents an attempt to address a trend of rising prison numbers and increasing prison costs identified in the report of the Thornton Hall Project Review Group in 2011.¹ Concerns about prison overcrowding and projected further growth in prison numbers led the Group to recommend alternatives to custody from two perspectives – front-door and back-door strategies.

Community Return is a back-door strategy, along the lines of a proposal made by the Group: 'A positive step would be for the Minister to introduce a form of earned temporary release with a requirement of community service to prepare offenders for release on completion of their sentences' (p.60). The programme is a joint Probation Service and Irish Prison Service (IPS) initiative whereby selected prisoners

Releasing prisoners early *(continued)*

are granted temporary release on condition they perform unpaid supervised work in the community.

A recent evaluation of the programme describes the Community Return programme as 'a unique and innovative initiative, developed and introduced in Ireland in 2011'.² It began as a pilot between October 2011 and April 2012, and proved to be 'extremely successful in assessed compliance with the conditions of the release and behaviour' (p.13), and in terms of the very low level of reconviction of participants. The success of the pilot led to the programme being mainstreamed.

The evaluation was conducted to assess the 'operation, impact, and effectiveness of the Community Return programme through a piece of descriptive and evaluative research' (p.8). The study cohort comprised all 761 Community Return programme participants between October 2011 and 31 December 2013. A mixed methods approach was used in the study, as well as analysis of anonymised pre-existing data on participants held by the IPS. Questionnaires were completed by relevant IPS and Probation Service personnel.

The Community Return programme participants were predominantly male, with women comprising approximately 6%. Seventy-seven per cent of participants were aged between 21 and 40, with the greatest concentration of both genders (43%) being aged between 21 and 30 years.

Some of the key findings are listed below:

- 62% of participants were from Leinster, and 43% of all participants were from Dublin. Of the total population who commenced the programme, approximately 53% were located in three major urban areas (Dublin, Cork and Limerick).
- Of the 761 offenders who commenced the programme, 90% were serving custodial sentences of less than six years, and 45% were serving sentences of between two and four years imprisonment. The average sentence length was 3.2 years.
- 40% of participants had been convicted of drug offences, 16% of assaults and related offending, and 9% of robbery and related offences.
- 38% of participants were released from open prisons – Shelton Abbey and Loughan House. Among closed prisons, Mountjoy Prison contributed the highest proportion of participants, at 11%.
- Of the 761 participants who had commenced the programme, 548 had completed it and 108 were still in progress. Eighty-eight, approximately 11%, breached conditions of the programme and were returned to custody. Of those participants released during the first year of the programme (n=233), 91% had not been committed to prison on a new custodial sentence in the period up to the end of 2013.
- 9,580 weeks of unpaid work, comprising 201,056 hours, were completed by participants. Based on the national minimum wage in 2014 for an adult worker of €8.65 per hour, this represents €1,739,135 worth of unpaid work completed for the community by Community Return participants.

The most common types of work undertaken by participants were landscaping/gardening, painting/decorating and renovation, with the study finding 'participants preferring work which allowed them to see a job through from beginning to end rather than constant switching between jobs' (p.9). Supervisors interviewed for the study reported that participants performed positively in their work and displayed a positive attitude towards the work.

Over 80% of Probation Officers attributed participant compliance primarily to a desire to avoid returning to prison. In some cases this was complemented by secondary motivational factors such as 'participant enjoyment of the work experience, appreciation of their early release or, a sense of commitment to the Community Return contract' (p. 9).

The single biggest difficulty faced by participants following their release involved access to social protection entitlements ('social welfare'), affecting one third of participants. Other reported challenges included coping with the strictness and frequency of the signing-on conditions, difficulties accessing entitlements and payments, and time and costs in travelling to worksites. Particular benefits of the programme included the 'structure and routine which aided re-integration, the work ethic and self-esteem developed, their positive profile in working in the community and the learning of work skills transferable to employment' (p.9). The programme also reportedly helped participants 'stay out of trouble...', by keeping them occupied, providing positive supports and a starting point to build on, particularly in the early stages after release' (p.10); research shows that newly-released prisoners are particularly vulnerable to relapse to anti-social behaviour and offending.

The report concludes that the Community Return programme has potential for further expansion. There is, the report concludes: 'capacity available at present on supervised Community Service sites that could be used to accommodate extra prisoners on the Community Return Programme. It is recommended that the Community Return Programme selection process be reviewed and revised as appropriate to, as outlined, expand the Community Return Programme, enhance supervised resettlement and reduce the prison population' (p.43).

In their joint strategic plan for 2015–2017, the IPS and the Probation Service have committed to implementing many of the recommendations in the evaluation report including aiming to match or exceed the target of 450 participants each year in reparative and restorative structured releases.

(J Connolly)

1. Thornton Hall Project Review Group (2011) *Report of the Thornton Hall Project Review Group* Dublin: Department of Justice and Equality <http://www.drugsandalcohol.ie/15678/>
2. Irish Prison Service & Probation Service (2014) *Community return: a unique opportunity. A descriptive evaluation of the first twenty six months (2011–2013)*. Dublin: Department of Justice and Equality. <http://www.drugsandalcohol.ie/23016/>

Inchicore Bluebell Community Addiction Team – annual review 2014

The Inchicore Bluebell Community Addiction Team (IBCAT) recently published its 2014 annual review.¹ IBCAT was formed in 2011 with the merger of Inchicore Community Drugs Team and Bluebell Addiction Service. The service underwent a change of leadership in 2014, with Stuart Fraser succeeding Celine Martin, who was director for 15 years.

Services

IBCAT recognises that many of its users struggle with issues such as homelessness, poverty and mental health problems, and aims to offer a holistic approach to addiction treatment. In 2014 the service provided 25,311 interventions to problem drug users, their children and families. This was a slight increase on 2013, achieved despite funding cutbacks. Services provided include:

- key working,
- counselling,
- a drop-in service,
- a children’s project,
- family support,
- outreach (including prison visits), and
- aftercare.

IBCAT operates several groups for specific target populations. The women’s and men’s groups offer a safe environment for discussion and support around gender-specific issues. The family support group offers a safe space and peer supports for local people living with addiction. The cannabis group offers a peer support model to help service users make more informed choices and to reduce their usage. Progression of clients in the cannabis group is tracked every three months by evaluating how cannabis use is affecting the client financially, physically, emotionally and socially.

Let It Shine programme

The main focus of IBCAT’s 2014 annual review is the pilot polysubstance misuse group. The ‘Let It Shine’ group was created in response to a perceived trend of service users misusing more than one drug. This trend had also been reported in a 2010 ethnographic study of drug use in the Canal Communities area.²

Ten IBCAT clients took part in the pilot – five women and five men, all of whom were also on the methadone programme. The average age of the participants was 38, and the average number of different drugs being used weekly before attending the group was five. The programme lasted 12 weeks and the aim was ‘to give those attending factual, relevant information so that they could be more aware of their drug use and make more informed choices...Peer support is to be encouraged at all times’ (p. 19).

A contingency management method of treatment was used, whereby each participant was given a loyalty card and received incentives for regular attendance. The facilitators monitored the behaviours they were trying to change, including attendance and abiding by group rules. Positive reinforcement was in the form of credits, which could be exchanged for phone credit, food vouchers and so on. When the participant did not attend or the group rules were broken, positive reinforcement was withheld. The three aims of a contingency management approach are to reduce alcohol and drug use, retain problem drug users in treatment programmes, and promote positive contributions to society.

The programme was evaluated using two metrics: (1) drug spend before and after the programme, and (2) a ‘happiness scale’ to test for changes in happiness, again before and after the programme. Table 1 tracks the changes in drug use and drug-related spending over the course of the 12-week programme. Although the number of participants is very small (n=10), the reductions in drug use are notable.

Table 1: Comparison of use of, and money spent on, drugs before and after participation in pilot polysubstance misuse group, 2014

Drug	Number of participants using weekly (total participants=10)			Average weekly spend		
	Before	After	% Change	Before	After	% Change
Heroin	8	3	-63%	€115	€32	-74%
Cannabis	5	4	-20%	€97	€45	-54%
Alcohol	5	3	-40%	€102	€52	-49%
Crack cocaine	4	2	-50%	€225	€25	-89%
Benzodiazepines	4	3	-25%	€27	€15	-45%

Source: Inchicore Bluebell Community Addiction Team (2015): Appendix II

IBCAT annual review (continued)

Of particular interest are the 74% decrease in average weekly spend on heroin, and the 89% decrease in the average weekly spend on crack cocaine. The number of clients using heroin reduced from eight before the programme to three after the programme.

Increases in happiness were reported across the nine areas of their lives about which participants were asked, ranging from a 13% increase in happiness about their 'personal life' and a 14% increase in happiness in relation to their 'drug use' up to a 37% increase in 'job or educational prospects' and a 38% increase in relation to their 'social life'. Overall, participants reported a 39% increase in 'general happiness'.

The happiness scores for individual participants were not reported.

(Martin Grehan)

1. Inchicore Bluebell Community Addiction Team (2015) *Inchicore Bluebell Community annual review 2014*. Dublin: Inchicore Bluebell Community Addiction Team. <http://www.drugsandalcohol.ie/24226/> For further information on IBCAT, visit www.icdt.eu
2. Saris A J and O'Reilly F (2010) *A dizzying array of substances: an ethnographic study of drug use in the Canal Communities area*. Dublin: Local Drugs Task Force. <http://www.drugsandalcohol.ie/13503/>

Coolmine Therapeutic Community annual report 2014

The Coolmine Therapeutic Community (CTC) annual report for 2014 was launched by Aodhán Ó Ríordáin TD, Minister of State with special responsibility for the Drugs Strategy, on 14 July 2015.¹ It contains information and statistics relating to services, strategic partners, funders and supporters.

The year 2014 saw CTC providing treatment and rehabilitation services to over 1,250 people, supporting them and their families in overcoming their addiction. The report notes the continuing increased demand for CTC's services. The services offered by CTC and the numbers of people accessing them in 2014 are shown in Table 1 overleaf.

New initiatives during 2014 were established and resourced through existing funding. February 2014 saw the establishment of the 'Parenting under Pressure Programme', which has been used by clients from across the service. Most notably, during May 2014 CTC began to implement its pilot 'Community Alcohol Treatment Programme' (CATP). Also started in 2014 was a 'Recovery through Nature' (RtN) programme, which provides clients with the opportunity to volunteer in a nature-rich environment once a week, and offers an additional therapeutic outlet for clients to aid their retention in service while gaining new life skills. During the first six months of this programme, 84 clients participated and the retention rate was 73%. CTC clients volunteered over 3,000 hours in conservation projects in Fingal County Council Millennium Park, Tolka Area Partnership, Wicklow Mountains National Park, and in Dublin City Council projects such as Bull Island biosphere conservation works and bulb/flower planting in St Anne's Park.

Coolmine's work is evidence-based and its commitment to formal research is evidenced by the completion of its three-year longitudinal study, due to be published in 2015. Among the key findings of the study are:

- 71% of clients were drug-free 24 months after concluding therapy,
- 97% of clients did not engage in criminal activity 24 months after therapy, and
- 25% of clients were employed 24 months after therapy.

Coolmine hosted the European Working Group on Drugs-Oriented Research (EWODOR) symposium at Trinity College Dublin in May 2014 and will host the conference of the European Federation of Therapeutic Communities (EFTC) in 2017.

(Vivion McGuire)

1. Coolmine Therapeutic Community (2015) *Annual review 2014* Dublin: CTC. Available at <http://www.drugsandalcohol.ie/24309/>

Coolmine annual report *(continued)*

Table 1: Services/interventions offered by CTC, number of participants and outcomes, 2014

Service	Type of intervention	No of participants	Outcomes
Ashleigh House	<ul style="list-style-type: none"> • Therapeutic groups • Health promotion • Relapse prevention • Social skills • Self/peer evaluation groups • Art classes • Computer courses • Horticultural projects • Complementary therapies 	67 women	<ul style="list-style-type: none"> • 23 clients had a methadone detox and 18 completed their detox. • 51 mothers were worked with: <ul style="list-style-type: none"> – 22 mothers had their child (children) on site on a permanent basis – 28 children were worked with and attended the full-time crèche
Coolmine Lodge	<ul style="list-style-type: none"> • Therapeutic groups • Health promotion • Relapse prevention • Social skills • Self/peer evaluation groups • Art classes • Computer courses • Horticulture • Complementary therapies 	147 men	<ul style="list-style-type: none"> • 11 clients had a methadone detox and 73% completed their detox. • 42% of admissions were referrals from prison/probation services.
Outreach	<ul style="list-style-type: none"> • Prisons and Community 	981 clients	<ul style="list-style-type: none"> • 710 clients assessed by outreach services teams: <ul style="list-style-type: none"> – 131 client assessments for methadone detox admission – 353 client placements in Ana Liffey/CTC pre-entry groups – 65 expectant mother and child assessments for admission
Drug-free day programme		54 clients (Lord Edward Street)	<ul style="list-style-type: none"> • 38 new admissions • 14 progressions to aftercare • 9 graduated
		19 clients (Dublin 15)	<ul style="list-style-type: none"> • 4 progressions to aftercare
Welcome Stabilisation Programme		54 clients	<ul style="list-style-type: none"> • 49 new admissions • 17 progressions to further supports
Family support services	<ul style="list-style-type: none"> • Group and 1:2:1 setting 		<ul style="list-style-type: none"> • 56 attended weekly support groups • 46 were supported 1:2:1 • 19 attended Community Reinforcement Approach Family Training (CRAFT) groups
Career Guidance Service	<ul style="list-style-type: none"> • Career guidance sessions • Community Employment (CE) Schemes • Literacy support • Business in the Community (BiTC) programme • Work placements • Volunteer work 	427 individual 1:2:1 sessions with Career Guidance officer	<ul style="list-style-type: none"> • 238 clients seen in group career guidance sessions • 146 clients applied for education/training • 14 CE Schemes • 47 clients provided with literacy support • 29 clients took part in BiTC programme • 39 clients gained placements or volunteer work
Contingency Management Programme		31 clients	<ul style="list-style-type: none"> • 24 new admissions • 20 progressions to further supports

EMCDDA update

Drugs policy and the city in Europe

On 25 June 2015, ahead of International Day Against Drug Abuse And Illicit Trafficking (26 June), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published *Drugs policy and the city in Europe*.¹ The paper looks at drugs in cities across Europe, revealing how some cities are developing drug strategies of their own.

The European Union is one of the most urbanised areas in the world and its cities are set to become more densely populated. Currently 73% of the EU's population resides in cities and this is projected to increase to 82% (or 30 million new residents) by 2050. The report identifies 10 European capitals with a dedicated drugs strategy: Berlin, Bucharest, Copenhagen, Helsinki, Lisbon, Madrid, Prague, Stockholm, Vienna and Warsaw. The report focuses on four topics: urban spaces and drug use; businesses and recreational drug use; city-level drug policies; and coordinating and funding city-level policies.

Urban spaces and drug use

Eight capital cities report current 'open drug scenes', which can vary from the 'concentrated' (up to hundreds of users per day) to the 'dispersed' (multiple smaller gatherings). Despite these variations, common features exist, namely: the presence of polydrug use, health issues linked to injecting, and problems relating to congregations of users. The report explores some of the responses currently used, including needle- and syringe-exchange programmes, drop-in centres, drug consumption rooms, and measures to reduce drug-related litter (e.g. sharp bins, needle-exchange machines).

Businesses and recreational drug use

Cities contain a high density of premises where psychoactive substances are sold and consumed. Frequently, specific areas exist where many of these businesses are clustered together. This can give rise to zones where drug use and intoxication are tolerated, if not accepted. Given the diversity of the drug problems found in such areas, a spectrum of responses is being implemented. These range from prevention and harm-reduction initiatives in recreational settings (e.g. information campaigns, pill-testing) to legislative measures targeting new psychoactive substances and street-based outlets for their sale.

City-level drug policies

The report defines city-level policies as 'measures taken by local policy actors to address all or some aspects of drug problems in a specific urban location'. It finds that city-level drug strategies frequently mirror the focus of national and regional level documents. Other cities, however, adopt a more thematic approach, addressing specific issues such as open drug scenes (Copenhagen, Oslo), anti-social behaviour (Dublin) and crack cocaine (London and Paris).

Coordinating and funding city-level policies

Generally, city authorities are formally responsible for the coordination of city-level drug policy, in some cases this being established by law (Helsinki, Madrid, Warsaw). Some cities have dedicated drug policy units, while others address drug issues via generic policy units. Officially appointed 'city drug coordinators' exist in some capitals. Where no formal coordination structures exist at city level, national-, regional- or local-level structures are responsible for strategy implementation (Ankara, Bratislava, Bucharest, and Dublin).

Irish parliamentarians visit EMCDDA

A delegation of members of the Joint Committee on Justice, Defence and Equality of the Oireachtas visited the EMCDDA on 4 and 5 June 2015. The delegation attended the launch of the European Drug Report 2015 (see separate report on this publication elsewhere in this issue), after which they met EMCDDA experts regarding the Portuguese drug law in the context of drug legislation in the EU member states. They also met the EMCDDA Director.

Following the visit to the EMCDDA, the delegation held meetings with Dr João Goulão, a representative of the Commission for Addiction Dissuasion (CDT) in Portugal, members of the Committee on Health of the Portuguese Parliament, and the National Deputy Director of the Polícia Judiciária from Portugal. They also visited the Taipas treatment centre in Lisbon.

1. European Monitoring Centre for Drugs and Drug Addiction (2015) *Drugs policy and the city in Europe*. EMCDDA Papers. Luxembourg: Office for Official Publications of the European Communities. <http://www.drugsandalcohol.ie/24173/>

Recent publications

Flexible emotion-based decision-making behavior varies in current and former smokers

Briggs Z, O'Connor M, Jollans EK, O'Hallorhan L, Dymond S, Whelan R (2015) *Addictive Behaviors* (45): 269–275

www.drugsandalcohol.ie/24350/

The influence of smoking status on flexible decision-making was examined. Both current and former smokers displayed poorer decision-making than non-smokers. Current smokers had poorer flexible decision-making than former and non-smokers.

Young people's perceptions of tobacco packaging: a comparison of EU Tobacco Products Directive & Ireland's Standardisation of Tobacco Act

Babineau K, Clancy L (2015) *BMJ Open* (5/6) e007352

URL: <http://bmjopen.bmj.com/content/5/6/e007352.abstrac...>

www.drugsandalcohol.ie/24349/

The removal of brand identifiers, including colour, font and embossing, reduced the perceived appeal of cigarette packs for young people across all three tested brands. Packs standardised according to Irish legislation were perceived as less attractive, less healthy and smoked by less popular people than packs which conform to the EU TPD (Tobacco Products Directive) 2014 guidelines.

Recent publications (*continued*)

Patients accessing ambulatory care for HIV-infection: epidemiology and prevalence assessment

Tuite H, Horgan M, Mallom PWG, McConkey SJ, Mooka B, Mulcahy F, Walsh C, O'Hora A, O'Flanagan D, Bergin C, Fleming C (2015) *Irish Medical Journal* (108/7)

URL: <http://www.imj.ie/ViewArticleDetails.aspx?Article...>

www.drugsandalcohol.ie/24348/

This study describes the demographics and treatment status of HIV-infected adults accessing ambulatory care in the Republic of Ireland and estimates diagnosed HIV prevalence rates.

Youth engagement with an emerging Irish mental health early intervention programme (Jigsaw): participant characteristics and implications for service delivery

O'Reilly A, Illback R, Peiper N, O'Keeffe L, Clayton R (2015) *Journal of Mental Health* Early online: pp. 1–6

www.drugsandalcohol.ie/24343

Data about young people who engaged with Jigsaw for the first time during 2013 were captured through an online system designed to record salient clinical, case management, service delivery, and outcome information. Participant characteristics were summarised to portray the young people who engaged with the service (N=2,420).

The majority of young people engaging with Jigsaw were female, aged 15–17 years, and were referred by their parents. Over half were in full-time education, although many 21–25-year-olds were unemployed. Young people presented with a range of difficulties, which varied by age and gender. They reported high levels of distress, with age and gender having a significant impact on their well-being.

Implementing a harm reduction approach to substance use in an intimate partner violence agency: practice issues in an Irish setting

Morton S, Hohman M, Middleton A (2015) *Partner Abuse* (6/3): 337–350

www.drugsandalcohol.ie/24305/

There has been growing recognition of the co-occurrence of substance use and intimate partner violence (IPV) victimisation in women's and men's lives, yet many IPV service providers have not developed an integrated response to these issues. Fewer still have implemented substance use services from a harm reduction approach. This article outlines the approach, policy changes, initial outcomes, and learning points for an IPV agency in Ireland, which implemented a harm reduction response to female IPV survivors who were also using substances problematically. Barriers and challenges for staff and management seeking to coordinate and integrate service delivery on the dual issues are also presented.

Attitudes and perceived risk of cannabis use in Irish adolescents

Barrett P, Bradley C (2015) *Irish Journal of Medical Science* Early online

www.drugsandalcohol.ie/24297

This was a descriptive, cross-sectional study using a structured, anonymous questionnaire. The study was undertaken in nine public and private secondary schools in Cork City and suburbs. Students aged 15–18 and in fourth, fifth or sixth year of school were included.

What are reasons for the large gender differences in the lethality of suicidal acts? An epidemiological analysis in four European countries

Mergl R, Koburger N, Heinrichs K, Székely A, Tóth MD, Coyne J, Quintao S, Arensman E, Coffey C, Maxwell M, Várník A, van Audenhove C, McDaid D, Sarchiapone M, Schmidtke A, Genz A, Gusmão R, Hegerl U (2015) *PLoS ONE* (10/7) e0129062

URL: <http://journals.plos.org/plosone/article?id=10.137...>

www.drugsandalcohol.ie/24288/

In Europe, men have a lower rate of attempted suicide compared to women and at the same time a higher rate of completed suicides, indicating major gender differences in lethality of suicidal behaviour. The aim of this study was to analyse the extent to which these gender differences in lethality can be explained by factors such as choice of more lethal methods or lethality differences within the same suicide method or age group. In addition, we explored gender differences in the intentionality of suicide attempts.

Men used highly lethal methods in suicidal behaviour more frequently, but there was also a higher method-specific lethality, which together explained the large gender differences in the lethality of suicidal acts. Gender differences in the lethality of suicidal acts were fairly consistent across all four European countries examined. Males and females did not differ in age at time of suicidal behaviour. Suicide attempts by males were rated as being more serious independent of the method used, with the exceptions of attempted hanging, suggesting gender differences in intentionality associated with suicidal behaviour. These findings contribute to understanding of the reasons for gender differences in the lethality of suicidal behaviour and should inform the development of gender specific strategies for suicide prevention.

The voice of the child in social work assessments: age-appropriate communication with children

O'Reilly L, Dolan P (2015) *British Journal of Social Work* Early online

URL: http://www.tusla.ie/uploads/content/Age_Appropriat...

www.drugsandalcohol.ie/24246

This article describes a child-centred method for engaging with children involved in the child protection and welfare system. One of the primary arguments underpinning this research is that social workers need to be skilled communicators to engage with children about deeply personal and painful issues.

Recent publications (continued)

There is a wide range of research that maintains play is the language of children and the most effective way to learn about children is through their play. Considering this, the overarching aim of this study was to investigate the role of play skills in supporting communication between children and social workers during child protection and welfare assessments. The data collection was designed to establish the thoughts and/or experiences of participants in relation to a Play Skills Training (PST) programme designed by the authors. The study revealed that the majority of social work participants rated the use of play skills as a key factor for effective social work assessments of children. Of particular importance, these messages address how social work services can ensure that the voice of children is heard and represented in all assessments of their well-being and future care options.

Increase in diagnoses of recently acquired HIV in people who inject drugs

Glynn R, Giese C, Ennis O, Gibbons Z, O'Donnell K, Hurley C, Ward M, Igoe D, Fitzgerald M (2015) *EPI-Insight* (16/7)

URL: <http://ndsc.newsweaver.ie/epiinsight/1bumldnml2k?a...www.drugsandalcohol.ie/24244>

An increase in recently acquired HIV in people who inject drugs (PWID) has been noted in Dublin since early 2015. We have defined recently acquired HIV infections as those in which the person tests positive using a combined HIV antigen/antibody screening assay, negative or indeterminate on a confirmatory immunoblot assay, and is p24 antigen positive, or has had a HIV negative test within the 12 months prior to the positive test or who suffers an acute HIV sero-conversion illness.

A multidisciplinary incident team has been set up by the Director of Public Health in Dublin to investigate and respond to the increase. The team includes public health and HIV physicians, GPs providing services for drug users and homeless populations, Health Service Executive (HSE) social inclusion staff, addiction clinicians, a clinical virologist and the Health Protection Surveillance Centre (HPSC) Ireland. An epidemiological investigation is under way. Clinicians from the drug services are concerned that the increase is linked to

injection of a synthetic cathinone PVP (with the street name Snow Blow), with consequent more frequent injecting and unsafe sexual and needle-sharing practices. This has mainly been seen in chaotic drug users, who report polydrug use, and are often homeless.

Evidence to date indicates that the increase has been occurring since June 2014. Fifteen cases of recently acquired HIV infection (confirmed cases) and one case with epidemiological link to a recently acquired HIV infection (probable case) have been diagnosed in PWID in Dublin from June 2014 to June 2015. Of the 15 cases, seven are p24 antigen positive, indicating very recent infection. A further 16 possible cases among PWID are currently under investigation and new cases continue to be detected. Among the 16 confirmed and probable cases, 11 are male and five are female, and the mean age is 35 years (range 24 to 51 years). A case control study is under way to identify any association between use of Snow Blow and an increase in unsafe injecting practices, at-risk sexual behaviour and acquisition of HIV.

Treatment outcome for adolescents abusing alcohol and cannabis: how many 'reliably improve'?

Smyth BP (2015) *Irish Medical Journal* (108/5): 137-139

www.drugsandalcohol.ie/23955/

Alcohol and cannabis are the primary substances contributing to referrals of adolescents to substance abuse treatment services. Their outcome has not been examined in Ireland. A three-month follow-up was conducted in an outpatient adolescent treatment program. We followed up 35 high-risk users of alcohol and 55 high-risk users of cannabis. Although the high-risk drinkers achieved a significant reduction in median number of days drinking ($p=0.004$), only four (11%) were abstinent at follow-up. A further five (14%) achieved a reliable reduction in days of drinking. The high-risk cannabis users demonstrated a significant drop in median days of use ($p<0.001$), although only six (11%) were abstinent at follow-up. A further 20 (36%) achieved a reliable reduction in days of use. Calculation of reliable change allows examination of outcomes which fall short of the elusive goal of abstinence.

Upcoming events

October 2015

5-8 October 2015

Centre for Addiction Research and Education Scotland – 14th CARES Conference

Venue: Caird Hall, Dundee, Scotland

Further information: www.isamdundee2015.com

The topic for this year's CARES conference will be 'Novel interventions in the substance misuse field'. The speakers are coming from China, USA, Abu Dhabi, Germany, UK and Netherlands. They will present topical and clinically applicable material on new evidence showing the efficacy of neurosurgery, vaccines, heroin, cannabinoids and other novel psychoactive substances as potential future therapeutic agents and interventions in the treatment of substance misuse.

8-9 October 2015

Alcohol use conference

Venue: Portmarnock Hotel

Further information: <http://www.ndublinrdtf.ie/event/alcohol-use-confer...>

The North Dublin Regional Drugs And Alcohol Task Force is planning a conference addressing alcohol use in October 2015. The event will be open to all professionals working with people & families in North County Dublin and North Fingal affected by drugs and alcohol.

Upcoming events *(continued)*

16 October 2015

Cannabis - why not? A quality standards based conference for those who work with young people and families at risk of substance misuse

Venue: Radisson Blu Royal Hotel, Dublin 8

Further information: <http://www.eventbrite.ie/e/cannabis-why-not-regist...>

The day will include the following guest speakers:

Kevin A. Sabet PhD, consultant, advisor to three US presidential administrations, and assistant professor, has studied, researched, written about, and implemented drug policy for almost 20 years. He worked in the Clinton (2000) and Bush (2002–2003) administrations, and in 2011 stepped down after serving more than two years as the senior advisor to President Obama's drug control director. He is the author of *Reefer sanity: seven great myths about marijuana* (New York: Beaufort Books, 2013).

Deirdre Boyd, based in the UK, owns DB Recovery Resources (<http://www.dbrecoveryresources.com/>), which supplies a daily news service to the international alcohol/drug-treatment field on addiction recovery. Prior to that, she was for over 20 years CEO of the Addiction Recovery Foundation, editor of *Addiction Today*, cofounder/organiser of the UK/European Symposia on Addictive Disorders, and author of *Addiction & Recovery: self-help for friends, families and addicts* (2010). Deirdre will discuss the findings of an evaluation of the declassification of cannabis in the UK and also what DB Recovery Resources is and how it can assist those working with people in substance misuse.

Philip James trained as a psychiatric nurse in Dublin in 1999, was appointed as the first Clinical Nurse Specialist in Adolescent Substance Misuse in 2006 with YoDA, and is a qualified cognitive behavioural therapist. In addition to his clinical work, he has been involved in a number of research projects and publications. He lectures on addiction and mental health topics at a number of colleges including University College Dublin, Trinity College Dublin, University of Limerick and the Irish College of Humanities and Applied Sciences. Philip will present YoDA's findings on a study co-authored with Dr Bobby Smyth about 'cannabis – the perspectives of young smokers'.

Parentline will present information on non-violent resistance training – a brief, practical and research-based programme aimed at providing parents with strategies for coping with child-to-parent violence.

November 2015

12 November 2015

CityWide Drugs Crisis Campaign conference

Venue: The Hogan Suite, Croke Park, Dublin 3

Further information: <http://www.citywide.ie/news/>

2015 marks the 20th anniversary of CityWide Drugs Crisis Campaign. It is also a year when drug policy reform issues such as decriminalisation are being put on the policy agenda in Ireland in advance of the development of the next National Drugs Strategy. As part of its 20th anniversary celebrations, CityWide is holding a major conference on the overall theme of Drug Policy Reform to look at the following questions:

1. What have we learnt from 20 years' experience of trying to tackle the drugs issue here in Ireland?
2. How can we link our experience in Ireland to the international debate on moving from the 'war on drugs' to a public health and human rights approach?
3. How can we bring together the learning and evidence from the Irish and the international experience to feed into the new Irish National Drugs Strategy?

The conference will be addressed by President of Ireland, Michael D. Higgins.

January/February 2016

28 January 2016

Reporting for work under the influence of drugs and alcohol – employers' legal obligations

Venue: Rochestown Park Hotel, Cork

Organised by: EAP Institute

Further information: www.eapinstitute.com

Email: anita@eapinstitute.com

25 February 2016

Reporting for work under the influence of drugs and alcohol – employers' legal obligations

Venue: Hotel Kilkenny, Kilkenny

Organised by: EAP Institute

Further information: www.eapinstitute.com

Email: anita@eapinstitute.com

Under the Safety, Health and Welfare at Work Act 2005 all employees must ensure that they are not under the influence of an intoxicant (defined as including drugs and alcohol and any combination of drugs or of drugs and alcohol) to the extent that he or she is in such a state as to endanger his or her own safety, health or welfare at work or that of any other person. Employers are legally entitled to prevent an employee from working if he or she would be a danger to themselves or others due to being under the influence of an intoxicant to the extent that he or she is in such a state as to endanger his or her own safety, health or welfare at work, or that of any other person.

New measures to test all drivers, including those who drive company vehicles in Ireland, came into force on 27 November 2014. The Road Traffic Act 2014 allows Gardaí to conduct five random cognitive impairment tests and those who fail may be arrested and subject to additional medical examination to determine the presence of intoxicants, and failure will result in prosecution. In 2015 the roadside impairment testing will be followed by the introduction of a testing device which will be used by the Gardaí conduct roadside drug tests.

Speakers

Maurice Quinlan, Director of the EAP Institute

Mike Doyle, Country Manager Ireland, Alere Toxicology