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Drugs policy in the new programme for government



Catherine Byrne TD,
Minister of State for
Communities and the
National Drugs Strategy

May 2016 saw important developments for those working in the illicit drugs area. A new programme for government was published and a new Minister for Communities and the National Drugs Strategy appointed.

A programme for partnership government was published on 11 May 2016.¹ This document lays out the direction the new government plans to take across a range of policy areas, including those related to drug and alcohol use.

Subsequently, the Department of Health published its briefing for new ministers that describes the work of the department and those responsible for its delivery.² Developing the new National Drugs Strategy, providing policy input for the legislative changes required to introduce medically supervised injecting centres, and pursuing the adoption of the Public Health (Alcohol) Bill are all identified as part of the Department of Health's work.

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In brief

In common with many spheres of government activity which seek to curtail or manage personal freedoms in the interests of the perceived common good, drug policy confronts tensions between the obligation to support the individual citizen's rights and freedoms and the requirement to guarantee community safety and maintain public support.

A number of articles in this issue of *Drugnet Ireland* highlight recent reports and papers dealing with the impact of current drug policies on human rights. This is a global issue and the most severe consequences of drug control policies are felt in those societies least protective of their citizens' freedoms and most likely to use arbitrary arrest, detention, ill treatment and severe sanctions, including the death penalty, in their effort to combat drug use. Inadequate or punitive treatment regimes further erode rights by denying access to effective health care and stigmatising people who use drugs. Inevitably, the cost is felt greatest by the economically and culturally marginalised and by women and ethnic minorities. Of course, these consequences are less severe in more democratic societies but high levels of incarceration for drug-related offences, poor access to effective treatment and restrictions on participation in social and economic life all erode the human rights of drug users in developed societies.

The debate on the future of drug control is not confined to the specialist policy arena and occurs much more frequently in mainstream public discourse as negotiating positions are developed for a new global drug strategy in 2019. This debate is impacting on current policy and human rights are becoming an increasingly important lens through which drug policy is analysed. For those who emphasise human rights, official recognition that drug use is a health rather than a criminal problem is a prerequisite for a balanced drug policy. Elsewhere in this issue the place of drugs in the new programme for government is outlined.

This commits the government to pursuing a health-led rather than a criminal justice approach to drug use and continuing with what is generally regarded as a humane and progressive drug policy. A consistent commitment to a participatory approach to development of responses has been key to this policy but the financial crisis and security problems have been challenging for those working from a community perspective. Human rights can provide an ethical underpinning for a policy which seeks to protect these communities, maximise their contribution and, at the same time, support those with drug problems to participate fully in these communities.

New Programme for Government and new Drugs Minister continued

A number of specific commitments have been made in the new Programme for Government, including:

- complete and commence the new National Drugs Strategy within 12 months,
- pursue a health-led rather than criminal justice approach to drug use,
- legislate for medically supervised injection rooms,
- produce step-down services and facilities for people leaving drug rehabilitation,
- enact the Public Health (Alcohol) Bill,
- strengthen the regulation of alcohol advertising to children,
- support the expansion of Local Drugs Task Force projects and the Garda Youth Diversion programme,
- fund an expansion of youth services to early school leavers and other young people,
- reduce drug- and alcohol-related crime through a combination of policing, treatment and demand reduction activities, and
- properly resource An Garda Síochána to be able to reduce the sale and supply of illicit drugs on the streets.

New Minister of State for the National Drugs Strategy

Following the publication of these documents, on 19 May Catherine Byrne TD was appointed Minister of State for Communities and the National Drugs Strategy. Her brief is spread across the Department of Health and the Department of Regional Development, Rural Affairs, Arts and the Gaeltacht. She is a Fine Gael TD for Dublin South-Central, a former Lord Mayor of Dublin, and was the party's spokesperson on the National Drugs Strategy from 2007 to 2010. More recently she has been a member of the Oireachtas Cross-Party Group on Alcohol and the Oireachtas Committee on Health and Children. She attributes great importance to the role of Minister with responsibility for the National Drugs Strategy – in 2015 she called for it to be upgraded to a Cabinet position.³

Over the years Minister Byrne has made numerous contributions to the debate on drug and alcohol issues. With respect to the current Government's priorities, she has been a long-standing advocate for the introduction of medically supervised injecting centres.^{4,5} She has given her backing to all elements of the Public Health (Alcohol) Bill,⁶ in particular 'wholeheartedly' supporting the introduction of minimum unit pricing for alcohol.⁷ However, she has argued strongly against any alcohol sponsorship of sporting events,^{8,9} and has expressed the view that the Bill does not go far enough in relation to this issue. For example, in February 2015 she urged the Minister for Health to 're-examine how we can curtail alcohol sponsorship of sporting events because we need to send out a strong message that alcohol has no place in our sporting events'.⁸

Minister Byrne has been critical of the way in which drug services are structured and has expressed concern about the duplication of services in some areas.^{3,4} She has questioned the suitability of 'the drugs task force model', looking for its 'reconfiguration' so that the needs of users would be better met.¹⁰ Also she has sought changes to school-based drug and alcohol education programmes.⁴

At the time of writing it is unclear where the Minister stands on the issue of decriminalisation which had been put on the agenda by her predecessor Aodhán Ó Ríordáin and the findings of the Joint Committee on Justice, Defence and Equality.¹¹

Lucy Dillon

- 1 *A programme for partnership government* (2016) <http://www.drugsandalcohol.ie/25508/>
- 2 Department of Health (2016) *Departmental Brief for Minister May 2016* <http://www.drugsandalcohol.ie/25536/>
- 3 Byrne C (2015, 26 March) Drug addiction and recovery models. Joint Oireachtas Committee on Health and Children. Retrieved 9 June 2016 <https://www.kildarestreet.com/committees/?id=2015-03-26a.2086&s=Drug+Addiction+and+Recovery+Models>
- 4 Byrne C (2015, 9 July) National Drugs Strategy. Joint Oireachtas Committee on Health and Children. Retrieved 9 June 2016 <https://www.kildarestreet.com/committees/?id=2015-07-09a.3440&s=Drug+Addiction+and+Recovery+Models#g3455>
- 5 Byrne C (2015, 23 April) Appointment of Aodhán Ó Ríordáin as Minister of State for the National Drugs Strategy. Retrieved 9 June 2016 <http://www.finegae.ie/latest-news/2015/new-drugs-minister-could-/index.xml>
- 6 Byrne C (2015, 4 February) Public Health (Alcohol) Bill. Retrieved 9 June 2016 <http://www.finegae.ie/latest-news/2015/new-legislation-rightly-r/index.xml>
- 7 Byrne C (2015, 23 April) 'General Scheme of Public Health (Alcohol) Bill 2015'. Joint Committee on Health and Children Debate. Retrieved 9 June 2016 <https://www.kildarestreet.com/committees/?id=2015-04-23a.3377&s=I+wholeheartedly+support+minimum+unit+pricing#g3403>
- 8 Byrne C (2014, 18 June) Cross-Party Oireachtas Group on Alcohol Misuse. Retrieved 9 June 2016 <http://www.finegae.ie/latest-news/2014/discussion-of-alcohol-spo/>
- 9 Byrne C (2011, 1 December) Alcohol marketing debate. Joint Committee on Health and Children. Retrieved 9 June 2016 <http://oireachtasdebates.oireachtas.ie/Debates%20Authoring/DebatesWebPack.nsf/committeetakes/HEJ2011120100004>
- 10 Byrne C (2013, 10 July) Estimates for public services 2013. Committee on Health and Children: Select Sub-Committee on Children and Youth Affairs. Retrieved 9 June 2016 <https://www.kildarestreet.com/committees/?id=2013-07-10a.545>
- 11 Joint Committee on Justice, Defence and Equality (2015, 5 November) *Report of the committee on a harm reducing and rehabilitative approach to possession of small amounts of illegal drugs*. 31/JDAE/O35. <http://www.drugsandalcohol.ie/24750/>

POLICY AND LEGISLATION

National Drugs Strategy: progress in 2015

The Department of Health has published its annual report for 2015 on progress in implementing the actions included in the National Drugs Strategy.¹ The report is a descriptive account of activities over the period – in some cases they are reported at a national level, while in others they are reported at the level of the Community Healthcare Organisations (CHOs).²

Where there has been no change, the report tends to repeat the 2014 content. No reference is made in the report to the key performance indicators identified in the NDS and neither is there any overall assessment of the level of progress made in achieving outcomes. The overall messages under each pillar remain the same as in the 2014 report.³

This article focuses on some of the changes reported to have happened under each of the five pillars over the 12-month period.

Supply reduction

Overall progress in delivering on the supply reduction actions continued to be made in relation to local supply reduction initiatives, and compliance with EU-level obligations and operations. In 2015 progress was made on policy and legislative initiatives, including the Road Traffic Bill 2016, the Public Health (Alcohol) Bill 2015, and the proposed bill to amend the Misuse of Drugs Act to restore the government's power to declare substances to be controlled. Furthermore, some progress was made on activities that had been affected by the difficult economic situation:

- Forensic Science Ireland (FSI) received €1 million additional funding in the 2016 estimates for additional staff members.
- Funding was also allocated for a new forensic science laboratory. Construction is due to start in 2019.
- The DNA database was launched late in 2015 and is being used by the Gardaí and FSI.
- Some steps were taken to meet the need for an integrated system to track the progression of offenders with drug-related offences through the criminal justice system. A Chief Information Officer was appointed with responsibility for developing the concept of a 'justice and equality information hub'; approval was given for three 'Pathfinder' projects to prove the concept.

Prevention

This area of the strategy deals with both illicit drugs and alcohol. It continued to be the case that since the start of the strategy, most progress was made in setting up education programmes and drug policies in schools, developing youth interventions and facilities in out-of-school settings, and developing online prevention and help services. Work was on-going in progressing programmes targeting families experiencing difficulties owing to drug/alcohol use and the children of drug users. Work was also under way on selective prevention measures to reduce under-age and binge drinking.

Treatment and rehabilitation

Activity under the treatment and rehabilitation pillar is mainly illustrated by using examples of activities from CHOs. The overall message for 2015 was the same as in 2014 – the development and improvement of the range, integration and availability of treatment and rehabilitation services were reported to be on-going, as was improvement in access to these services. With regard to a drugs intervention programme (incorporating a treatment referral option) for young people who come to the attention of the Gardaí as a result of their drug use, Gardaí now have an information leaflet to give to young people.

No further action was reported since the last report in relation to the following actions:

- While work was reported to be well under way with regard to training programmes for all involved in the provision of substance misuse treatment services, treatment guidelines for treating blood-borne viruses had yet to be published.
- In response to the issue of drug-related deaths, the findings of the naloxone demonstration project were still awaited.
- No progress was reported in relation to the development of a National Overdose Prevention Strategy nor to the review of the regulatory framework in relation to prescription drugs.
- A statutory regulatory framework for the provision of counselling within substance misuse services continued to be delayed because counselling was not one of the 12 health and social care professions designated under the Health and Social Care Professionals Act 2005.

Research and information

Many activities under this pillar were on-going. 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 were all under continuous development. The HRB National Drugs Library continued to promote the use of evidence in drugs work and provide resources to those working in the area. In line with the EU Early Warning System, a communication protocol for notification of drug use emergencies was being further developed.

The 2015 research work programme of the National Advisory Committee on Drugs and Alcohol was the same as for 2014. Progress was hindered owing to the lack of a researcher and a reduced budget.

NDS progress in 2015 continued

However, there were some specific developments:

- The development of indicators for harm reduction, public expenditure and drugs and crime, was under way. In 2015, for the first time, data on drug treatment in prisons were included in the report on prisons provided to the EMCDDA.
- The HSE was finalising a plan for the establishment and rollout of the Individual Health Identifier (IHI).

Co-ordination

There was little change in relation to this pillar, with many of the proposed structures already in place. Some progress was made in developing engagement with specifically identified at-risk groups, including Travellers, new communities, LGBTs, the homeless and sex workers.

What are human rights?

According to the Irish Human Rights and Equality Commission (IHREC), 'human rights are the basic rights and freedoms that belong to everyone. International law, including treaties, contain the provisions which give human rights legal effect.'¹ In the decades since World War Two, human rights standards have been adopted at United Nations, Council of Europe and the European Union level. Ireland has committed to upholding many of these standards.

United Nations (UN)

Adopted by the UN General Assembly on 10 December 1948, the Universal Declaration of Human Rights (UDHR) spelt out for the first time in human history basic civil, political, economic, social and cultural rights that all human beings should enjoy. It set 'a common standard of achievement for all peoples and nations'.



There are nine core international human rights instruments. Each of these instruments has established a committee of experts to monitor implementation of the treaty provisions by its States parties.

1. International Covenant on Civil and Political Rights (1966)
2. International Covenant on Economic, Social and Cultural Rights (1966)
3. Convention on the Elimination of All Forms of Racial Discrimination (CERD)(1965)
4. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979)
5. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (1984)
6. Convention on the Rights of the Child (1989)²
7. Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)

A subgroup of the National Coordinating Committee for Drug and Alcohol Task Forces reviewed and updated the 2009 NDS Traveller Framework Document, and was identifying lead agencies to implement the recommendations in the document.

Lucy Dillon

- 1 Department of Health (2016) *National Drugs Strategy 2009-2016: progress report to end 2015*. <http://www.drugsandalcohol.ie/25365/>
- 2 Delivered through the HSE and its funded agencies, the nine Community Healthcare Organisations provide the broad range of services that are delivered outside of the acute hospital system, i.e. primary care, social care, mental health and health and wellbeing services. https://www.hse.ie/eng/services/publications/corporate/CHO_FAQ.pdf
- 3 Pike B (2015) National Drugs Strategy [NDS] 2009-2016: progress in 2014 *Drugnet Ireland* (55): 12- 13. http://www.drugsandalcohol.ie/view/journal_volume/Drugnet_Ireland/Issue_55_Autumn_2015.html

8. Convention on the Rights of Persons with Disabilities (CPRD)(2006)
9. Convention for the Protection of All Persons from Enforced Disappearance (CPPED)(2006)

Ireland has ratified the first six of these Conventions.

Additional information on the UN treaties can be found at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx>

Europe

Protection of human rights in Europe (a 'regional system') is provided by two institutions with separate sets of laws and courts – (1) the Council of Europe system comprising the European Convention on Human Rights, the Revised European Social Charter and the European Court of Human Rights, and (2) the European Union system comprising the Charter of Fundamental Rights, the EU Directives on Equality and the Court of Justice of the European Union.

Council of Europe system

When it came to giving binding legal force to the rights in the UDHR, the Council of Europe adopted two separate treaties – the European Convention of Human Rights, which guarantees civil and political rights, adopted in 1950, and the European Social Charter, which guarantees social and economic rights, e.g. everyday human rights related to employment, housing, health, education, social protection and welfare, adopted in 1961. The European Court of Human Rights rules on individual or State applications alleging violations of the civil and political rights set out in the European Convention on Human Rights.



Additional information can be found at [European Convention on Human Rights](http://www.echr.coe.int/Documents/Convention_ENG.pdf) http://www.echr.coe.int/Documents/Convention_ENG.pdf
[European Social Charter](http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/163) <http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/163>
[European Court of Human Rights](http://www.echr.coe.int/Pages/home.aspx?p=home&c=) <http://www.echr.coe.int/Pages/home.aspx?p=home&c=>

What are human rights? continued

European Union (EU) system

The EU's Charter of Fundamental Rights brings together in a single document the fundamental rights protected in the EU. The Charter contains rights and freedoms under six titles: Dignity, Freedoms, Equality, Solidarity, Citizens' Rights, and Justice.



Proclaimed in 2000, the Charter became legally binding on the EU with the entry into force of the Treaty of Lisbon in December 2009. The Court of Justice of the European Union interprets EU law to make sure it is applied in the same way in all EU countries, and settles legal disputes between national governments and EU institutions.

Additional information can be found at [Charter of Fundamental Rights](http://www.europarl.europa.eu/charter/pdf/text_en.pdf) http://www.europarl.europa.eu/charter/pdf/text_en.pdf
[Court of Justice of the European Union](http://europa.eu/about-eu/institutions-bodies/court-justice/index_en.htm) http://europa.eu/about-eu/institutions-bodies/court-justice/index_en.htm

Ireland

Bunreacht na hÉireann (the Irish Constitution) was signed into law in 1937. Articles 38–44 set out fundamental rights. The Irish courts have interpreted the Constitution as including certain other human rights, i.e. 'unenumerated rights', which are not explicitly set out in the Constitution but are recognised by the courts.



The European Convention on Human Rights Act 2003 gives effect to the standards set out in the European Convention on Human Rights in Irish law. This allows these rights to be considered before the Irish courts. The Constitution has primacy over the ECHR Act (in cases where there is any uncertainty) and, if the two conflict, the Constitution prevails.

Additional information can be found at [Bunreacht na hÉireann](http://www.taoiseach.gov.ie/eng/Historical_Information/The_Constitution/European_Convention_on_Human_Rights_Act_2003) http://www.taoiseach.gov.ie/eng/Historical_Information/The_Constitution/European_Convention_on_Human_Rights_Act_2003 <http://www.ihrec.ie/legal/europeanconvent.html>

This account has been compiled with the assistance of the Irish Human Rights and Equality Commission, www.ihrec.ie

- 1 Irish Human Rights and Equality Commission (2015) *Human rights explained: guide to human rights law*. Dublin: IHREC, p. 6. http://www.ihrec.ie/download/pdf/ihrec_human_rights_explained.pdf
- 2 Article 33 of the Convention on the Rights of the Child reads: 'States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.'

Drug users' human rights

Just what are the rights of drug users and how can legislators, policy makers, law enforcers and service providers ensure their rights are taken into consideration? In 2015 the Irish Council for Civil Liberties (ICCL) produced its first paper considering the drugs phenomenon from a human rights perspective, and in particular human rights as defined in the European Convention on Human Rights (ECHR).¹

Right to life (Art 2 ECHR)

With an average 600 drug-related deaths every year,² Ireland has almost four times the overall European Union (EU) average. ICCL identifies six harm reduction measures to help reduce this number, some of which have already been, or are in the process of being, introduced, and some of which are under discussion.

Prohibition of torture and inhuman or degrading treatment or punishment (Art 3 ECHR)

According to ICCL, persons with drug problems suffer considerably and their health is eroded by street drugs and by drug-taking practices, and there is also transmission and high prevalence of blood-borne viruses among the

drug-using population. Compounded by the stigmatisation associated with substance misuse, these and a range of other conditions can be perceived by the persons suffering them as inhuman or degrading. Policies focusing on drug use as a health problem rather than a criminal problem might strike a better balance in addressing these human rights concerns.

Drug use may be the result of lack of access to palliative treatment or failure by service providers to respond to the real or perceived somatic or mental health needs or conditions of the user, for example undisclosed traumatic experiences such as abuse suffered during childhood, that render a person more vulnerable to problematic substance use. ICCL invites policy makers to examine the degree to which suffering might be reduced or prevented, and non-medical use of prescription drugs or use of illegal drugs reduced, if doctors were to have greater prescription freedom, subject only to professional standards, without a criminal policy inspired gatekeeping role and associated sanctions for doctors perceived as over-prescribing psychoactive substances.

Prohibition of forced labour/slavery (Art 4 ECHR)

Drug policies that stigmatise, marginalise and exclude users often push them into the hands of persons who exploit them sexually or otherwise in situations that are tantamount to forced labour, sometimes modern slavery. ICCL asks whether different policies would eliminate these situations,

Drug users' human rights continued

and if so, does this raise questions from a human rights perspective. Although not under the potential scope of Article 4, ICCL notes that working conditions and work-place environments may be conducive to drug use. This may occur because of work-related stress, unreasonable performance objectives or demands, or an excessively competitive atmosphere. Performance enhancement drugs can also lead to problematic use.

Right to liberty and personal freedom (Art 5 ECHR)

Using UN estimates, ICCL points out that there may be around 30 million occasional drug users in the EU, and some 5 million problematic drug users. However, the EMCDDA reported only 1.25 million drug offences in the EU in 2014. Of these, 781,000 were for cannabis use and a further 223,000 involved use of other drugs; cannabis supply amounted to 116,000 recorded offences, with supply of other drugs accounting for 86,000 and other offences 42,000. Based on these figures, ICCL suggests that the application of criminal law to drugs is uneven and therefore risks being discriminatory. If use were punished systematically, ICCL asserts it would mean criminalising within the EU the equivalent of seven times the population of the Republic of Ireland, or more than once its population if only problematic users were targeted.

The ICCL asks whether drug-related criminal law fails on three counts:

- its vocation of general non-discriminatory application, while drug trafficking continues to be rampant despite considerable law enforcement efforts;
- its purpose of preserving public health given the scale of the drug problem and the reported collateral damage of drug policy; and
- its purpose of protecting children.

Right to private life, freedom of thought, expression, association (cf. Arts 8, 9, 10, 11 ...)

Referring to the right to private life, ICCL suggests this right arguably extends to enjoying an experience of one's choice, including those that alter one's mental perceptions or state of consciousness, especially if it does not transcend to the public or endanger others. ICCL goes on to point out that the interdiction of such activities (in terms of their mind-altering power) would be contrary to Article 8, unless provided for in law 'in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others'. The objective pursued would have to be demonstrably necessary in a democratic society and the interference proportionate. ICCL goes on to suggest that policy makers might wish to take such matters into account when considering decriminalisation and the home-growing of cannabis.

Prohibition of discrimination (Art 14 ECHR)

ICCL notes that drug laws affect far more people in disadvantaged communities than in other communities, although drug use is roughly the same across all communities. It also notes that some people argue that subordinating the treatment of substance use disorders to criminal policy or related moral considerations, as compared to other self-inflicted conditions that remain a purely medical matter, is also discriminatory. Examples of self-inflicted medical conditions that don't attract a criminal charge include tobacco-related cancer, alcohol-related diseases, diet-related hypertension, certain cases of diabetes, extreme sport-related injury or even suicide attempts.

ICCL suggests that these biases can affect access to and the modalities of palliative, substitution or maintenance treatment for substance use disorders, and invites policy makers to consider whether current drug policies that hinge on criminal law and repression (a) have an unnecessary, undesirable or discriminatory impact on the delivery of health care for persons suffering from substance use disorders, and (b) place the persons concerned in significantly less favourable conditions for access to and quality of treatment than people who suffer from other self-inflicted medical conditions.

Brigid Pike

- 1 Irish Council for Civil Liberties (2015, 6 August) *Submission to the Houses of the Oireachtas Joint Committee on Justice, Defence and Equality on the review of Ireland's approach to the possession of limited quantities of certain drugs*. Retrieved 28 April 2016 <http://www.drugsandalcohol.ie/25444/>
- 2 Health Research Board (2015) *Drug-related deaths and deaths among drug users in Ireland: 2013 figures from the National Drug-Related Deaths Index*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/24676/>



Human rights and drug policy – international perspectives

The work of four international bodies with a particular interest in investigating just what a human-rights based approach to drug policy might look like is outlined below.

International Centre on Human Rights and Drug Policy (HRDP)

The International Centre on Human Rights and Drug Policy (HRDP) is dedicated to developing and promoting innovative and high-quality legal and human rights research and teaching on issues related to drug laws, policy and enforcement. It pursues its mandate by publishing original, peer-reviewed research on drug issues as they relate to international human rights law, international humanitarian law, international criminal law and public international law.

In a six-page joint submission to the 2016 UNGASS on drugs, HRDP and Amnesty International took the following view:¹

The UNGASS on drugs must be viewed as the beginning of a wider reflective process underpinned by a rigorous and inclusive assessment of the global state of drug control in the negotiations of a new Political Declaration and Plan of Action to be adopted in 2019. The lead up to 2019 is a critical moment to ensure that political commitments to drug control have clear, unambiguous articulations of international human rights law and standards.

International Network of People Who Use Drugs (INPUD)

The International Network of People who Use Drugs (INPUD) is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs. In October 2015 it published a 42-page 'consensus statement' on human rights, health, and the law in relation to people who use drugs.² The statement lists ten 'established and recognised human rights' to which people who use drugs are entitled:

1. human rights, which must be protected by the rule of law;
2. the right to non-discrimination;
3. the right to life and security of person;
4. the right not to be subjected to torture or to cruel, inhuman, or degrading treatment;
5. the right to the highest attainable standard of health;
6. the right to work, to free choice of employment, to just and favourable conditions of work, and to protection against unemployment;
7. the right not to be subjected to arbitrary arrest or detention;

8. the right to bodily integrity;
9. the right to found a family entitled to protection by the law, entitled to privacy, and entitled to be free from arbitrary interference; and
10. the right to assemble, associate, and form organisations.

Johns Hopkins–Lancet Commission on Drug Policy and Health

Ahead of UNGASS 2016 on drugs, the Johns Hopkins–Lancet Commission, comprising 22 experts from a wide range of disciplines and professions in low-, middle- and high-income countries, examined the emerging scientific evidence on public health issues arising from drug-control policy in order to inform and encourage a central focus on public health evidence and outcomes in drug policy debates. The Commission's work was framed by the UN-endorsed Sustainable Development Goals (SDGs) for 2030, which aspire to human-rights-centred approaches to ensuring the health and wellbeing of all people. In their 50-page report, the Commission made 11 recommendations regarding future drug policy, including the following:

- Decriminalise minor, non-violent drug offences – use, possession, and petty sale – and strengthen health and social-sector alternatives to criminal sanctions.
- Ensure easy access to harm-reduction services, e.g. opioid substitution treatment, nsp, supervised injection sites and access to naloxone, for all who need them, and recognise the effectiveness and cost-effectiveness of scaling up and sustaining these services.
- Prioritise people who use drugs in treatment for HIV, HCV infection, and tuberculosis, and ensure that services are adequate to enable access for all who need care.
- Reduce the negative impact of drug policy and law on women and their families, especially by minimising custodial sentences for women who commit nonviolent offences and developing appropriate health and social support, including gender-appropriate treatment of drug dependence, for those who need it.
- Health, development and human rights indicators should be included in metrics to judge success of drug policy, e.g. access to treatment, frequency of overdose deaths, and access to social welfare programmes for people who use drugs. All drug policies should also be monitored and assessed as to their impact on racial and ethnic minorities, women, children and young people, and people living in poverty.
- Move gradually toward regulated drug markets and apply the scientific method to their assessment.

Pompidou Group

Part of the Council of Europe, the Pompidou Group comprises 38 states, including Ireland. Its core mission is to contribute to the development of multidisciplinary, innovative, effective and evidence-based drug policies in its member states. 'Bringing human rights to the forefront of drug policy' is its top priority for 2015–2018.

Human rights – international perspectives continued

The aims of the Pompidou Group's current work programme include:

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

Brigid Pike

Human rights, equality and the National Drugs Strategy

In 2014 Ireland became the first EU member state to introduce legislation that combines equality and human rights as a 'public sector duty'. This public sector duty requires public bodies to take proactive steps to promote equality, protect human rights and fight discrimination in relation to their functions and powers. Section 42 of the Irish Human Rights and Equality Commission Act 2014 states:¹

A public body shall, in the performance of its functions have regard to the need to:

- eliminate discrimination,
- promote equality of opportunity and treatment of its staff and the persons to whom it provides services, and
- protect, promote and fulfil the human rights of its members, staff and the persons to whom it provides services.

The Act requires public bodies both to set out in their strategic plans an assessment of the human rights and equality issues it believes to be relevant to its functions and purpose, and to have policies, plans and actions in place to address those issues, or to include proposals on how such policies and plans will be put in place. Annual reports need to report on developments and achievements in regard to these issues.

- 1 International Centre on Human Rights Centre and Amnesty International (2016, 12 April) *Joint submission: The promotion and protection of human rights and international drug control*. Retrieved 28 April 2016 http://www.hr-dp.org/files/2016/04/12/AI_HRDP_UNGASS_Submission_FINAL1.pdf
- 2 INPUD (2015) *Consensus statement on drug use under prohibition: human rights, health and the law*. London: INPUD. Retrieved 28 April 2016 <http://www.inpud.net/en/news/inpud-consensus-statement-drug-use-under-prohibition-human-rights-health-and-law>
- 3 Johns Hopkins–Lancet Commission on Drug Policy and Health (2016) Public health and international drug policy *Lancet* Vol. 387: 1427–1480. Published Online, 24 March 2016, [http://dx.doi.org/10.1016/S0140-6736\(16\)00619-X](http://dx.doi.org/10.1016/S0140-6736(16)00619-X)
- 4 Pompidou Group (2014) *Pompidou Group work programme 2015–2018: 'Drug policy and human rights: new trends in a globalised context'*. P-PG/MinConf (2014) 4. Retrieved 28 April 2016 [http://www.coe.int/T/DG3/Pompidou/Source/Documents/P-PG_MinConf%20\(2014\)%204%20WorkProgramme%202015-18_ENGLISH.pdf](http://www.coe.int/T/DG3/Pompidou/Source/Documents/P-PG_MinConf%20(2014)%204%20WorkProgramme%202015-18_ENGLISH.pdf)

The Irish Human Rights and Equality Commission (IHREC), established under the 2014 Act, published its first strategy in January 2016, covering the years 2016–2018. One of the goals in the strategy is the 'proactive implementation of our legal powers, in particular positive public duty'.² Among the outcomes the Commission will be measuring in relation to this goal are whether there is an increase in awareness of human rights and equality issues, and in positive action among 'duty bearers', i.e. public bodies.

It is within this legislative context that Niall Crowley, the former Chief Executive Officer of the now defunct Equality Authority in Ireland (1999–2009), gave a presentation at CityWide's 20th anniversary conference in November 2015.³ He explored the opportunities that this statutory public sector duty offers the National Drugs Strategy. He discussed how to develop an equality and human rights statement for the strategy that will ensure equality and human rights are built into the planning, implementation and evaluation of the strategy. He also noted that this public sector duty will ensure the full integration of 'communities of interest' such as LGBT, travellers, New Communities and other minority groups, into the development of the strategy.⁴

Lucy Dillon

- 1 Irish Human Rights and Equality Commission Act 2014 <http://www.irishstatutebook.ie/eli/2014/act/25/enacted/en/html>
- 2 Irish Human Rights and Equality Commission (2016) *Strategy statement 2016–2018*. Dublin: IHREC, p. 9. Retrieved 30 June 2016 <http://www.ihrec.ie/download/pdf/strategystatement.pdf>
- 3 Niall Crowley's presentation is available at <http://www.citywide.ie/citywide-20th-anniversary/workshops.html>
- 4 For an account of human rights and drug policy in Ireland prior to the finalisation of the current National Drugs Strategy, see B Pike (2008) Human rights and illicit drugs policy. *Drugnet Ireland* (27): 11–12. <http://www.drugsandalcohol.ie/12108/>

After UNGASS 2016

UNGASS 2016 has been and gone. Held on 19–21 April in New York, it comprised not only the general assembly sessions but also over 40 side events, which were organised by individual member states, UN agencies and international NGOs.¹

Two policy statements to emerge from the UNGASS process that are relevant to Ireland's national drugs policy are described below. The language used and the points emphasised in the two papers differ, particularly in relation to demand reduction, supply reduction and human rights issues, reflecting the challenges of reaching a consensus among 28 European countries as opposed to some 200 countries from around the globe.²

EU common position

Ahead of UNGASS 2016, the European Union (EU) adopted a common position paper, which formed the basis for EU member states' contributions.² Grounded on two general principles – the need for an integrated, balanced and evidence-based approach and a sound public health approach – the nine-page position paper is broken into ten sections, listed below, which contain a total of 36 policy statements, some of which are noted here.

- **International legal framework** – there is 'sufficient scope and flexibility within the provisions of the UN Conventions to accommodate a wide range of approaches to drug policy';
- **Human rights** – states parties are invited 'to develop and implement, when appropriate, alternatives to incarceration and coercive sanctions applicable to persons having committed minor, non-violent drug-related offences';
- **Role of civil society** in formulating, implementing, monitoring and evaluating drug policies, 'especially in the field of drug demand reduction' is affirmed;
- **Demand reduction and related measures, including prevention and treatment** – 'dependent drug users should be first and foremost considered as people in need of attention, care and treatment in order to improve their health and condition and enhance social integration, tackling marginalization and stigmatization' and, in this context, states parties 'should make sure that access to risk and harm reduction measures is guaranteed, as such measures have proved effective in reducing the number of direct and indirect drug-related deaths and notably blood-borne infectious diseases associated with drug use';
- **Access and availability of drug demand reduction measures** – states parties are urged to 'guarantee broad availability, coverage and access' to drug dependence treatment for all members of society';
- **Availability of controlled substances for medical and social purposes** – 'as regards psychoactive substances with proven legitimate medical or scientific use, a thorough and careful assessment is crucial before a decision is taken, with a view to avoiding undue restrictions on legitimate use of such substances';

- **Supply reduction and related measures** – covers drug trafficking, international cooperation, with particular attention to the spreading and diversification of precursor chemicals;
- **Alternative development** – to establish viable economic alternatives to prohibited cultivation of crops in source countries;
- **Drugs policy and children, youth and women** – reference is made to article 33 of the Convention on the Rights of the Child, asserting the need 'to protect children from the illicit use of narcotic drugs and psychotropic substances', and differences in the ways men and women are affected by drugs and drug policies are acknowledged;
- **New challenges, threats and realities in preventing and addressing the world drug problem** including new psychoactive substances and the role of new communication technologies.

UNGASS outcome statement

Agreed by member states at the 59th meeting of the UN Commission on Narcotic Drugs (CND) in Vienna in March 2016, this outcome document, entitled 'Our joint commitment to effectively addressing and countering the world drug problem', was adopted at UNGASS 2016.³ Having reaffirmed member states' commitment to the three UN drug conventions and member states' determination 'to tackle the world drug problem and to actively promote a society free of drug abuse in order to help ensure that all people can live in health, dignity and peace, with security and prosperity and to address public health, safety and social problems resulting from drug abuse', the 24-page outcome statement sets out a series of operational recommendations under seven headings.

Demand reduction and related measures, including prevention and treatment

Under treatment, the document eschews use of the term 'harm reduction' but invites national authorities to consider 'effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes, injecting equipment programmes, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other blood-borne diseases associated with drug use'.

Availability of and access to controlled substances exclusively for medical and scientific purposes

Focuses on improving processes for ensuring availability and access.

Supply reduction including law enforcement, drug-related crime, money laundering and judicial cooperation

As well as strengthening efforts to tackle international drug trafficking and its links to other forms of organised crime, the outcome statement calls on member states to strengthen multi-disciplinary measures to 'promote comprehensive supply reduction efforts that include preventive measures addressing, inter alia, the criminal justice and socio-economic related factors that may facilitate, drive, enable and perpetuate organized crime and drug-related crime'.

After UNGASS 2016 continued

Cross-cutting issues: human rights, youth, children, women and communities

Along with nine recommendations regarding youth, children and women, the outcome statement discusses the need for proportionate and effective policies and responses in the criminal justice sector, in compliance with the provisions of the three UN drug conventions. Recommendations include encouraging the development, adoption and implementation of 'alternative or additional measures with regard to conviction or punishment of an appropriate nature' and also promoting 'proportionate national sentencing policies, practices and guidelines for drug-related offences whereby the severity of penalties is proportionate to the gravity of offences and whereby both mitigating and aggravating factors are taken into account'.

Cross-cutting issues in countering the world drug problem

This section contains 25 recommendations relating to new psychoactive substances, amphetamine-type stimulants, precursors, and the non-medical use of prescription drugs, as well as enhancing capacity to respond to the evolving reality and emerging and persistent challenges and threats.

Strengthening international cooperation

This will continue to be based on the principle of common and shared responsibility, strengthening assistance and enhancing cooperation between member states.

Alternative development

This section sets out the measures by which UN member states will address drug-related socio-economic issues related to the illicit cultivation of narcotic plants and the illicit manufacture and production and trafficking of drugs around the world.

Two reports – one by Ireland's Department of Health and one by an international non-governmental organisation – assess what UNGASS 2016 achieved.

Ireland's Department of Health

In its briefing to the incoming Minister for Health in May 2016, the Department of Health wrote:

The UN General Assembly held a Special Session (UNGASS) on drugs from 19th to 21st April 2016 in New York. This Special Session was an important milestone in achieving the goals in the policy document of 2009 'Policy Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem' which defined action to be taken by Member States as well as goals to be achieved by 2019. An Outcomes Document, adopted by acclaim at the first plenary session, contained a series of operational recommendations to counter the world drug problem. It showed progress in agreeing language on proportional sentencing, the importance of evidence-based policies, gender mainstreaming, greater consideration of human rights aspects, new psychoactive substances/NPS, and in taking account of WHO resolutions.⁴

International Drug Policy Consortium (IDPC)

IDPC is global network of 143 NGOs that focus on issues related to drug production, trafficking and use, promoting objective and open debate on the effectiveness, direction and content of drug policies at the national and international level, and supporting evidence-based policies that are effective at reducing drug-related harm. IDPC commented regarding UNGASS 2016:

Although the Outcome Document does include some good language on some points (such as access to essential medicines, development, overdose prevention and alternatives to incarceration), it could have been a very different document if the more progressive inputs had not been overlooked.

IDPC has compiled a document containing a selection of the 'more strong, progressive and evidence-based language', which had been on the table during the negotiations.⁵

Brigid Pike

- 1 Information retrieved 13 May 2016 <https://www.unodc.org/ungass2016/>
- 2 European Union (2016) *Common position on UNGASS 2016*. Retrieved 13 May 2016 http://www.unodc.org/documents/ungass2016/Contributions/IO/EU_COMMON_POSITION_ON_UNGASS.pdf
- 3 *Draft resolution submitted by the President of the General Assembly: Our joint commitment to effectively addressing and countering the world drug problem*. 14 April 2016. E/CN.7/2016/L.12/Rev.1. Retrieved 13 May 2016 <https://documents-dds-ny.un.org/doc/UNDOC/LTD/V16/017/77/PDF/V1601777.pdf?OpenElement>
- 4 Department of Health (2016) *Departmental Brief for Minister May 2016*. <http://www.drugsandalcohol.ie/25536/>
- 5 Document retrieved 10 June 2016 https://dl.dropboxusercontent.com/u/64663568/Press%20releases/UNGASS-shadow-declaration_FINAL.pdf

PREVALENCE AND CURRENT SITUATION

European drug trends 2016

In May 2016 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published the **European drug report 2016: trends and developments** summarising the latest trends across the 28 EU member states, and Norway and Turkey.¹ The report highlights the increasing use of MDMA following a period of decline in recent years, with greater levels of production helped by new sources of precursors and production techniques. The drug's popularity with existing stimulant users has grown and a new generation of users is emerging, presenting greater health risks as more high potency products become available.

The EU Early Warning System (EWS) reported 98 new substances, including 24 synthetic cannabinoids and 26 synthetic cathinones. The growing number of new synthetic opioids is a cause for concern and may indicate that producers are targeting existing opioid users. Several deaths associated with NPS and stimulants have been reported in Europe but most of the 6,800 overdose deaths in 2014 were related to heroin and other opioids. Increased heroin availability, higher purity, ageing users and changing consumption patterns may be factors in this increase. Just over half of the 1.2 million people who received treatment for illicit drug use in the EU in 2014 received substitution treatment for opioid use.

Use of cannabis among young Europeans (15–34) does not appear to have fallen and there have been increases in use in some European countries. Potency levels of herbal cannabis are historically high, presenting health and social risks particularly to the one per cent of European adults who are estimated to be daily or almost daily users. The numbers of those entering treatment for the first time for whom cannabis is their main problem drug has increased steadily since 2006, indicating greater levels of use, more potent products and greater availability of treatment services.

At the launch of the report, Dimitris Avramopoulos, European Commissioner for Migration, Home Affairs and Citizenship, said:

Europe faces a growing problem with drugs. New psychoactive substances, stimulants, heroin and other opioids continue to be in high demand and supply, with major impacts on public health. That is why the 2016 European Drug Report is an important addition to our evidence base on the drugs problem and a helpful tool for European policymakers to shape policies and actions to address it. With this knowledge in hand, we will continue to call on EU Member State authorities, third countries, internet companies and civil society to redouble cooperation in fighting this global challenge.

The situation described in the European drug report is presented below under a series of headings. The EMCDDA used 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 16.6 million (13.3%) young Europeans (15–34) used cannabis in the last year and 9.6 million of these (16.4%) are aged 15–24 years.

- The most recent survey results show different trends in last-year cannabis use. Surveys for relatively high-prevalence countries, such as Germany, Spain and the United Kingdom, all show decreasing or stable cannabis prevalence over the past decade, while France shows increases in prevalence after 2010. Countries which have historically reported lower cannabis use have seen increases in recent surveys.
- Levels of lifetime cannabis use in 2013/14 among school-aged children ranged from 5 per cent of girls and 7 per cent of boys in Sweden, to 26 per cent of girls and 30 per cent of boys in France.
- The number of first-time treatment entrants for cannabis as their main problem drug increased from 45,000 in 2006 to 69,000 in 2014, with 55 per cent of these reporting daily use.
- In 2014, 682,000 seizures of cannabis were reported in the European Union (453,000 of herbal cannabis, 229,000 of cannabis resin). There were a further 33,000 seizures of cannabis plants. The quantity of cannabis resin, transported in large quantities and over long distances, seized in the European Union is much higher than that of herbal cannabis (574 tonnes versus 139 tonnes).

Opioids (mainly heroin)

The number of clients reporting opioids as their primary drug when entering specialised treatment for the first time seems to have levelled off, dropping from 59,000 in 2007, when they accounted for 36 per cent of all new clients, to 23,000 in 2013 (16% of new clients). Of the 185,000 opioid clients entering treatment in Europe in 2014, 34,000 were first-time entrants.

- In 2014, 19 European countries reported that more than 10 per cent of all opioid clients entering specialised services presented for problems primarily related to opioids other than heroin including methadone, buprenorphine, fentanyl, codeine, morphine, tramadol and oxycodone.
- Among first-time clients entering drug treatment in 2014 with heroin as their primary drug, 36 per cent reported injecting as their main route of administration, down from 43 per cent in 2006.

European drug trends continued

- The EMCDDA estimates that at least 6,800 overdose deaths occurred in the European Union in 2014, an increase from 2013.
- Viral hepatitis, particularly infection caused by the hepatitis C virus (HCV), is highly prevalent among injecting drug users across Europe, with six of the 13 countries with national data reporting a prevalence rate in excess of 50 per cent. Drug injection is a risk factor for other infectious diseases including hepatitis B, tetanus and botulism.
- The quantity of heroin seized within the European Union had been declining steadily from 2002 until 2013 when 5.6 tonnes were seized. A total of 8.9 tonnes were seized in 2014. The reversal in trends is largely due to an increase in large seizures (above 100 kg) in several countries.

Cocaine

- Cocaine is the most commonly used illicit stimulant drug in Europe, although its use is more prevalent in the south and west of Europe. It is estimated that about 2.4 million young adults aged 15 to 34 (1.9% of this age group) used cocaine in the last year. Only three countries report last-year prevalence of cocaine use among young adults aged 15 to 34 of 3 per cent or more.
- The decreases in cocaine use reported since 2008 have not been observed in the most recent surveys; of the countries that have produced surveys since 2013, six reported higher estimates, two reported a stable trend and four reported lower estimates than in the previous comparable survey.
- Overall, cocaine was cited as the primary drug by 59,000 clients entering specialised drug treatment in 2014 and by 27,000 first-time clients. After a period of decline, the overall number of cocaine first-time treatment entrants has been stable since 2012.
- In 2014, almost 5,500 clients entering treatment in Europe reported crack cocaine as their primary problem drug, with the United Kingdom accounting for more than half of these (3,000), and Spain, France and the Netherlands most of the remainder (2,000).
- In the United Kingdom, deaths involving cocaine increased from 169 in 2013 to 247 in 2014. In Spain, where cocaine-related deaths have been stable for some years, the drug continued to be the second most often cited drug in overdose deaths in 2013 (236 cases).
- In 2014, around 78,000 seizures of cocaine, amounting to 61.6 tonnes, were reported in the European Union. The situation has remained relatively stable since 2010, although both the number of seizures and the quantity seized are at levels considerably lower than in the peak years, 2006–2008.

Other stimulants and new psychoactive substances

- Data on new psychoactive substances (NPS) are based on notifications by member states to the EU Early Warning System (EWS). In 2015, 98 new substances were reported for the first time (101 in 2014). Once again, the list of new substances reported was dominated by synthetic cannabinoids and synthetic cathinones (24 and 26 reported respectively).



At the European Drug Report 2016 launch in Lisbon: Dimitris Avramopoulos, European Commissioner for Migration, Home Affairs and Citizenship and Alexis Goosdeel (director) and Rosemary Martin de Sousa (head of communications) of the EMCDDA

- In 2014, almost 50,000 seizures of new substances, weighing almost 4 tonnes (3,990 kg), were made across Europe. Together, synthetic cannabinoids and cathinones accounted for almost 80 per cent of the total number of seizures and over 60 per cent of the quantity seized during 2014. Other groups included non-controlled benzodiazepines and potent narcotic analgesics, such as fentanyl.
- Some insights into the use of new drugs are provided by respondents to the 2015 Flash Barometer on young people and drugs, a survey of young adults aged 15–34, 8 per cent of whom reported lifetime use of these substances, with 3 per cent reporting use in the last year. This represents an increase from the 5 per cent reporting lifetime use in a similar survey in 2011. Of those reporting use in the last year, 68 per cent had obtained the substance from a friend.
- Despite drug injecting having declined in Europe overall, stimulant injecting is now a concern. Nearly half (47%) of new clients entering treatment in 2014 with amphetamines as their primary drug reported injecting as their main route of administration.
- Latest survey data point to increased use of MDMA in Europe following a period of decline. Around 2.1 million young adults (15–34 years) report having used MDMA in the last year (1.7% of this age group). There are also signs that the drug is moving out of niche or sub-culture dance clubs into mainstream nightlife settings, such as bars and house parties.

Accompanying the European drug report are **Perspectives on drugs** (PODs), online interactive articles providing insights into specific issues in the drugs field. The three themes in focus this year are: cocaine trafficking to Europe, comorbidity of substance use and mental health disorders in Europe, and strategies to prevent diversion of opioid substitution treatment.²

Brian Galvin

1 European Monitoring Centre for Drugs and Drug Addiction (2016) *European drug report 2016: trends and developments*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/25579/>

2 For more information visit <http://www.emcdda.europa.eu/edr2016>

Drug and alcohol trends in Blanchardstown

On 8 March 2016 Blanchardstown Local Drugs and Alcohol Task Force (BLDATF) launched its *Drug and alcohol trends monitoring system (DATMS) 2016*.¹

BLDATF developed the DATMS to provide up-to-date information about drug and alcohol use among people living in Dublin 15. The monitoring system identifies the types of drug being used within the local community, and also identifies emerging trends at an early stage of development. To gather the relevant data, clients of treatment services were interviewed and outreach workers administered questionnaires in the local community.

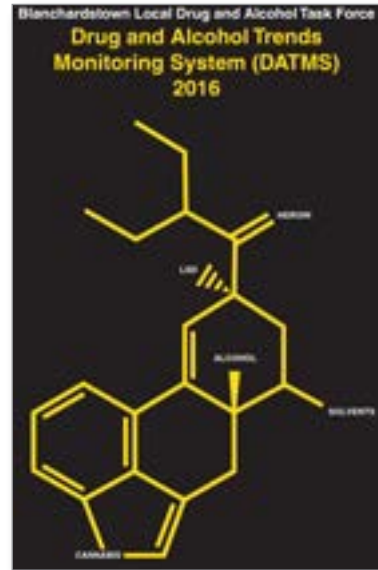
This type of information is necessary in order to recognise key local issues and to develop appropriate strategies in response. The data will serve as a baseline for local trends from which future variations can be monitored over time.

Key research findings for treated drug and alcohol use

- The main problem drugs for which adult drug users sought treatment included heroin, methadone, alcohol, cannabis (weed), benzodiazepines, Z drugs and cocaine powder.
- The main problem drugs for which under-18-year-old drug users sought treatment included cannabis (weed) and alcohol. Ecstasy and solvents were involved to a lesser extent.
- Service providers reported an increase in the use of the following drugs by treated drug users: cannabis (weed), benzodiazepines and Z drugs, crack cocaine, alcohol, Lyrica/Pregabalin (prescribed pain killer) and codeine-based over-the-counter (OTC) drugs.
- The increase in the use of weed related to both treated under-18 and adult drug users. The increase in the use of the other drugs is related to treated adult drug users only.
- The number of heroin users entering treatment is in decline; clients are an ageing population of long-term users, with fewer young people accessing treatment.
- Poly-drug use was reported to be the norm by the majority of both treated under-18 and adult drug users.
- Steroid use by some men in recovery from problematic drug use was associated with relapse.

Key research findings for untreated drug and alcohol use

- Alcohol was the most commonly used drug, with binge drinking being a common occurrence among both males and females.
- Cannabis (weed) was the second most commonly used drug; among young people frequency of use varied from daily to less frequent use, with some young males reporting daily use before and during school.



- Cocaine powder, ecstasy and ketamine were the next most commonly used drugs, with benzodiazepines and Z drugs being used to a lesser extent.
- Service providers reported an increase in the use of these drugs by untreated young drug users aged between 15 and early 20s.
- Ecstasy has made a 'resurgence' in terms of popularity.
- Ketamine has become increasingly popular over the last twelve months.
- Poly-drug use was perceived to be the norm, occurring at weekends among young people aged 15 and over.
- Alcohol was reported to be a fundamental part of poly-drug use. A typical drug-taking session started with alcohol and was then accompanied by other drugs.
- The frequency of poly-drug use was dependent on the age of the drug user, with those aged 18-30 reporting more regular polydrug use.

Speaking at the launch Jim Doherty, BLDATF Coordinator, said:

Decisions on how to spend the Task Force budget have to be made on the best available evidence of what the needs of the community are. If this evidence isn't already being gathered then the Task Force has to do this job itself. This is what we have done, using the best methods known and asking the community what the issues are. We also intend to keep on doing it on a regular basis, so that we are never out of touch with the community we serve.

Vivion McGuire

1 Blanchardstown Local Drugs and Alcohol Task Force (2016) *Drug and alcohol trends monitoring system (DATMS) 2016*. Dublin: Blanchardstown Local Drugs and Alcohol Task Force. www.drugsandalcohol.ie/25281/

HIV infection among homeless people who inject drugs

A paper published in September 2015 outlines a case-control and epidemiological study conducted in response to an increase in recently acquired HIV infection among a population of homeless people who inject drugs (PWID) in Dublin.¹ The report defines recently acquired HIV infections as those in which the person who tests positive is p24 antigen, or has had an HIV negative test within the previous 12 months, or suffers an acute HIV sero-conversion illness.

Clinicians in the drug treatment services were concerned that the increase might be linked to injection of a synthetic cathinone PVP, with the street name 'Snow Blow', which was being used by homeless drug users. In response, an epidemiological investigation and case-control study were instigated.

Between 2014 and 2015, 38 confirmed or probable cases of recently acquired HIV were reported (see Figure 1). Of these, 16 were female, the median age was 35 years (range 24–51) and 29 were registered homeless.

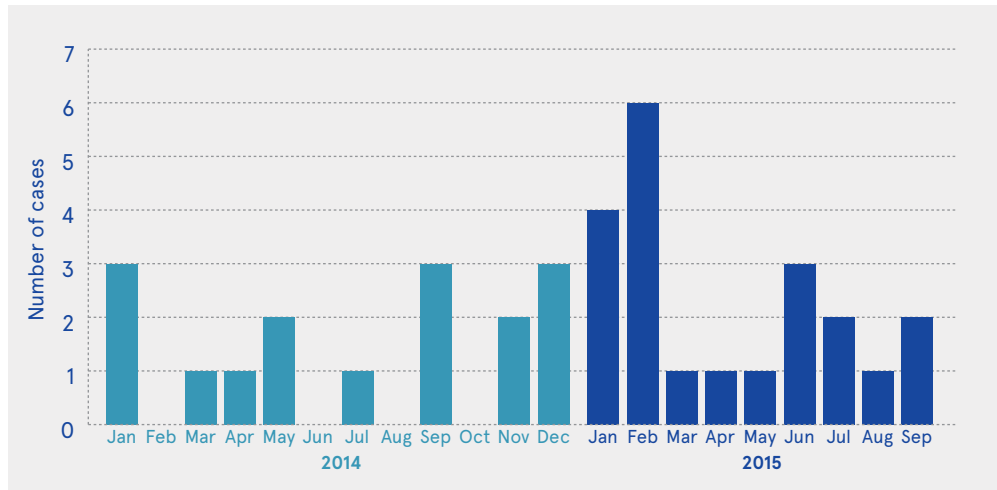
Of the 20 for whom injecting information was available, 18 reported recent injecting of 'Snow Blow'. Twenty reported having sex with a person who injected drugs or with an HIV-positive partner.

For the case-control study, 15 of the reported cases were recruited. A random sample of 39 HIV-negative, homeless, chaotic drug users were recruited from the National Drug Treatment Centre as a control group. There was no difference between cases and controls in age, duration of injection or living circumstances.

The study found that compared with the controls, the cases were more likely to have reported injecting methamphetamine and Snow Blow, and using amphetamines, other head shop drugs or benzodiazepines. Cases were also more likely to have reused needles or syringes, and to have had sex with partners who inject drugs.

Multivariate logistic regression was used to determine which of these factors were associated with HIV infection. The factor with the strongest association with HIV infection was injecting Snow Blow. However, being female, reusing needles and syringes and having sex with a partner who injects drugs were all independently associated (see Table 1).

Figure 1: Recent HIV infections with epidemiological link to PWID in Dublin, by month of first diagnosis, January 2014 to September 2015 (n=38)



Source: Giese C et al.¹

Table 1: Factors positively associated with recent HIV infection in multiple regression analysis

Factors positively associated with recent HIV infection	Adjusted odds ratio	95% Confidence Interval	P value
Injecting Snow Blow	49	3.6 – 669	0.003
Reusing needles/ syringes	13	1.01 – 177	0.049
Having sex with PWID	36	1.6 – 782	0.022
Female sex	3.5	0.27 – 44	0.34

Source: Giese C et al.¹

HIV infection among homeless PWID continued

In response to the increased incidence of HIV, the authors report that the following control measures were immediately implemented:

- provision of antiretroviral therapy to PWID diagnosed with HIV, where possible, and contact tracing to detect any additional cases among sexual or drug-sharing partners;
- review of clients attending drug services, to identify those most at risk, and offering urgent HIV testing;
- pilot point-of-care testing (POCT) of PWID clients attending Safetynet homelessness services (Safetynet is a networking organisation for nurses, doctors and voluntary agencies providing primary health care to homeless people in Dublin, Cork and Galway);
- enhanced surveillance to identify new HIV cases as early as possible, including mode of transmission;
- awareness-raising among clients, clinicians, networks of PWID and other stakeholders;

- provision of greater access to needle exchange and other preventive activities within the drugs services, homeless hostel services and prisons (the need for additional measures, including extended opening hours for needle exchanges, is being evaluated);
- development and distribution of communications material, aimed at raising awareness of the risk of HIV posed by unsafe injecting and unsafe sex (available on the website of the Health Protection Surveillance Centre [HPSC]); and
- active case finding including Recent Infection Testing of possible cases, and phylogenetic analysis of cases.

Margaret Curtin

1 Giese C, Igoe D, Gibbons Z, Hurley C, Stokes S, McNamara S, Ennis O, O'Donnell K, Keenan E, De Gascun C, Lyons F, Ward M, Danis K, Glynn R, Waters A and Fitzgerald M (2015) 'Injection of new psychoactive substance snow blow associated with recently acquired HIV infections among homeless people who inject drugs in Dublin, Ireland, 2015'. *Euro surveillance: bulletin Européen sur les maladies transmissibles = European communicable disease bulletin* 20(40): Euro Surveill. <http://www.drugsandalcohol.ie/25015/>

National Registry of Deliberate Self-Harm – Annual Report 2014

The 13th annual report from the National Registry of Deliberate Self-Harm was published in September 2015.¹ The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in Ireland in 2014, and complete national coverage of cases treated. All individuals who were alive on admission to hospital following deliberate self-harm are included, along with the methods of deliberate self-harm that were used. Accidental overdoses of medication, street drugs or alcohol are not included.

There were 11,126 recorded presentations of deliberate self-harm, involving 8,708 individuals, in 2014. This implies that more than one in five (2,418, 22%) of the presentations were repeat episodes. There was virtually no change in the rate of presentations between 2013 and 2014, following a six per cent decrease between 2012 and 2013. The rate in 2014 remained six per cent higher than the pre-recession rate of 188/100,000 in 2007 (Figure 1). The only age group in which there was significant change in the rate of deliberate self-harm between 2013 and 2014 was boys aged 10 to 14 years, among whom the rate increased by 44 per cent, from 34 to 49 per 100,000.

Forty-six per cent of self-harm presentations in 2014 were men, and just over half (54%) were aged under 30 years. People living in hostels for the homeless or of no fixed abode made up five per cent (n=514) of self-harm presentations. Presentations peaked in the hours around midnight and were highest on Sundays and Mondays, with 31 per cent of

episodes occurring on these two days. There was evidence of alcohol consumption in 3,860 (35%) presentations and this was more common among men (37%) than women (33%).

Drug overdose was the most common form of deliberate self-harm reported in 2014, occurring in 7,314 (66%) episodes. This was a small decrease (-2%) on 2013. Overdose rates were higher among women (72%) than among men (58%). In 70 per cent of cases the total number of tablets taken was known, with an average of 28 tablets taken in these episodes.

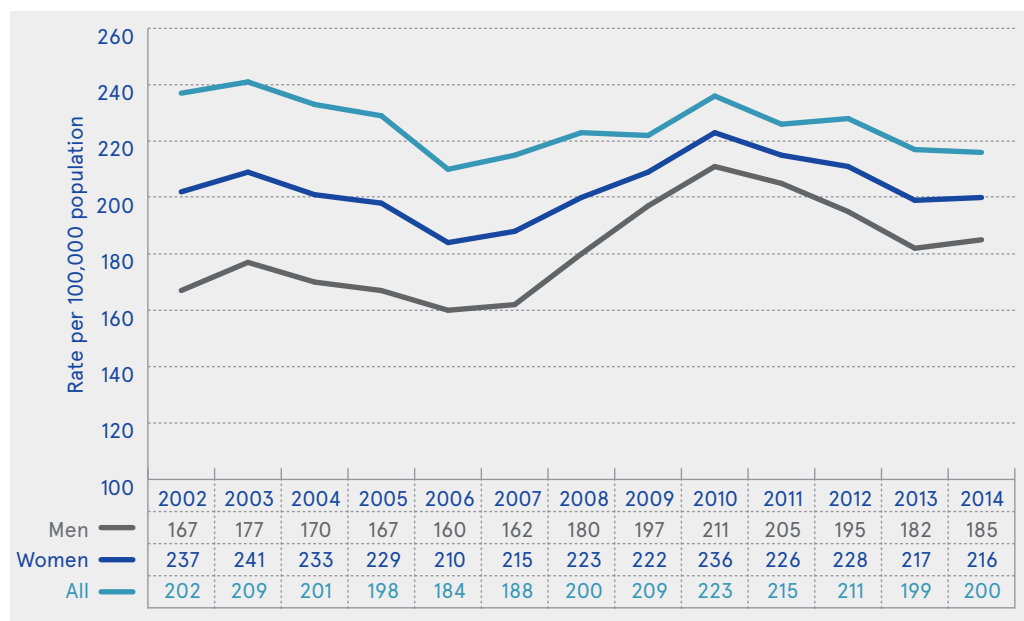
A minor tranquilliser (most commonly benzodiazepines) was involved in 37 per cent of all drug overdoses; 28 per cent of overdoses involved paracetamol-containing medicines; 21% involved antidepressants or mood stabilisers (most commonly selective serotonin reuptake inhibitors [SSRIs]); 10 per cent involved a major tranquilliser; and 26 per cent other prescribed drugs.

There was an 11 per cent increase in the number of presentations involving street drugs, from 420 in 2013 to 465 in 2014 (following annual decreases from 2010 to 2013). The 2014 level was similar to the level recorded in 2008 – 461.

The next steps, or referral outcomes, for the deliberate overdose cases were 51 per cent discharged home; 28 per cent admitted to an acute general hospital; six per cent admitted to psychiatric in-patient care; a small proportion (1%) refused admission to hospital; and 14 per cent discharged themselves before receiving referral advice.

The report provides information on what was being or could be done to reduce the number of self-harm cases. Particularly encouraging were the facts that over 30 self-harm specialist nurses had taken up positions in various hospitals in 2014 and that increased numbers of patients were receiving mental health assessments.

Figure 1: Person-based rate of deliberate self-harm, 2002–2014, by gender



Source: Griffin E et al.¹

While the total number of presentations involving drug overdose rose, there was a significant reduction in overdoses involving minor tranquillisers. The report relates this to proactive monitoring of prescribing patterns in primary care services since 2012. The authors recommend that reducing access to minor tranquillisers should be an on-going priority.

The authors report that, as in previous years, alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, and in the hours around midnight. These findings underline the need for on-going efforts to:

- enhance health service capacity at specific times and increase awareness of the negative effects of alcohol misuse and abuse such as increased depressive feelings and reduced self-control;
- intensify national strategies to increase awareness of the risks involved in the use and misuse of alcohol, starting at pre-adolescent age, and intensify national strategies to reduce access to alcohol and drugs;
- educate self-harm patients and their families about the importance of reduced use of and access to alcohol; and
- arrange active consultation and collaboration between the mental health services and addiction treatment services in the best interest of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).

The authors report that there was variation in the next care recommended to deliberate self-harm patients, and in the proportion of patients who left hospital before receiving a recommendation. While overall, nearly three quarters of all patients were discharged with a referral, variations were seen in referral pathways across HSE hospital groups. The authors recommend that the national guidelines for the assessment and management of patients presenting to Irish emergency departments following self-harm be implemented nationally as a matter of priority.²

The report highlights the on-going work by the National Suicide Research Foundation to link data on deliberate self-harm with suicide mortality data. This linking has shown that individuals who self-harm are over 42 times more likely to die by suicide than the general population. Further linkage is recommended in order to enhance insight into predictors of suicide risk.

Margaret Curtin

- 1 Griffin E, Arensman E, Dillon CB, Corcoran P, Williamson E and Perry IJ (2015) *National self-harm registry Ireland annual report 2014*. Cork: National Suicide Research Foundation. <http://www.drugsandalcohol.ie/24654/>
- 2 Cassidy E, Arensman E, Keeley HS and Reidy J ((2012) *Saving lives and reducing harmful outcomes: care systems for self-harm and suicidal behaviour*. Dublin: HSE, and Cork: National Suicide Research Foundation. <https://www.hse.ie/eng/about/Who/clinical/natclinprog/mentalhealthprogramme/selfharm/selfharm.pdf>

Frequent attenders at a Dublin inner-city emergency department

A recently published paper retrospectively examined the demographics, substance use, mental health and co-morbidities of the 20 most frequent attenders at the Mater Misericordiae University Hospital in 2014.¹

The study found that the majority (17) of the 20 most frequent attenders were male, all were unemployed and the median age was 38.5 years (range 21 to 59). Seven were of no fixed abode and a further five were living in temporary hostel accommodation. Nineteen were either single or separated.

Among the 20, 16 misused either drugs or alcohol: 10 were current illicit drug users, six had a benzodiazepine addiction, three a heroin addiction, and one was polydrug dependent. The average attendance rate by illicit drug users was twice that of non-drug users. The majority (12) were alcohol dependent, with a further two reporting alcohol abuse. Seventeen were smokers. Thirteen had mental health issues, four of these had depression and a further four had both

depression and schizophrenia. Two had personality disorders. Full details of the demographics, substance use, mental health status and co-morbidities of the 20 most frequent attenders are provided in Table 1.

The authors point out that a small number of repeat attenders may be responsible for a disproportionate level of emergency department attendances. These repeat attenders generally have substance misuse and psycho-social issues. Moreover, the authors highlight the burden of alcohol and drug dependence on the Irish health services and state that in 2007, €1.2 million was spent on alcohol-related illnesses. The authors also highlight the high incidence of mental health problems among frequent attenders and propose that this may be due to insufficient community-based mental health services. They conclude that frequent attenders are a complex group needing a holistic multi-disciplinary approach that would involve addressing underlying issues such as drug and alcohol dependency, mental health issues and social deprivation, with significant investment outside the hospital setting to relieve pressure on emergency departments.

Margaret Curtin

- 1 Ramasubbu B, Donnelly A and Moughty A (2016) Profile of frequent attenders to a Dublin inner city emergency department. *Irish Medical Journal* (109/4). <http://www.drugsandalcohol.ie/25379/>

Table 1: Demographics, substance misuse and co-morbidities of the 20 most frequent emergency department attenders, Mater Misericordiae University Hospital, 2014

Attendances (n)	Gender	Age	Drug Misuse	Alcohol Misuse	Mental Health Issues	Co-morbidities	Marital status	Living arrangement
404	m	37	Benzodiazepines	Dependence	Yes	Gastritis	Single	Hostel
120	m	39	Heroin	Dependence	Yes	Hepatitis B	Single	No fixed abode
101	m	24	Benzodiazepines	Dependence	Yes	Nil	Single	Hostel
91	f	21	Benzodiazepines	No	Yes	Epilepsy	Single	Own residence
91	m	52	Nil	Dependence	Yes	Peptic Ulcer	Divorced	No fixed abode
81	m	38	Heroin	Dependence	Yes	Hepatitis C	Single	No fixed abode
80	m	58	Nil	Dependence	No	Nil	Single	No fixed abode
64	f	46	Benzodiazepines	No	Yes	COPD	Separated	Own residence
62	m	27	Nil	No	Yes	Nil	Single	No fixed abode
50	m	38	Nil	Dependence	Yes	Asthma	Single	Hostel
49	m	26	Polydrug	Dependence	Yes	Nil	Single	Own residence
43	m	42	Nil	Dependence	No	Liver Cirrhosis	Separated	Hostel
41	f	25	Benzodiazepines	Abuse	Yes	Nil	Single	Hostel
39	m	56	Nil	Dependence	Yes	Liver Cirrhosis	Single	Own residence
39	m	46	Benzodiazepines	Dependence	Yes	Pancreatitis	Single	Own residence
38	m	51	Heroin	Dependence	No	Hepatitis C	Civil Partnership	Own residence
37	m	37	Nil	No	No	Chronic renal failure	Single	Own residence
36	m	36	Nil	Abuse	No	Deaf, congenital heart disease	Single	No fixed abode
35	m	54	Nil	No	No	Asthma	Single	No fixed abode
35	m	59	Nil	No	No	COPD	Widowed	Own residence

Source: Ramasubbu B et al.¹

EU drug markets report 2016

On 5 April 2016 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol published their second joint study of European drug markets.¹ This in-depth strategic examination builds on the 2013 report, which was the first attempt to bring together intelligence on the functionality and structure of European drug markets in the wider illicit drugs setting.² The overall aim of both reports has been to inform policy and responses aimed at drug supply reduction.

The recent report focuses on three areas. Firstly, it examines the consequences of the illicit drug market and what drives its development. Secondly, it examines the main drug markets, such as cannabis, heroin and other opioids, cocaine, methamphetamine and methylenedioxymethamphetamine (MDMA), and new psychoactive substances (NPS). Each chapter recommends actions which highlight areas that should continue or need to be addressed. Finally, the report examines policies and responses aimed at reducing the supply of illicit drugs.

Consequences of the illicit drug market

Legal economy

The illicit drug market has a broad impact, not just on individuals who use drugs but also on society as a whole. A number of impacts are identified in the report.

A challenge for organised crime groups (OCGs) is moving money that has been generated via illicit drug dealing into circulation. This has an impact on the legal economy as legitimate businesses are necessary to launder the cash, and they are at risk of being linked with 'trade-based money laundering schemes'.

Wider criminal activity

OCGs have been shown to be increasingly adaptable and flexible in their operational activities and interactions, and hence the opportunities to act illegally are immense. The ability of law enforcement agencies to fill the knowledge gaps about these interactions is viewed as essential. The report highlights three such knowledge gaps that represent 'intelligence-gathering opportunities':

- drug supply carried out alongside other activities, for example firearms or migrant smuggling;
- drug supply that funds other crimes, for example terrorism or exploitation of people; and
- other crimes committed when dealing drugs, for example forcing trafficked individuals to take part in producing and selling drugs.

Terrorism

Links exist between OCGs engaged in drug trafficking and terrorist groups. These interactions are functional in that terrorists appear to avail of the drug markets as a way of funding other activities. From a European perspective, this link is viewed as a 'threat' as it has resulted in renewed interest in producing opium and other drugs in Afghanistan

and its neighbours, Africa and the Middle East. Volatility and nearness to Syria have led to the development of a 'geographical hotspot of multiple and potentially interconnected threats' such as drug and other organised crime and human relocation.

The risk factors associated with drug crime and with radicalisation are considered to overlap, for example disadvantaged individuals are at greater risk of being imprisoned for drug offences, and prison is a setting known to contribute to radicalisation. The report points out that because terrorism and drugs are viewed as separate entities, knowledge gaps are extensive and links between the two areas are often missed.

Government institutions and corruption

In the majority of EU states, a large proportion of drug-related public expenditure is used to try to reduce drug supply. Nonetheless, there is often pressure to reassign funds to address other issues considered more urgent. In addition, the power of governments can be damaged by corruption and coercion, for example in the judiciary or within law enforcement agencies.

Impacts on wider society and global stabilisation efforts

Society is affected by the operation of drug markets in a variety of ways, from increased acquisitive crime owing to addiction, to homicide, or feeling unsafe living in an area. In addition, in areas where drugs are produced, the environment may be directly affected by chemicals used during production, deforestation or erosion, and indirectly, depending on the location, by migration, destabilisation and climate change.

Main drug markets

The report examines the drug markets related to the main drug types and provides insights into their development from production through to supply. Key features of these markets include their global spread, the involvement of OCGs, the trafficking routes and the retail markets. Based on the most recent available figures up to 2015, the most prominent drug in Europe's illicit drug retail markets is cannabis, followed by heroin and then cocaine.

New psychoactive substances (NPS)

Although NPS are a relatively new addition to the EU drug market, their importance and growth cannot be overestimated. In 2015, 100 new substances were identified by the EMCDDA and approximately 650 were being monitored. As a result of the 'rapidly changing nature' of these substances, it is difficult to estimate NPS consumption. The report points out that the same brand name may be used for completely different substances, resulting in individuals not being aware of what they are taking.

The 2014 Eurobarometer Survey, which examined the use of NPS among 15–24-year-olds across EU member states,³ indicated that overall eight per cent of respondents reported using NPS, of whom one per cent reported using in the last 30 days, three per cent in the previous 12 months, and four per cent more than a year ago. Broken down by country, the highest level of NPS consumption was reported by Irish young people (22%). This figure illustrates that NPS consumption in Ireland has increased by six per cent since the 2011 Eurobarometer Survey (16%).⁴

EU drug markets continued

Policies and responses

The final chapter of the report examines policies and strategies aimed at reducing drug supply. The main strategic action highlighted is the EU drugs strategy (2013–20) and action plan (2013–16). The framework in this strategy and action plan are considered to mirror the challenges identified in the report. The report outlines the roles played by different EU institutions and agencies in the development and application of the EU's drugs policy.

The report highlights three areas of the drug market that are being targeted:

- organisations involved at national and international level in the production and supply of drugs, for example OCGs which are multifaceted, particularly in the areas of organisational structure, technical knowledge, connections with other organisations and areas of specialism;
- factors that enable drug activities, for example money, help from other professionals, and advances in globalisation and technology; and

- social factors that result in people getting involved in producing and selling drugs, for example human trafficking, exploitation as a result of poverty, and immigration.

Ciara Guiney

- 1 European Monitoring Centre for Drugs and Drug Addiction, Europol (2016) *EU drug markets report: in-depth analysis*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/25357/>
- 2 European Monitoring Centre for Drugs and Drug Addiction, Europol (2013) *EU drug markets report: a strategic analysis*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/19227/>
- 3 TNS Political and Social (2014) *Flash Eurobarometer 401. Young people and drugs*. Luxembourg: European Commission. <http://www.drugsandalcohol.ie/22196/>
- 4 The Gallup Organization (2011) *Youth attitudes on drugs. Flash Eurobarometer 330 Analytical report*. Luxembourg: European Commission. <http://www.drugsandalcohol.ie/15497/>

The quality of crime statistics

Since 2003 the production of crime statistics has been the responsibility of the Central Statistics Office (CSO). These statistics are based on data collated by An Garda Síochána using the Garda PULSE (Police Using Leading Systems Effectively) system.

In 2014 a report produced by the Garda Inspectorate drew attention to serious problems regarding the recording of crime on PULSE.¹ Issues included the non-recording of crimes, lack of timeliness in recording crimes, misclassifying crime incidents and non-crime incidents at initial stages, incorrect reclassification of incidents, and incorrect application of detection and invalidation status to certain crimes.

Given that the CSO draws on PULSE data to produce crime statistics, it was considered essential to carry out a review of the data received by the CSO to determine their accuracy.² The aim of the review was to determine how many legitimate offences were not being recorded on the PULSE system. Access was provided by the Garda Síochána to crime and non-crime data including CAD (Command Aided Dispatch), paper records and non-crime PULSE incident groups, such as Attention and Complaints, Property Lost and Domestic Dispute. A random selection of CAD and paper records was checked against corresponding records on PULSE. What follows is a summary of the main findings.

Non-recording of crimes

Twenty per cent of validated crimes (e.g. assault, burglary, criminal damage, public damage, robbery, theft) and 23 per cent of non-crimes (e.g. bomb scares, domestic disputes/domestic violence and sexual assault) reported on CADs were not reported on PULSE. In addition, 16.4 per cent of validated paper records were not reported on PULSE. The authors advised caution when interpreting these results as it was challenging to match records between CAD and PULSE, hence some records deemed not to be on PULSE may actually be there.

Lack of timeliness in recording crimes

Within the PULSE system a creation date and report date are recorded. The CSO found that following a crime being reported, there was a delay of over a week before seven per cent of incidents were recorded on PULSE.

Alteration of narratives

The narrative field on PULSE, which records details of a crime, can be amended as further information becomes available. To determine whether narratives had been edited to justify classification decisions, the narrative lengths of all incidents were analysed to see if any reductions in length had taken place between the January 2012 dataset and the April 2014 dataset, which would indicate unacceptable editing. Not a single case was identified.

As it was not possible to establish what records had been amended before January 2012, the audit trails for a sample of 500 PULSE criminal records were examined. The audit trail records every change to the narrative, the date and time of the change and who made the change. Only one of the 500 records (a reclassified crime case) revealed evidence that an alteration had been made to justify an incorrect reclassification.

Crime statistics continued

Misclassification of incidents

There are approximately 300 crime classifications on PULSE. How crimes are classified is essential for accurate reporting.

The CSO focused on six classifications of serious crimes – Assault Minor, Assault Causing Harm, Criminal Damage (Not Arson), Theft from Person, Burglary, and Robbery from the Person. The analysis indicated that three per cent of records were classified incorrectly and the classification of a further four per cent was unclear.

To determine whether non-crime incidents should have been classified as crimes, narratives from Attention and Complaints (n=1,000), Property Lost (n=500) and Domestic Dispute (n=300) were examined. Although the majority of records were classified correctly (91%–94%), a small number of records were either misclassified (4%–7%) or unclear (4%–7%). Further analysis indicated that 69 records from Attention and Complaints should have been in Assault or Fraud/Threatening Letters and one in Sexual Assault/Robbery; 18 Property Lost should have been in Theft; and 13 Domestic Disputes should have been in Assault or Assault causing Harm.

Incorrect reclassification of crime incidents

Crime classifications were compared on PULSE between January 2012 and January 2013. Three areas were examined: Assault (n=57), Assault Causing Harm (n=12) and Criminal Damage (n=189). The analysis indicated that 71 per cent of reclassifications were justified whilst 15 per cent were not. A further analysis of 'downgrades' in the Assault and Assault Causing Harm categories indicated that 51 per cent were justified and 26 per cent were not. Approximately 50 per cent of crimes were upgraded and 15 per cent were reclassified down in the Criminal Damage category. Within this category, the highest proportion of reclassifications occurred for Burglary (44%), followed by Theft (35%).

In non-crime categories, for example Attention and Complaints, Burglary and Related Offences (19%) and Theft and Related Offences (12%) were reclassified. A limitation of this analysis was that data from PULSE were only received by the CSO at the end of every month; hence the CSO was not privy to reclassifications that occurred when the crime was originally reported.

Incorrect application of detection status

To determine whether 'detected' crimes resulted in criminal proceedings, 138,807 'detected' crimes were examined, 54 per cent were linked to a charge or summons whereas 46 per cent were not. A further analysis of the accuracy of 'detection rules' on 'detected' crimes with no charge or summons (n=500) indicated that over a third of crimes were wrongly assigned 'detected' (35 per cent). This accounted for a 16 per cent (22,307) reduction in the total number of 'detected' crimes.

Incorrect application of invalidation status

Invalidation occurred when there was no crime or when 'counting rules' were wrongly applied. Out of 528 invalidated records, 23.1 per cent were unjustified. The highest proportions of unjustified invalidations was shown for 'Robbery, Extortion and Hijacking Offence' (18.9%; n=32) and 'Sexual Offences' (43.3%; n=26).

Conclusions/Recommendations

The CSO estimated the impact of the problems identified in their review. The largest percentage increases were 38 per cent in Group 03 (Attempts, Threats to Murder, Assaults, Harassments and Related Offences), 27 per cent in Group 08 (Theft and Related Offences) and 26% in Group 09 (Fraud, Deception, and Related Offences). Alterations owing to misclassifications within groups were not considered, for example Assault Causing Harm and Assault Minor are both in Group 03.

Consistent with the Garda Inspectorate report, the CSO review found discrepancies between crimes recorded on CAD/Paper and PULSE. The CSO made a number of recommendations to improve the quality of the data.

- The introduction of a unique identifying number between CAD/Paper reports and PULSE would enable data to be linked more effectively, and allow greater accuracy and quality control.
- The crime narrative should match subsequent crime classification, detection and/or invalidation status recorded.
- The decision-making process in PULSE should be centralised. This would ensure operational procedures were followed with regard to crime and non-crime classification, reclassification, detection and/or invalidation.

Ciara Guiney

- 1 Garda Inspectorate (2014) *Report of the Garda Síochána Inspectorate. Crime investigation*. Dublin: Garda Inspectorate. <http://www.drugsandalcohol.ie/22967/>
- 2 Central Statistics Office (2015) *Review of the quality of crime statistics*: Dublin: Government of Ireland. <http://www.drugsandalcohol.ie/24887/>

RESPONSES

Drug treatment courts

Studies carried out in Ireland suggest that the majority of offenders detected in Ireland present with some form of drug dependency.^{1,2,3} The study reported on here evaluates one approach that has been used within the justice system to treat drug dependency – drug treatment courts (DTCs).⁴

Origins

Broomfield describes how DTCs emerged in the United States (US) in response to the growing drug crisis in the 1980s. According to Broomfield, the DTC model brings together the ‘powers of court’ and drug treatment, with the aim of supporting steps to sobriety via regular contact with the user, monitoring substance use, evaluating responses to interventions and close supervision. Studies evaluating the effectiveness of DTCs in the US suggest that:

- reoffending and drug dependency are lower among DTC participants,
- progress is impacted by ‘severity of misuse’, previous history, and use of stimulants,
- programme completion was higher in users receiving pharmacotherapy, and
- more completions occurred when the presiding judge was there longer and when the court was smaller.⁵

However, Broomfield notes that other reviews provide evidence contradicting these findings. When pre-trial release and drugs testing were compared with parole and probation, effect sizes demonstrated that the latter were better.⁶ Another review suggested that the impact of diversions reducing drug dependency was small.⁷

Dublin DTC

The Dublin DTC (DDTC) pilot programme started in 2001. Similar to the US DTC, the aim was to reduce offending and drug dependency with help from addiction nursing, education and probation supervision. There were three stages: bronze, silver and gold. Participants were required to:

- attend court regularly (weekly, fortnightly or monthly),
- attend education programmes daily,
- meet with a probation officer regularly, and
- engage in treatment relating to their drug of choice.

During the programme, progress was reviewed by the DDTC judge. Following successful completion of the DDTC, charges were ‘struck out’. Broomfield casts doubts on the merits of using completion rewards, in particular for those with extensive offences, no desire to travel or live abroad, or those who were not afraid of having a criminal record. Despite this, he argues that the DDTC programme provides a structure which can reduce destructive behaviour.

Not everyone can be helped through the DDTC. Broomfield points out that the combination of drug dependency, crime and other difficulties such as coming from a disadvantaged socio-economic background or a dysfunctional family background (e.g. drug-abusing parents or siblings), homelessness or mental illness, result in challenging environments for addiction treatment, making it necessary to adapt interventions accordingly.

Completers

Two separate evaluations of the effectiveness of the DDTC have indicated that the number of completers was low but offending behaviour had declined. A review in 2002 gained insights from completers regarding the DDTC process, and the pros and cons of sticking with the programme.⁸ No information was reported on attitudes or quality of life changes or on the progress of non-completers. A second review in 2010 aimed to determine why referrals were low and to identify how ‘increased throughput’ could be attained.⁹ As in 2002, the main finding was the low number of completers; again, the progress of non-completers was not considered. Broomfield argues that it is concerning that evidence about participants in the 2010 evaluation appears to have been obtained from professionals rather than participants themselves.

Drawing on the work of Butler,¹⁰ who examined how the DTC policy transferred from the USA to Ireland, Broomfield notes that (1) the development of the DTC in Ireland was politically driven; (2) therapeutic jurisprudence (an active, problem-solving judiciary) and the ability to buy addiction treatment evident in the US were not present in the Irish system; (3) although professionals viewed participation as beneficial, they were uncertain that credit for the positive outcomes should be attributed to the DDTC; and (4) disparities were evident in the socio-economic backgrounds of participants in the US and in Ireland – Irish participants were economically deprived and addicted to opiates while American participants were more affluent.

Non-completers

Research on DTCs has focused on completers, which could suggest that non-completers are failures. To redress this gap, grounded theory has been used to examine the benefits (including intention-to-treat and harm reduction) of the DTC programme for non-completers.¹¹

A significant harm reduction effect was identified, which led the authors to conclude that the provision of a harm reduction model alongside the abstinence-based model would be beneficial. Despite the limited sample size, Broomfield argues that this research has provided valuable insights.

Drug treatment courts continued

Using narrative inquiry with DTC participants

The main finding from DTC research has been that the majority of participants are non-completers. Determining the reasons for this has been neglected by researchers. Broomfield suggests that a lot of information could be gleaned from the narratives or stories of non-completers regarding why programmes did not work for them and what adjustments would enable them to complete. A narrative inquiry approach would be the most apt approach to examine 'internal and external dialogues' that occur when deciding to remain or leave.

Additionally, obtaining descriptions of the offending, lifestyle and addiction of non-completers would provide insights into how other individuals with similar experiences might be helped. It would allow individual stories to be heard. Reasons to support this argument are put forward, such as:

- Life stories of individuals would include not only the story about the addiction and treatment but also insight into their experiences of marginalisation and resilience.
- The transition into drug dependency often co-occurs with a life changing event. Broomfield suggests it is not just the importance of the event but also whether resources are available to manage it.
- Narratives of those with addiction occur within larger narratives of emotive, financial and social systems.
- Narratives that unpack the thoughts, needs and risks faced by drug users involved with crime would provide greater knowledge and understanding to those not affected by drug use and crime.

Ciara Guiney

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Psychological health of heroin-dependent teenagers in treatment

A recent Irish study examined the effect of psychologically supported opiate substitution treatment (OST) on the psychological well-being of an adolescent population attending an outpatient clinic in Dublin for their heroin dependence.¹ It is an important study because of the dearth of data reported in the literature on the psychological well-being of adolescents undergoing OST.

Background and methodology

Following previously published findings that substance abuse and mental health issues often occur simultaneously, especially in adolescents,² Smyth and colleagues sought to examine the prevalence of mental health issues among heroin-dependent adolescents and to determine the effect of psychologically supported treatment on their mental health.

In a previous Irish study, it had been noted that heroin-dependent adolescents experienced more psychological distress and a greater number of problems than their peers with other substance use disorders.³

Despite knowing this, the psychological well-being of drug users, especially adolescents, remained under-studied.

Psychological health of heroin-dependent teenagers in treatment continued

The authors of the current paper hypothesised that psychological support during OST would result in improvements in the psychological health of adolescent patients. The study was carried out prospectively on individuals aged 18 years or younger who were seeking treatment for opiate addiction between May 2006 and December 2013 in Dublin. In addition to OST with either methadone or buprenorphine, participants in the study were also in receipt of individual counselling and group work which focused on life skills. Psychological well-being was measured at the beginning of the study (baseline) and again after four months of treatment (follow-up), using the 2nd edition Beck Youth Inventory (BYI-II).⁴

The BYI-II is a self-reporting tool with 100 questions based on a Likert scale (never, sometimes, often, always), designed for use with people aged 18 years or younger. It was created to assess the participants' experience of the following five subscales:

- self-concept,
- depression,
- anxiety,
- anger, and
- disruptive behaviour.

For each parameter, scores are converted into a standardised score, known as a T-score, which enables score comparison between individuals. T-scores were compared to age- and gender-matched scores from a general population sample.

While these scores are not diagnostic of psychiatric disorders, Smyth and colleagues established 'normal' and 'abnormal' cut-off points. For the subscale of self-concept, scores of <44 were considered 'abnormal', and for the other four subscales a score of >55 was considered 'abnormal'. At baseline, structured clinical sessions were carried out to assess drug use, and the socio-demographic and clinical characteristics of the participants.

Of the 55 participants that were eligible at the beginning of the study, 32 completed treatment and had baseline and follow-up (BYI) questionnaires, while 23 participants did not complete the follow-up BYI.

Results

The most novel finding was that all five subscale scores improved during the OST period, and the improvements in the mean scores for depression, anxiety and anger were statistically significant. Interestingly, approximately a third of participants with 'abnormal' scores for anxiety and depression had follow-up scores that were categorised as 'normal'. In an attempt to further elucidate the relationship between improved scores for depression and heroin use, the authors conducted linear regression analysis, which revealed greater improvements in depression scores among those who were heroin abstinent.

Interestingly, there were stark differences between those who did not complete the follow-up BYI and those who did. The participants who did not complete the follow-up (n=23) were statistically significantly more likely to experience homelessness or imprisonment compared to those who did complete the follow-up (p=0.02 and p=0.03 respectively). Furthermore, the group who did not complete the follow-up BYI were more likely to be misusing methadone, heroin and cocaine (p<0.001, p=0.001 and p=0.02, respectively).

Conclusion

The results reported in this study highlight the importance of psychosocial support for adolescents undergoing OST. They mirror the results found in studies of adults receiving OST, where psychological support during treatment was found to have a positive impact on psychological well-being.⁶ Additionally, this study gives insight into the psychological health of teenagers seeking treatment for opiate addiction in Dublin and some of the problems experienced by this group, which remains poorly characterised. The socio-demographics of the adolescent cohort in this study is reflective of similar adolescent groups internationally, especially with regards to poor educational status, family difficulties and mental health problems.^{7,8}

Aoife Cannon

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Modelling OST outcomes with urinalysis and DAIS data

The need for ongoing, prompt, cost-efficient and comprehensive monitoring and evaluation of drug treatment is well recognised. The scientific literature supports the use of randomised controlled trials (RCTs) as the 'gold standard' research design for evaluating interventions and treatment outcomes. However, in community substance-use treatment settings, the use of RCTs is not always possible or appropriate. There are ethical issues and questions about relevance, feasibility and costs.

Given the limitations of RCTs and the demand for ongoing, timely and effective monitoring of treatment outcomes, Comiskey and Snel sought to test the feasibility of linking laboratory data and client intake data and its usefulness for modelling retrospectively five-year longitudinal drug treatment outcomes in an Irish opiate treatment setting.¹

Methodology

A multi-site, retrospective, longitudinal cohort study was implemented to evaluate outcomes for opiate users across Dublin from January 2006 to December 2010.

Longitudinal urinalyses were extracted from two national laboratories which provide substance use screening tests to 17 drug treatment sites and to two buses providing mobile needle exchange services. During the five-year study period a total of 1,734,283 test results were identified for 330,802 urine samples presented by a total of 4,518 unique individuals across Dublin.

In addition to the urinalysis database, data were extracted at a number of *ad hoc* time points from all the treatment sites which use a client electronic record system, which is known as the Drugs and AIDS Information System (DAIS). This system records data about drug-users seeking treatment, including their demographic characteristics, assessment prior to treatment, prescriptions, hepatitis C status, treatment programmes, needle exchange programmes and rehabilitation integration services. During the study period, 5,430 records relating to 2,832 unique individuals were recorded in DAIS; of these unique individuals, 97 per cent were Irish, 72 per cent were male, 59.7 per cent had no children and seventeen known deaths were recorded. These data were linked, via a unique client identity number, at the individual client level to the longitudinal urinalysis data.

Once the full database of unique clients was created, with each repeat episode of treatment linked, captured and recorded for that client, the longitudinal outcome variables in the form of drug positive urinalyses results were derived. Outcomes were tracked sequentially, with the first urinalyses denoted as time point 1 (the intake/baseline measurement) and each subsequent urinalysis result was then recorded as test 1, 2, 3 ... up to a maximum of 260.

Results

Across the five-year period 62 per cent of the urine samples tested positive for benzodiazepines, 43 per cent for cannabis, 40 per cent for opiates and 11 per cent for cocaine. Analysis of substances used at treatment intake, at six months and at one- to five-year follow-ups, revealed:

Differences in urinalysis protocols: Extraction of urinalysis data from the two national laboratories revealed that treatment sites varied considerably regarding the number and frequency of urinalysis tests conducted; for example two of the seven DAIS treatment clinics requested over 83 per cent of analyses, but accounted for only 68 per cent of all DAIS clients. The researchers attribute these variations to a difference in treatment-site philosophy and practice rather than variations in client characteristics.

A further inconsistency occurred between the stated tests conducted as part of a routine urine test and what was found in the analysis: while 99.9 per cent of urine samples were tested for opiates and cocaine as required by policy, only 72 per cent were tested for benzodiazepines.

Age of first drug use: Clients who did and did not test positive for opiate use at year five were compared on a number of variables. No significant difference was found apart from age at first drug use (mean age of 15.53 years vs. mean of 14.63 years, $p=0.008$)

Opiate use: The proportion of clients who tested opiate positive fell from 61.8 per cent at initial treatment intake to 12.5 per cent at the end of the five-year period. The researchers' time series analysis of weekly proportions testing opiate-positive had predicted 16 per cent (95% confidence interval: 7%-25%) of clients would be opiate positive at the end of the five years.

Other drug use: Significant increases were found in benzodiazepine use, and significant increasing effects of concurrent cocaine and benzodiazepine use on the likelihood of using opiates. It was also possible to link and describe the changes in the methadone doses prescribed: analysis of the DAIS system revealed there were only minor changes in the doses of methadone prescribed over the five years.

Conclusion

With this research the authors have demonstrated that data from existing multi-sited, cross-sectional sources can be linked, matched, mined and modelled to develop prompt, retrospective, sequential outcome results that are useful for policy makers, service providers and service users.

Ita Condron

1 Comiskey CM and Snel A (2016) Using clients' routine urinalysis records from multiple treatment systems to model five-year opioid substitution treatment outcomes. *Substance Use & Misuse* (51/4): 498-507. <http://www.drugsandalcohol.ie/25363/>

Women and methadone maintenance treatment

A study conducted between 2006 and 2007 in the National Drug Treatment Centre, a large specialist addiction clinic in Dublin, sought to discover whether women in methadone maintenance treatment (MMT) had more unmet needs and lower quality of life than men in MMT.¹

Any service user who had been receiving MMT for three months or more was eligible for inclusion, excluding those with a history of acute psychiatric problems or end-stage health difficulties. In total, 190 service users were eligible to participate in the study, of whom 108 (57%) agreed to participate. Of those 108 participants, 35 (32%) were women. No statistical difference was found in the demographic characteristics of those who did and did not participate in the study.

Three different standardised questionnaires were used:

1. WHO Quality of Life – Brief Version (WHO-QOL-Bref),
2. Maudsley Addiction Profile, and
3. Camberwell Assessment of Need Short Appraisal Schedule, Patient Version.

Shared measurement of personal outcomes in recovery

In April 2016 a number of drugs and alcohol taskforce coordinators and other staff along with representatives of various drugs projects participated in a workshop on shared measurement of personal outcomes in recovery. The purpose of the workshop was to help services identify common outcomes and work towards a shared system of measurement for interventions in rehabilitation and social reintegration.

The workshop was hosted by the HRB National Drugs Library, which seeks to encourage the use of research-based evidence in decision-making and to contribute to learning in drugs and alcohol taskforces and addiction services.

The workshop facilitators have compiled a report based on the discussions at the workshop, the findings from a survey of taskforces and interviews with a number of taskforce coordinators.

The mean age of participants was 32.7 years, with women slightly younger than men (30.7 years versus 33.7 years). There were no differences in the demographic and social characteristics of women and men, except that women were more likely to have accessed the support of a social worker. Recent drug use was assessed by self-report and urinalysis. Men self-reported more use of heroin in the past month and had a higher proportion of positive urines for cocaine.

Women were statistically more likely to report unmet needs and achieve lower psychological quality of life scores than men. This difference could not be explained by on-going drug use, as the men in the study had higher levels of recent drug use.

The authors note the limitation of the small sample size. In addition, the findings may not be fully representative as the study was conducted in a specialist addiction service which treats the most complex cases. The generalisability of the study is also affected by the fact that the data were collected over ten years ago.

The authors suggest that the needs and quality of life of women in MMT warrant further research. They also call on addiction services to ensure that the psychological and social care needs of women clients are addressed.

Suzi Lyons

- 1 Byrne P, Ducray K and Smyth BP (2016) The impact of sex upon needs and quality of life within a population on methadone treatment *Journal of Addiction Medicine* 10(1):60–67. <http://www.drugsandalcohol.ie/24979/>

The report comprises three sections:

- a guide for understanding a person's recovery, identifying groups of factors that contribute to successful recovery;
- a series of measures of each aspect of recovery, drawn from published resources which are freely available; and
- guidance on how to implement the shared measurement framework, including practicalities such as gathering input from service users, training and the use of technology in enabling data collection and analysis.

To use the shared measurement framework, services need to identify three to five outcomes, match these outcomes to the shared outcomes in the framework and identify the recommended measurement that accompanies that shared outcome. This is the first step in deciding on and using common outcomes. The framework recommends established questionnaires and psychometric scales to measure these outcomes. Services will need training in using these questionnaires to gather data and a technical infrastructure to facilitate data management and analysis. Understanding how shared outcomes data are aggregated and compared will help to determine the relative effectiveness of interventions. Results must be presented in a way that allows services to learn about what is and is not working in recovery services and to make the necessary changes and improvements.

Personal outcomes in recovery

continued

Responding to the needs of those recovering from addiction is multi-faceted and demanding work, requiring knowledge, personal skills and determination. Good service is built by selecting interventions which are known to be effective, monitoring the implementation of these services and responding to information gained through rigorous evaluation and sharing of knowledge. In this way good practice is identified and spread, resources are used effectively and services developed in a shared learning environment.

Housing, education and employment have been identified as key elements in reintegrating those overcoming addiction into their communities. Recovering drug users need social and emotional support beyond the initial treatment period to develop their capacity to participate in the housing, education and employment spheres. Recovery is multi-faceted but this project is particularly concerned with the measurement of personal outcomes in this process, the types of change in outlook and self-perception that enable progress along the recovery path.

The HRB's evidence review on social capital in recovery¹ looked at the role played by friends and families in helping the service user to develop a secure social network, to find examples of success and to develop the confidence to plan their own lives. The review found good evidence that social and human capital contribute to recovery. It identified a number of areas for future work so that service providers can understand how

needs change over the course of the recovery process and how needs differ from person to person.

There is an evidence gap in this area and a lack of consistency when it comes to evaluating recovery interventions. Shared measurement of the impact services have on recovering drug users would help to lessen this gap, improve services and make achievements in this work more apparent. It would lead to better outcomes for the people using services and provide evidence that taskforces play an integral and valuable part in responding to problem drug use in Ireland. Deciding on appropriate personal outcomes in recovery, which services can recognise as milestones in the achievement of their goals, and agreeing on indicators to measure these outcomes are important first steps in building knowledge, sharing it and using it to spread good practice.

Over the coming weeks a number of taskforces will work on the next phase in the development of the outcomes framework and seek to ensure that it is relevant and meaningful to services users, making it more likely to be implemented and used effectively. Service user consultation will encourage a sense of ownership of the measurement system, ensure the measurements used are proportionate and the service user experience is clearly and accurately articulated.

Brian Galvin

1 Munton T, Wedlock E and Gomersall A (2014) *The role of social and human capital in recovery from drug and alcohol addiction*. HRB Drug and Alcohol Evidence Review 1. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/23078/>

Community mobilisation and local alcohol action plans: an evaluation

A report on the National Community Action on Alcohol Pilot Project (NCAAPP) was published in December 2015.¹ The findings of this report, a process evaluation of the project which began in 2015, are outlined below.

Background

On foot of the National Substance Misuse Strategy,² the remit of the drugs task forces was expanded in 2014 to include alcohol. To support the task forces in meeting the demands of this new remit, the NCAAPP was established. Its aim was to support task forces in developing a 'community mobilisation approach' which would inform the development of policies to address alcohol use, and reduce alcohol-related harm, in their area. The project was delivered by the Alcohol Forum in partnership with the Drug Programmes and Policy Unit of the Department of Health and the Wellbeing Division of the Health Service Executive.

Community mobilisation

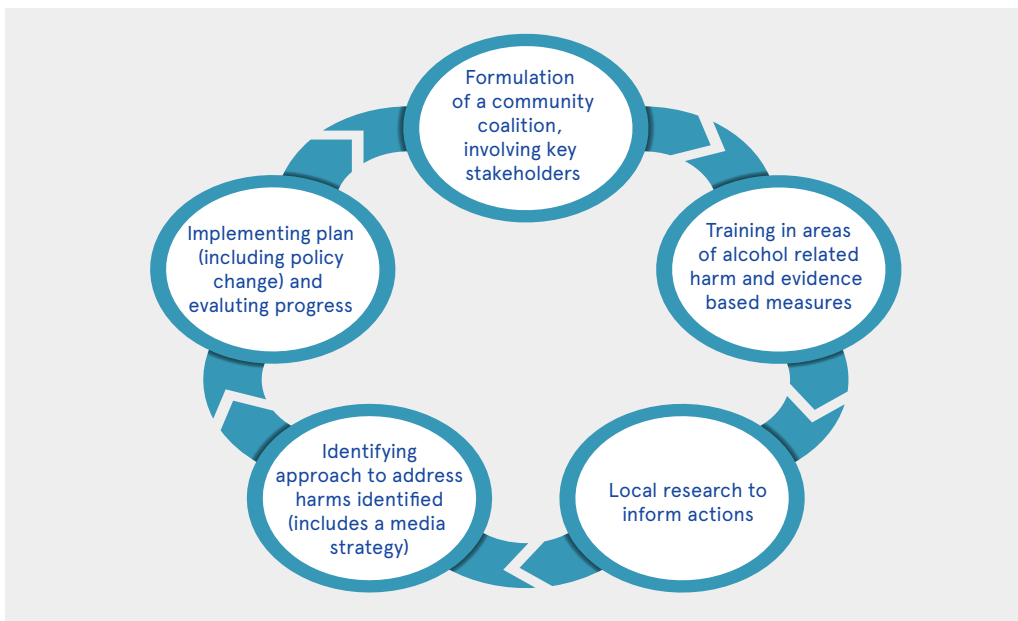
Underpinning the pilot project's approach was the finding of the National Substance Misuse Strategy that community mobilisation is successful in bringing stakeholders together to develop alcohol and drug policies. The author of the evaluation report describes community mobilisation as a public health approach to reducing alcohol-related harm: it changes the context in which alcohol use occurs, rather than focusing on the 'problem drinker'. It is a process through which communities work together to take action and bring about change, working with a range of stakeholders from the public, statutory and private sectors to identify the changes they want to bring about in their area. Based on the best evidence available the different stakeholders plan together how to bring about the desired changes. The community then implements the plan and monitors its progress in reducing alcohol-related harm. Some common features of the approach are shown in Figure 1 on the next page.

The evaluation report contains a review of the literature on community mobilisation and shows how elsewhere it has been effective in reducing alcohol-related harm. The author identifies key elements that contribute to positive results when working in this way, including:

- establishing well-functioning coalitions,
- getting wider community buy-in to the process and its aims,
- changing the policy context,

Community mobilisation and local alcohol action plans continued

Figure 1: Common stages in a community mobilisation process (Galligan 2016: p24)



- taking an evidence-based approach,
- giving the project adequate time to get established and deliver on outcomes (in excess of three years),
- taking a multi-strategy approach, and
- using the media to support interventions.

Evaluation findings

Drawing any conclusions about the effectiveness of the NCAAPP in reducing alcohol-related harm was beyond the scope of this evaluation. Instead, the report explored the effectiveness of the process put in place to deliver on community mobilisation and to establish local alcohol action plans.

Five task forces were selected to take part in the project, each of which identified a project lead and established an 'alcohol sub-committee' with responsibility for delivering on the project in their area. Each sub-committee sent a representative on five one-day formal training sessions in Dublin. These covered a range of topics including community mobilisation, data collection, research and evaluation methods, logic models, alcohol-related harm, using the media, and effective policy measures to address alcohol harms. The task forces then received on-site tailored support to help develop their local plans, as well as access to follow-up support via phone calls, emails, one-on-one meetings and some on-site group training. One individual from the Alcohol Forum had responsibility for delivering this programme of training and support.

Broadly speaking, the goals of the project were to train stakeholders on drug-related harm, raise awareness of policy measures, support community engagement, and develop local action plans. The evaluation found that, overall, the project was successful in these areas.

The training and support delivered was of a high quality and was delivered by a highly dedicated trainer. Participants improved their knowledge of alcohol-related harms and the networking opportunities afforded by the centralised training sessions were seen as beneficial. The training also led to changes in work practices, for example a public health approach to alcohol issues was adopted, evidence-based measures were applied, and a community mobilisation model was used.

At the core of the project was the production of local alcohol action plans. Four of the five task forces completed local alcohol action plans by the end of the project and the fifth had an outline plan. All the completed action plans included monitoring, review and self-evaluation measures.

A number of critical barriers were identified. Building local leadership and commitment to the project proved challenging, as did engaging stakeholders to lead a collective approach. Limited resources presented hurdles when it came to making and implementing a plan. Finally, local policy changes to help lower alcohol-related harm needed to be reinforced by a government-level commitment to adopting such evidence-based policies.

The author makes a range of recommendations at the end of the report. She highlights the fact that community action on alcohol is a long-term process and that the pilot project was just the beginning of the process for those involved.

Lucy Dillon

1 Galligan C (2016) *National community action on alcohol pilot project 2015: external evaluation project*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/25098/>

2 Department of Health (2012) *Steering group report on a national substance misuse strategy*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/16908/>

SERVICES

Service users' rights

According to a presentation by Niall O'Connell of Service User Rights in Action Group and Community Action Network (CAN) at CityWide's 20th Anniversary conference in November 2015,¹ users of MMT services encounter three practices which may be classed as human rights abuses. The practices were identified in the course of research conducted with clients of methadone maintenance treatment (MMT) services in 2013, which included a questionnaire completed by 101 respondents.

The three practices are:

- **Urine sampling** – procedures for obtaining samples were based on the assumption that people will cheat, and there was a lack of consistency in the frequency of sampling and conduct of the tests.
- **Lack of meaningful review** – 83 per cent of respondents were not asked their opinion; 62 per cent were never

given a care plan; 43 per cent never felt they had a meaningful discussion with a doctor, and 34 per cent did not know this was an option.

- **Lack of choices** – 94 per cent said they had never been offered an alternative to MMT.

Following a dialogue process regarding these findings, the researchers identified three emerging themes:

- **Powerlessness within the whole system** – who has the power to make change, and who is accountable?
- **Voice and participation of the service user is valued** – but who is listening?
- **Stuck conversation** – harm reduction versus abstinence.

Brigid Pike

¹ O'Connell N (2015, 12 November) *Developing a human rights approach to delivery of drug services*. PowerPoint presentation delivered at CityWide 20th Anniversary conference. Retrieved 27 April 2016 at <http://www.citywide.ie/publications/listing/developing-a-human-rights-approach-to-delivery-of-drug-services>

New app for drug information

North Dublin Regional Drugs and Alcohol Task Force (NDRDATF) has developed SAND (Substance Abuse North Dublin), an app that provides clear, factual and accessible information on alcohol and drugs.

The app was launched on 27 April 2016 by Dr Gerry McCarney from SASSY (Substance Abuse Service Specific to Youth), along with Louise McCulloch, care coordinator for NDRDATF, who project managed the project, and Bríd Walsh, coordinator of NDRDATF.

Louise McCulloch described how the task force had been looking for a way to provide information on alcohol and drugs to as many people as possible in their region, a large and varied geographic area. The task force felt that using social media would help them engage better with young people.

Development of the app was a collaborative process, involving the community and with local Leaving Cert students testing the app and providing invaluable feedback.

The app has four sections:

1. Information on alcohol and drugs
2. A quiz to test your knowledge about drugs – six questions only, but they change randomly
3. Signs to look out for
4. How to get help

The app is free and can be downloaded for Android or Apple from the usual sources, using the search terms 'sand drugs' or simply scan the QR code. It can then be used on- or off-line.

Android



Apple



To get more information see: <http://www.ndublinrdtf.ie/sand-drug-alcohol-information-app/>

Suzi Lyons



UPDATES

Recent publications

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

The association between scholastic measures, alcohol outcome expectancies and alcohol use: a cross-sectional study in Northern Ireland
McKay MT and Harvey SA (2015) *Child Care in Practice* 21 (4): 357–373
<http://www.drugsandalcohol.ie/25319/>

Alcohol use among adolescents is associated with both short-term (truancy, illness, trouble with police) and long-term (dependence, unemployment) negative consequences. Moreover, because of its developmental nature, adolescent drinking behaviour is difficult to accurately assess. Individual-level scholastic variables and alcohol outcome expectancies have been found to be associated with drinking behaviours. This study used a cross-sectional design to investigate: the relationship between alcohol use and individual-level scholastic variables, namely academic motivation and academic self-efficacy; and the relationship between alcohol use and alcohol outcome expectancies, while controlling for a wide range of other variables.

Participants were post-primary (high) school pupils in the greater Belfast area of Northern Ireland. They completed a range of questionnaires including measures assessing academic self-efficacy, academic motivation, alcohol outcome expectancies, and a composite measure of alcohol use. Results showed that, controlling for the hierarchical nature of the data, socio-demographic variables and other possible confounders, lower reported scores on the individual-level scholastic measures, higher reported scores on positive alcohol outcome expectancies, and lower reported scores on negative alcohol outcome expectancies remained significantly associated with more problematic drinking. Results are discussed in the context of contemporaneous school-related research.

Opt-out panel testing for HIV, hepatitis B and hepatitis C in an urban emergency department: a pilot study
O'Connell S et al *PLoS ONE* 11 (3)
<http://www.drugsandalcohol.ie/25298>

Studies suggest 2 per 1000 people in Dublin are living with HIV, the level above which

universal screening is advised. We aimed to assess the feasibility and acceptability of a universal opt-out HIV, Hepatitis B and Hepatitis C testing programme for Emergency Department patients and to describe the incidence and prevalence of blood-borne viruses in this population.

An opt-out ED blood borne virus screening programme was piloted from March 2014 to January 2015. Patients undergoing blood sampling during routine clinical care were offered HIV 1&2 antibody/antigen assay, HBV surface antigen and HCV antibody tests. Linkage to care where necessary was co-ordinated by the study team. New diagnosis and prevalence rates were defined as the new cases per 1000 tested and number of positive tests per 1000 tested respectively.

Over 45 weeks of testing, of 10,000 patient visits, 8,839 individual patient samples were available for analysis following removal of duplicates. A sustained target uptake of >50% was obtained after week 3. 97(1.09%), 44(0.49%) and 447(5.05%) HIV, Hepatitis B and Hepatitis C tests were positive respectively. Of these, 7(0.08%), 20(0.22%) and 58(0.66%) were new diagnoses of HIV, Hepatitis B and Hepatitis C respectively. The new diagnosis rate for HIV, Hepatitis B and Hepatitis C was 0.8, 2.26 and 6.5 per 1000 and study prevalence for HIV, Hepatitis B and Hepatitis C was 11.0, 5.0 and 50.5 per 1000 respectively.

Opt-out blood borne viral screening was feasible and acceptable in an inner-city ED. Blood borne viral infections were prevalent in this population and newly diagnosed cases were diagnosed and linked to care. These results suggest widespread blood borne viral testing in differing clinical locations with differing population demographic risks may be warranted.

Chillin, buzzin, getting mangled, and coming down: Doing differentiated normalisation in risk environments
O'Gorman A (2016) *Drugs: Education Prevention and Policy* 23 (3): 247–254
<http://www.drugsandalcohol.ie/25573/>

This paper examines differentiated normalisation through the lens of young drug users from a marginalised Dublin neighbourhood where drugs are readily available, prevalence rates are high, and a flourishing drugs market operates. The narratives of these marginalised young people illustrate how drug use and drug choices are shaped by different intentions, avowed identities and diverse structural, temporal and socio-spatial settings. Their routines and drug repertoires echo the (mainly) reasoned consumption choices, the cost-benefit

analyses and the emphasis on pleasure and fun ascribed to recreational drug users, including those who underpin the normalisation concept. However, their drug using practices continue to be rendered deviant due to their experience of social exclusion; exclusion from consumption-orientated lifestyles and from the night time economy; and their inclusion in the informal drugs economy.

Normalisation is relative (not just differentiated) to the social status of the drug user. A reconstructed normalisation thesis inclusive of class (and race, and gender) could explore why the use of similar drugs and similar drug using behaviours by different social groups is differentially accommodated and accepted by mainstream society.

Off the record: substance-related disorders in the undergraduate medical curricula in Ireland
Willson M, Cullen W and Klimas (2016) *Journal of Substance Use* Early online
<http://www.drugsandalcohol.ie/25572/>

Substance use disorders (SUDs) are a worldwide problem, and have become a major health concern in Ireland particularly. We aimed to determine the extent to which addiction medicine is embedded in the undergraduate medical curriculum in Ireland. To further investigate the degree to which drug addiction is taught in the Irish medical curriculum an online literature search was performed using Google Scholar, PubMed (from 2009 to present), EMBASE, PsycINFO, CINAHL, and Medline using the keywords "substance-related disorders," "undergraduate," "curriculum" and "Ireland." Additionally, all Irish medical school websites were examined (n = 6), and a Google search and manual searches of conference programs were performed. We used the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) guidelines to systematically review and discuss findings.

A total of zero published studies met the criteria for inclusion in an updated systematic literature search of addiction medicine education in the undergraduate medical curriculum in Ireland. There is currently no documentation of drug addiction teaching sessions in Irish medical schools. Investigations that offer direct contact with medical schools, such as a telephone survey, may provide a more accurate representation of how addiction medicine education is incorporated into the medical school curricula.

Recent publications continued

Use of hierarchical cluster analysis to classify prisons in Ireland into mutually exclusive drug-use risk categories

Codd M et al. (2016) *Drugs: Education Prevention and Policy* 23 (2): 93–98
<http://www.drugsandalcohol.ie/25537/>

The aim of this paper is to propose a methodology for classifying prisons into distinct drug-use risk categories based on prisoners' use of specified prescription and illegal drugs. The categories of prisons thus defined have particular relevance for the planning of drug-related interventions, education and services in Irish prisons. The methodology may be transferable to, and of value in, prison systems elsewhere.

From the 14 prisons in Ireland, 824 randomly selected prisoners completed a self-administered questionnaire on lifetime, last year and last month use of specified prescription and non-prescription drugs. Questions were derived from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and other sources. Oral fluid samples were collected for verification of recent drug use. The EMCDDA definition of "recent problematic drug use" was used in post hoc hierarchical cluster analysis to define categories of prisons with similar drug-use patterns. Four categories of prisons, designated "low", "medium", "high" and "very high" drug use, were identified. While the prisons comprising each category were known, drug use patterns in individual prisons were not disclosed because of concerns about prisoner confidentiality in a small jurisdiction. The clusters identified were used to contextualise subsequent analyses of drug use, the availability and use of harm-reduction services and differential service requirements by prison category.

The methodology described allows for identification of prison categories by drug-use patterns. With restrictions on disclosure of information by individual prison, it provides more valuable information than would derive from data on all prisons combined.

Using clients' routine urinalysis records from multiple treatment systems to model five-year opioid substitution treatment outcomes

Comiskey C M and Snel A (2016) *Substance Use & Misuse* 51 (4): 498–507
<http://www.drugsandalcohol.ie/25363/>

At global, national, and local level, the need for ongoing, timely and cost efficient, comprehensive drug treatment monitoring, and evaluation systems have clearly been well recognized.

To test the feasibility of linking laboratory data and client intake data and its

usefulness for modeling retrospectively, for the first time, 5-year longitudinal drug treatment outcomes in an Irish opiate treatment setting.

A multisite, retrospective, longitudinal cohort study was implemented to evaluate outcomes for opiate users based on 1.7 million routine urinalysis results collected from 4,518 individuals presenting for opioid substitution treatment in Ireland from January 2006 to December 2010.

Analysis of opiates, cocaine, benzodiazepine, and cannabis use at treatment intake, 6 months and at 1–5 year follow-ups revealed differences in urinalysis protocols; significant differences in age of first drug use between those using and not using opiates at 5 years; significant decreases in opiate use; increases in benzodiazepine use and significant increasing effects of concurrent cocaine and benzodiazepine use on the odds of using opiates. Time series analysis of weekly proportions opiate positive predicted 16% (95% confidence interval: 7%–25%) of clients would be opiate positive 5 years postinitial intake.

Conclusions/Importance: Underutilized urinalysis data can be used to address the need for cost effective, efficient evidence of drug-treatment outcomes across time, place, and systems. Linking and matching the cross-sectional data across sites and times also revealed where improvements in electronic records could be made.

Ireland's financial crisis and its influence on alcohol and drug issues

Butler S and Hope A (2015) *Nordic Studies on Alcohol and Drugs* 32 (6): 623–628
<http://www.drugsandalcohol.ie/25123/>

Budget 2009 (announced in December 2008) increased tax on alcohol, resulting in a drop in consumption; Budget 2010 decreased tax and consumption increased; Budget 2013 increased tax and, again, consumption decreased. Prior to the crash of 2008, a shift in the pattern of alcohol purchasing, from pub or 'on-premise' to supermarket or 'offlicence' purchasing had already emerged; this was a shift which had been facilitated by the introduction in the year 2000 of more liberal licensing regulations (Hope, 2014). What this meant in practice was that the number of pubs declined while, between 2002 and 2009, the number of off-licence retail outlets doubled (Revenue Commissioners Annual Reports). One key influence on the expansion of the off-licence sector was the abolition in 2006 of the Groceries Order. This meant that, for the first time, Irish retailers could now sell alcohol at below-cost price; and supermarkets in particular, were quick to seize the advantage of using very cheap

alcohol as a loss leader which would increase 'footfall', thereby increasing their customer bases

Alcohol consumption among university students in Ireland and the United Kingdom from 2002 to 2014: a systematic review

Davoren MP, Demant J, Shiely F and Perry I J (2016) *BMC Public Health* 16 (1): 173
<http://www.drugsandalcohol.ie/25221/>

Alcohol is a leading cause of global suffering. Europe reports the uppermost volume of alcohol consumption in the world, with Ireland and the United Kingdom reporting the highest levels of binge drinking and drunkenness. Levels of consumption are elevated among university students. Thus, this literature review aims to summarise the current research on alcohol consumption among university students in the Republic of Ireland and the United Kingdom.

MEDLINE, CINAHL, EMBASE and PsychInfo were systematically searched for literature from January 2002 until December 2014. Each database was searched using the following search pillars: alcohol, university student, Ireland or the United Kingdom and prevalence studies.

Two thousand one hundred twenty eight articles were retrieved from electronic database searching. These were title searched for relevance. 113 full texts were retrieved and assessed for eligibility. Of these, 29 articles were deemed to meet inclusion criteria for the review. Almost two thirds of students reported a hazardous alcohol consumption score on the AUDIT scale. Over 20 % reported alcohol problems over their lifetime using CAGE while over 20 % exceed sensible limits each week. Noteworthy is the narrowing of the gender gap throughout the past decade.

This is the first review to investigate consumption patterns of university students in Ireland and the United Kingdom. A range of sampling strategies and screening tools are employed in alcohol research which preclude comparability. The current review provides an overview of consumption patterns to guide policy development.

Modeling problem behaviors in a nationally representative sample of adolescents

O'Connor K L et al. (2016) *Journal of Adolescence* 50: 6–15
<http://www.drugsandalcohol.ie/25524/>

Research on multiple problem behaviors has focused on the concept of Problem Behavior Syndrome (PBS). Problem Behavior Theory (PBT) is a complex and

Recent publications continued

comprehensive social-psychological framework designed to explain the development of a range of problem behaviors. This study examines the structure of PBS and the applicability of PBT in adolescents. Participants were 6062 adolescents; aged 12-19 (51.3% female) who took part in the My World Survey-Second Level (MWS-SL). Regarding PBS, Confirmatory Factor Analysis established that problem behaviors, such as alcohol and drug use loaded significantly onto a single, latent construct for males and females. Using Structural Equation Modeling, the PBT framework was found to be a good fit for males and females. Socio-demographic, perceived environment system and personality accounted for over 40% of the variance in problem behaviors for males and females. Our findings have important implications for understanding how differences in engaging in problem behaviors vary by gender.

Screening and brief interventions for illicit drug use and alcohol use in methadone maintained opiate-dependent patients: results of a pilot cluster randomized controlled trial feasibility study

Darker CD et al. (2016) *Substance Use & Misuse* Early online : 1-12
<http://www.drugsandalcohol.ie/25507/>

The present study evaluated the effectiveness of a single clinician delivered brief intervention (BI) to reduce problem alcohol use and illicit substance use in an opiate-dependent methadone maintained cohort of patients attending for treatment. Four addiction treatment centers were randomly assigned to either treatment as usual (TAU; control group) or BI (intervention group). Clinicians screened patients using the alcohol, smoking, and substance involvement screening test (ASSIST) screening tool at baseline and again at three-month follow up. Fidelity checks were performed to ensure that training was delivered effectively and uniformly across all study sites. Feasibility of administering a BI within daily practice was assessed through intervention fidelity checks, patient satisfaction questionnaires and process evaluation

A total of 465 patients were screened (66% of the overall eligible population) with a total of 433 (93%) ASSIST positive cases. Randomization was effective,

with no differences in the control versus the intervention arms at baseline for key demographic or clinical indicators including substance use. There was a statistically significant difference between global risk score for the intervention ($x = 39.36$, $sd = 25.91$) group and the control group ($x = 45.27$, $SD = 27.52$) at 3-month follow-up ($t(341) = -2.07$, $p < .05$). This trial provides the first evidence that a single clinician delivered BI can result in a reduction in substance use within a methadone maintained opiate-dependent cohort, and this effect is sustained at three month follow up.

Safe storage of methadone in the home. An Irish audit of the effectiveness of information provision in pharmacies

Horan JA, Gooney M and Van Hout MC (2016) *Heroin Addiction and Related Clinical Problems* 18 (2): 31-40
<http://www.drugsandalcohol.ie/25212/>

Safe storage of oral methadone at home is an important issue given the risk of accidental paediatric consumption. Pharmacy protocols centre on provision of information to patients relating to general and paediatric dangers of methadone and safe storage of methadone in the home. The study aimed to audit the effectiveness of pharmacy provision of information on safety of methadone consumption and storage in the home.

The study involved an audit of five criteria relating to patient awareness of general dangers of methadone use and paediatric risks, patient information recall on safe storage of methadone in the home; take home methadone dispensing in child resistant containers and safe and secured storage of methadone. Audit information was collected using a survey with consecutive adult patients attending a specialist methadone clinic over the course of four weeks ($n=94$), and telephone interviews with dispensing pharmacists recorded in the specialist clinic register ($n=43$).

None of the criteria reached a 100% standard. 51% reported never being provided with safety information. 97% of patients were aware of the dangers of methadone use, with females significantly more aware of dangers of methadone to users. 86% did not place their take-home methadone in a locked place. 90% reported they would seek medical help if a child had accidentally consumed

methadone. 58% of pharmacists never questioned patients around storage, but 58% reported counselling patients on safe storage.

A typology of alcohol consumption among young people – A narrative synthesis

Davoren MP et al. (2015) *Addiction Research & Theory* Early online
<http://www.drugsandalcohol.ie/25207/>

Currently, alcohol consumption levels are significantly higher among younger age groups. However, previous research has noted the diversity of motivations and patterns. These patterns of drinking have yet to be synthesised into a typology. The aim of the current study was to synthesise information from studies that produced types of alcohol consumption among young people.

Quantitative and qualitative literature investigating the different types of drinkers among young people [aged 12-24 years], published in peer reviewed journals, were eligible for inclusion in this systematic review. MEDLINE, PsychInfo and CINAHL were systematically searched for relevant articles published between January 1st 2000 and December 31st 2014. Included papers were critically appraised. A narrative synthesis approach was employed based on guidance from the UK Economic and Social Research Council.

In total, 13 studies were eligible for inclusion: 11 quantitative, one qualitative and one mixed methods. Six classes of drinkers were formed within this typology. Abstainers reported no alcohol consumption. Light drinkers reported drinking small amounts of alcohol infrequently. In comparison, social and hedonistic drinkers drank most in social situations and to have fun. Heavy and harmful consumers reported increased volume and frequency of consumption including harmful consequences.

Currently, policy makers are attempting to combat the high levels of harmful alcohol consumption among young people. The current typology provides guidance for targeted interventions in addition to a practical analytic tool in future research.