

The newsletter of
Ireland's focal point
to the EMCDDA

drugnet IRELAND

Issue 59 | Autumn 2016

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Overview of alcohol consumption, alcohol- related harm and alcohol policy in Ireland



Alcohol can be described as a psychoactive substance with dependence-producing properties and is responsible for a considerable burden of death, disease and injury in Ireland.

A recent report by the Health Research Board provides an overview of the current situation in Ireland regarding alcohol consumption and harm and trends over time as well as outlining the available policy responses to alcohol-related harm.¹ The data in this report were based predominantly on published Irish literature and existing information systems.

Dr Deirdre Mongan and
Dr Jean Long of the HRB,
authors of *Overview of alcohol
consumption, alcohol-related
harm and alcohol policy
in Ireland*

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In brief

Recent work by epidemiologists examining the social determinants of health and well-being has demonstrated the adverse consequences of inequality, including increased levels of incarceration, crime and illicit drug use.

This research concludes that it is not the overall level of wealth of a society that determines the prevalence of poor health and social problems but the extent of the difference between the richest and the least well off. While this link is not made explicit in Irish drugs policy, the link between socioeconomic disadvantage, marginalisation and exclusion, and drug use has been recognised in the formulation of policy in this area for nearly 20 years. This is reflected in the framing of the 2001-2008 and 2009-2016 National Drug Strategies in the context of the broader social inclusion agenda. The link between drug use and social deprivation underpins the rationale behind the location of local drugs task forces, and the relationship between illicit drug use and social exclusion and inequality is a key consideration in the strategies of the regional task forces set up nearly a decade later.

The evolution of social inclusion policy and the positioning of illicit drug use within it are examined in detail in this issue of *Drugnet Ireland*. Economic deprivation is not the sole determinant of marginalisation. Membership of an ethnic minority, sexual orientation or disability often present economic and social challenges - risk factors which may increase the likelihood of drug use. While well-established monitoring systems provide valuable data on population drug use, examining the link between social marginalisation and drug use requires more refined analysis. Research using National Drug Treatment Reporting System (NDTRS) data has highlighted aspects of drug use among members of the Traveller community. Recent developments in the NDTRS also provide valuable information on drug prevalence in prisons and the treatment needs of members of the lesbian, gay, bisexual and transgender (LGBT) community. Homelessness is a particularly important risk factor associated with a wide range of health problems, including drug use, and in this issue we look at a recent study of users of a dedicated primary care service for homeless people in Dublin.

Social and economic policies designed to reduce inequality will impact on overall drug prevalence. Developing services which can respond effectively to the particular needs of marginalised and vulnerable groups will need to be informed by robust evidence from studies focused specifically on these groups.

Overview of alcohol consumption and alcohol-related harm continued

Alcohol consumption in Ireland

Ireland has a high level of alcohol consumption and many Irish people engage in harmful drinking patterns. In 2014, Irish drinkers consumed 11 litres of pure alcohol each. This is equal to 29 litres of vodka, 116 bottles of wine or 445 pints of beer. As 20.6% of the adult population abstain from alcohol completely, those who drink alcohol consume even greater quantities. Survey data from 2013 indicate that drinkers in Ireland consume alcohol in an unhealthy pattern: 37.3% of drinkers engaged in monthly, risky single-occasion drinking (RSOD), more commonly known as binge drinking, in the previous year; 54.3% of drinkers had a positive score on the AUDIT-C screening tool; 6.9% scored positive for dependence, which indicates that there were somewhere between 149,300 and 203,897 dependent drinkers in Ireland in 2013. At least three-quarters of the alcohol consumed was done so as part of a binge-drinking session.

There has been a shift from consuming alcohol in on-trade premises to consuming alcohol bought from the off-trade, which is reflected in Irish licence data. Between 1998 and 2013, the number of pub licences in Ireland decreased by 19.1% (from 10,395 to 8,402). During the same period the combined number of wine and spirits off-licences increased by 377% (from 1,072 to 5,116). In 2013, there was one licence per 197 adults aged 18 years and over.

Alcohol-related harm in Ireland

Alcohol-related morbidity

Alcohol-related morbidity was analysed using data from the Hospital In-Patient Enquiry (HIPE) scheme. The analysis included all alcohol-related discharges that were either wholly attributable (alcohol is a necessary cause for these conditions to manifest) or partially attributable (alcohol must be a component cause). The number of wholly attributable alcohol-related discharges increased from 9,420 in 1995 to 17,120 in 2013, an increase of 82%, with males accounting for 72.4% of discharges and females accounting for 27.6% of discharges. In 2013, alcohol-related discharges accounted for 160,211 bed days or 3.6% of all bed days that year, compared with 56,264 bed days or 1.7% of the total number of bed days in 1995. The mean length of stay increased, from 6.0 days in 1995 to 10.1 days in 2013, which suggests that patients with alcohol-related diagnoses are becoming more complex in terms of their illness. Alcoholic liver disease was the most common chronic alcohol disease, accounting for approximately four-fifths of all alcohol-related chronic diseases in 2013. The rate of these discharges increased from 28.3 per 100,000 adults aged 15 years and over in 1995 to 87.7 in 2013, an increase of 210%. The most pronounced increase was among 15–34-year-olds, albeit from a low base.

The number of discharges with a partially attributable alcohol condition increased between 2007 and 2011 by 8.8%, from 52,491 to 57,110. The estimated cost to the health system in 2012 of dealing with inpatients with either a wholly or partially alcohol-attributable condition was €1.5 billion,

which accounted for 11.0% of all public healthcare expenditure that year. The majority of these costs (77.4%) were associated with discharges with partially attributable alcohol conditions. This excludes the cost of emergency cases, GP visits, psychiatric admissions and alcohol treatment services.

Alcohol-related mortality

Alcohol mortality data from the National Drug-Related Deaths Index (NDRDI) were analysed for 2008–2013. There were 6,479 alcohol-related deaths between 2008 and 2013. In 2013, there were 1,055 deaths, which is an average of 88 deaths per month or three deaths per day. Overall, 73.2% were aged under 65 years, which may be described as of working age. From 2008 to 2013, medical causes accounted for 4,462 (68.9%) of alcohol-related deaths, poisonings accounted for 1,045 (16.1%), and traumatic causes accounted for 972 (15.0%) of alcohol-related deaths, with a similar pattern for males and females.

Alcohol and the workplace

In Ireland, alcohol is associated with harm in the workplace. According to the National Alcohol Diary Survey 2013,² unemployed people were twice as likely as employed people to have a positive DSM-IV score for dependence. Among those who were unemployed, 1.4% reported that they had lost their job as a result of their alcohol consumption; when the experience among this representative sample is applied to the unemployed population, it is possible that 5,315 people on the Live Register in 2013 had lost their job due to alcohol use. The survey also indicated that 4.2% of employed respondents reported that they had missed days from work due to their alcohol use in the 12 months prior to the survey. On average, each of these respondents missed 3.3 days. Based on 2013 employment figures, we can extrapolate that of the 1,869,900 persons in employment, 78,536 missed work in the previous year due to alcohol. If we assume that the average daily cost is €159.32 per person, this suggests that the direct cost of alcohol-related absenteeism was €12,600,000 in 2013. This estimate does not include the costs associated with reduced productivity at work or the cost of alcohol-related injury at work. Of those who reported missing work due to alcohol, 82.6% engaged in monthly binge drinking and 40.8% scored positive for alcohol dependence.

Conclusion

The data presented in this overview indicate that harmful drinking has become the norm in Ireland. The health of Irish people would improve if we reduce overall alcohol consumption and address risky drinking patterns. There is a comprehensive body of international evidence regarding the most effective policies to reduce alcohol-related harm. These include making alcohol more expensive, restricting its availability and reducing its promotion. The new Public Health Alcohol Bill contains these evidence-based measures and needs to be implemented without delay.

Deirdre Mongan

- 1 Mongan D and Long J (2016) *Overview of alcohol consumption, alcohol-related harm and alcohol policy in Ireland*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/25697/>
- 2 Long J and Mongan D (2014) *Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/22138>

POLICY AND LEGISLATION

Misuse of Drugs (Amendment) Act 2016

Following increased drug-related violence and the emergence of new psychoactive substances to the Irish drug market, it became necessary to expedite a shortened version of the Misuse of Drugs (Amendment) Act 2016,¹ which was enacted on 27 July 2016. The aim of the Act is to amend schedules from the Misuse of Drugs Acts 1977–2015.²

The Misuse of Drugs Acts 1977–2015 is the main legislation that aims to protect society from the impact of drugs in Ireland. Protection is provided by firstly controlling access to substances that can be harmful if abused, e.g. benzodiazepines and heroin, via ministerial regulations and orders. This ensures that controlled drugs are used safely. Secondly, protection is provided by setting up a system that controls substances that are viewed as unsafe or destructive when not used for therapeutic reasons. Due to the transient and ever-changing nature of the drugs and the drug market, this Act is constantly monitored and updated.

Provisions of the new Act

The main provisions of the 2016 Act include the addition of new substances, revocation of regulations and orders confirmed in the Misuse of Drugs (Amendment) Act 2015,³ and some technical amendments.

Addition of new substances

A number of new substances are to be added to the existing list of controlled substances:

- Zopiclone
- Zaleplon
- Phenazepam
- Lisdexamfetamine
- Clockwork Orange
- MT-45
- 25B-NBOMe
- 25C-NBOMe
- 4,4'-DMAR
- MDMB-CHMICA

The inclusions will allow law enforcement authorities to deal more effectively with the illegal trafficking in Ireland, for example, on-street dealing of prescription medication, some of which are not controlled by current legislation.⁴ In addition, it will allow Ireland to fulfil its obligations in accordance with EU directives, such as EU Council Decision 2005/387/JHA⁵ – which demands information exchange, risk assessment, and control of new psychoactive substances – the United Nations Single Convention on Narcotic Drugs 1961⁶ and Convention on Psychotropic Substances 1971.⁷

Revocation of ministerial regulations and orders

Section 3 of the Act amends section 5 of the Misuse of Drugs Act and allows the Minister for Health to revoke ministerial regulations and orders confirmed by the Misuse of Drugs (Amendment) Act 2015.³ The aim of this amendment is to enable the Minister to create new regulations or orders as necessary to control new substances under the Act.

Technical amendments

To allow the commencement of a section in the Irish Medicines Board (Miscellaneous Provisions) Act 2006,⁸ responsibility for issuing licences under the Misuse of Drugs Act 1977 will be reassigned from the Minister for Health to the Health Products Regulatory Authority. Finally, following alterations to the Nurses and Midwives Act 2011,⁹ the reference to nurses and midwives in the Misuse of Drugs Act 1977 will be brought up to date.

Commencement

The Act involves a two-step process. Controlling substances are dealt with in the first stage of the Act. This will be followed by the drafting of regulations that will enable legitimate users (e.g. patients with prescriptions) access to controlled substances. The Act will commence when appropriate regulations are in place.

Extensive debate

As the Act progressed through the Dáil and Seanad, extensive debate occurred between deputies. Predominantly, the Act is welcomed by many. In light of recent events in Ireland, Deputy John Lahart purported that it was clear that there was a necessity to reinforce the legislation around drug misuse (p. 597).⁴ Deputy Jack Chambers argued that allowing law enforcement agencies to pursue gangs that control the supply and sale of drugs was an essential route to targeting drug-related crime in Ireland (p. 595).⁴ However, numerous concerns were raised that the Act was not going to address the root causes of the problem. For example:

- Deputy Jonathan O'Brien purported that the Act was being rushed at the request of An Garda Síochána and raised concerns that neither drug service providers nor medical practitioners were consulted. He further argued that the Act 'will criminalise vulnerable drug addicts' and purported that a model of decriminalisation of drugs for personal use was necessary. This, he argued, should be centred on evidence, based on international best practice, for example, the Portuguese model. He cautioned that thus far the introduction of this kind of Act went against ministerial talk about availing of evidence-based practice, which seemed to be ignored in this instance (pp. 600–04).⁴
- Deputy Louise O'Reilly viewed the Act as solving only half the problem, namely drug crime, and did not address any measures to provide support to help addicts, nor did it address the socioeconomic impacts of addiction nor the issue of drugs overall. Deputy O'Reilly argued that although this legislation would alter drug-related antisocial behaviour, and increase Garda presence and capability, it was not targeting the root causes of the problem (pp. 604–06).⁴
- Deputy Maurice Quinlivan argued that 'criminalising young people who, more often than not, are already disadvantaged is a lazy and bankrupt response of what is an exceptionally serious issue the legislation will not work as it offers nothing to address the root causes of

Misuse of Drugs (Amendment) Act 2016 continued

this problem, which are disadvantage, marginalisation and the political indifference of the middle classes' (p. 53).¹⁰

- Another issue raised was the lack of resources and funding.

This is the first step of a series of approaches that are being taken to target the drug problem in Ireland. A further Misuse of Drugs (Amendment) Bill is due to be presented in the autumn term, which aims to establish supervised injection rooms.

Ciara H Guiney

- 1 Misuse of Drugs (Amendment) Act 2016 as initiated. Available online at <http://www.oireachtas.ie/documents/bills28/acts/2016/A0916.pdf>
- 2 Misuse of Drugs Act 1977. Available online at <http://www.irishstatutebook.ie/eli/1977/act/12/enacted/en/html>
- 3 Misuse of Drugs (Amendment) Act 2015. Available online at <http://www.irishstatutebook.ie/eli/2015/act/6/enacted/en/pdf>
- 4 (2016, 6 July). *Dáil Éireann debate. Misuse of Drugs (Amendment) Bill 2016: second stage*, vol. 916, no. 3. <http://www.drugsandalcohol.ie/25774/>
- 5 EU Council Decision 2005/387/JHA. Available online at <http://www.emcdda.europa.eu/topics/law/drug-law-texts?pluginMethod=eldd.showlegaltxtdetail&id=3301&lang=en&T=2>
- 6 United Nations Single Convention on Narcotic Drugs 1961. Available online at https://www.unodc.org/pdf/convention_1961_en.pdf
- 7 United Nations Convention on Psychotropic Substances 1971. Available online at https://www.unodc.org/pdf/convention_1971_en.pdf
- 8 Irish Medicines Board (Miscellaneous Provisions) Act 2006. Available online at <http://www.irishstatutebook.ie/eli/2006/act/3/enacted/en/html>
- 9 Nurses and Midwives Act 2011. Available online at <http://www.irishstatutebook.ie/eli/2011/act/41/enacted/en/print>
- 10 (2016, 7 July). *Dáil Éireann debate. Misuse of Drugs (Amendment) Bill 2016: second stage (resumed)*, vol. 917, no. 1. <http://www.drugsandalcohol.ie/25797/>

Outcomes: drug harms, policy harms, poverty and inequality

On 28 April 2016, Clondalkin Drug and Alcohol Task Force (CDATF) held a conference on 'Outcomes: drug harms, policy harms, poverty and inequality', at which they launched their report of the same name.¹

The day brought together 120 delegates and stakeholders, including policy-makers, service providers, service users and other representatives from community, voluntary and statutory agencies.

Key findings from the report

Research aims

Key findings from the report were presented by its lead author Dr Aileen O'Gorman of the University of the West of Scotland. The overall aim of the research was to provide an in-depth understanding of: patterns of drug use and drug-related harm in the Clondalkin area; and the needs of individuals, families and members of the broader community. It also set out to explore and identify the relationship between poverty, inequality and drug use, and review the effectiveness of the partnership approach to the coordination and delivery of community-based responses to drug use in the area.

Poverty, inequality and policy-related harms

The report described the CDATF area as home to a disproportionate number of people experiencing poverty, with the situation having worsened as a result of political responses

to austerity. Some people in the Clondalkin area had been subjected to a range of 'policy induced harms' that have put them at a higher risk of experiencing drug-related harms. The authors argued that the current media and political debate tended to pathologise people, groups and communities that experience poverty as an outcome of individual or family dysfunction. Furthermore, that 'little attention was paid to the role government decisions and policies play in shaping negative life outcomes for people' (p. 6).

Drug trends

Drug use within the area was found to be characterised by polydrug use. The 'polydrug activity' tended to involve cannabis and 'tablets' (e.g. benzodiazepines and the 'Z drugs') combined with alcohol. Cocaine, new psychoactive substances (e.g. mephedrone) and various 'ecstasy type' substances were reported to be widely used in 'recreational settings'. Heroin and crack cocaine were perceived to be used by a small proportion of habitual users in high-risk conditions, and rarely by young people. While the drugs used varied somewhat depending on what was available, there was a general consensus that drugs were widely available in the area.

Risk groups for drug-related harms

Four groups living in the area were found to be at particularly high risk of experiencing drug-related harm:

- The in-treatment population whose needs were not being met by the range of services available.
- Family members of those involved in problematic drug use, including children living with parental drug use.
- Members of the Traveller community.
- Young people in the area who, given the multiple and interconnected deprivations they experienced, were at risk of becoming users themselves. Furthermore, in the absence of viable employment opportunities they were at risk of becoming involved in the local drugs economy. The study found that this economy provided 'one of the few employment and economic opportunities for

Outcomes: drug harms, poverty and inequality^{continued}

young people, leastways for a time, to access the status and goods that work provides' (p. 7). The associated violence was an additional risk to which these young people were exposed.

Changing policy environment and partnership working

The authors found that CDATF operated in a very different policy environment when compared with that in which it had been established. They described a move towards a neo-liberal policy environment in which the centralisation of decision-making had increasingly become the norm. This undermined the way in which the Drug and Alcohol Task Force (DATF) had worked traditionally and caused a shift from working in a community-based bottom-up approach to delivering on the National Drugs Strategy to a 'hierarchical top-down approach' (p. 8). They identified two ways in particular in which the community-based interagency and partnership approach had been undermined: first, there were fewer 'spaces' (p. 8) for communities and community-based services to input into decision-making; and, secondly, there were 'extreme levels' of monitoring, reporting requirements, and effectiveness and value-for-money evaluations.

Conclusion

The authors argued that there was a need to review the impact of austerity and reform policies on drug-related harms and the ability of local services and the DATFs to respond to the increased levels of need in their areas. They called for a social inclusion pillar to be included in the National Drugs Strategy, due to commence in 2017, as well as the introduction of drug and poverty proofing for future public and social policies:

Drug policy in Ireland has become more focused on addressing individual drug using behaviour as if these issues were context free. Little attention is paid in policy discourses to the underlying issues of poverty and inequality and even less consideration is given to the harmful outcomes of policy. (p. 8)

Other presentation themes

Presentations at the conference were also made by:

- Professor Kathleen Lynch, UCD School of Social Policy, Social Work and Social Justice
- Professor Susan MacGregor, London School of Hygiene and Tropical Medicine

- Fr Peter McVerry of the Peter McVerry Trust
- Pearse Stafford, service user representative

A number of themes recurred throughout the presentations, including:

- Certain sections of society have been disproportionately affected by political austerity measures (in particular young people). This has contributed to a progressively unequal society and an environment in which people are increasingly socially excluded.
- Drug use does not occur in a vacuum and the social context in which people are living needs to be considered when discussing how best to tackle the issue of problematic drug use in an area. This is challenging in what was described as an increasingly 'neo-liberal State'.
- In the absence of 'legitimate' employment opportunities in some areas, participating in the drugs economy was perceived to offer young people an opportunity to generate an income and attain standing in their community.
- There has been an increasing level of violence associated with the drug trade. This was affecting whole communities, not just drug users.
- There has been a tendency towards less and less meaningful community consultation and engagement in policy development and delivery. There were concerns that this would continue to be the case with the development of the new National Drugs Strategy.

Throughout the day the report was warmly welcomed by conference delegates; the findings of the report echoed the experiences of those working in other task force areas. In addition, the findings of the report and the conference were to be used to inform the following: CDATF's forthcoming strategic plan; their submission to the new National Drugs Strategy; and the debate on poverty, inequality and drug-related harm more broadly. The report was cited in Leaders' Questions in the Dáil on 25 May 2016.²

Lucy Dillon

- 1 O'Gorman A, Driscoll A, Moore K, Roantree D (2016) *Outcomes: drug harms, policy harms, poverty and inequality*. Dublin: Clondalkin Drug and Alcohol Task Force. <http://www.drugsandalcohol.ie/25577/>
- 2 Adams G (2016, 25 May). *Dáil Éireann debate. Leaders' questions*, vol. 910, no. 2. <http://www.drugsandalcohol.ie/25560/>

Where next for social inclusion?

In 2006–2007, *Drugnet Ireland* carried a series of articles reviewing how illicit drugs were addressed in the new social inclusion policy framework, i.e. the new Social Partnership Agreement 2006–2015,¹ the *National Development Plan 2007–2013*,² and the *National action plan for social inclusion 2007–2016*.³ In 2011, *Drugnet* carried an article on the new

Programme for Government, which, while retaining the concept of social inclusion, brought two new terms to the fore in relation to social policy – fairness and equality.⁴

In 2016, as a new Programme for Government is published, and as the suite of social inclusion policy documents conceived during the Celtic Tiger reach their endpoints, it is timely to review the current status of Ireland's social inclusion policy framework.

Leading up to 2016

In 2005, the National Economic and Social Council (NESCC) published a report, *The developmental welfare state*,

Where next for social inclusion? continued

which proposed a new streamlined and comprehensive approach to tackling poverty and social exclusion in Ireland.⁵ Acknowledging that serious social deficits remained despite Ireland's economic progress, the NESC report combined the economic and the social, suggesting that this would help to build consensus across the social partners, government and wider society. It proposed two innovations in the way of presenting social inclusion interventions:

- 1 Interventions should be organised according to a *life cycle framework*, comprising four categories: children, people of working age, older people, and people with disabilities. This arrangement both placed the individual at the centre of policy-making and encouraged a more joined-up and multidisciplinary approach to policy-making.
- 2 Greater recognition and weight should be given to (a) the role of services in providing protection against risks, and (b) activist measures, or innovative social policy initiatives, in meeting unmet needs and pre-empting problems, as opposed to focusing entirely on income transfers.

Published in 2006, the 10-year Social Partnership Agreement *Towards 2016* was the first policy framework to adopt the new life cycle approach.⁶ Drug-related initiatives were identified in the childhood and young working adult stages of the framework.

In 2007, as well as setting a national poverty target of reducing the number experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating consistent poverty by 2016,⁷ the *National action plan for social inclusion 2007-2016* (NAPinclusion) also adopted the life cycle framework, adding an extra category 'Communities'.⁸

Within this Communities category, NAPinclusion itemised a series of community-based programmes (including the National Drugs Strategy) and a number of innovative measures in areas such as the arts, sport, and active citizenship, which were expected to have an impact on the illicit drugs issue.

In June 2010, the European Council adopted *Europe 2020: a strategy for smart, sustainable and inclusive growth*, which aims to promote employment, improve living and working conditions, provide an appropriate level of social protection, and develop measures to combat exclusion.⁹ In 2012, Ireland revised its national poverty target (now named 'national social target for poverty reduction') - to reduce consistent poverty to 4% by 2016 (interim target) and 2% or less by 2020, from the 2010 baseline rate of 6.3% - and identified the contributions that Ireland would make to the *Europe 2020* poverty target.¹⁰

Updated national action plan for social inclusion 2015-2017

Following the 2012 revisions, a revised national action plan for social inclusion for 2015-2017 was published.¹¹ Maintaining the life cycle approach, this revised action plan reflects new

emerging issues, with the number of high-level goals being expanded to include early childhood development, youth exclusion, access to the labour market, migrant integration, social housing and affordable energy.

The revised action plan describes how the context of social inclusion policy has altered. The 2007 action plan was 'designed to ensure that those experiencing poverty and social exclusion would share in the fruits of the economic development being achieved at that time', but since 2008 Ireland has experienced a 'major economic recession complicated by banking and fiscal crises'. The Government's response to combating poverty now concentrates on transforming the social protection system into one that focuses on maximising employability, by improving effectiveness and efficiency of social transfers by providing training, development and employment services along with income supports, and by strengthening active inclusion policies, which are described as follows:

Active inclusion means enabling every citizen, notably the most disadvantaged, to fully participate in society, including having a job. Active inclusion is intended to tackle various challenges including: poverty, social exclusion, in-work poverty, labour market segregation, long-term unemployment and gender inequalities. (p. 4)

Programme for Government 2016

The new Partnership Government's programme for a 'fairer Ireland' contains a chapter headed 'Creating a Social Economy', which is the model the Government will apply in order to deliver 'a strong economy and a fair society'.¹² Reflecting the shift already noted in the revised national action plan on social inclusion, the Programme for Government identifies four foundations of a social economy, including 'a just and fair society and a more inclusive prosperity'. Four tasks will be undertaken to build this just and fair society and a more inclusive prosperity:

- developing a new integrated framework for social inclusion, to tackle inequality and poverty;
- reducing poverty levels by improving the take-home pay of families on low-incomes;
- reducing poverty levels by supporting an increase in the minimum wage to €10.50 per hour over the next five years; and
- reinforcing labour market activation.

Just what an 'integrated framework for social inclusion' comprises is outlined in the Programme for Government:

Our Integrated Framework will outline measures to help eliminate any persisting discrimination on grounds of gender, age, family status, marital status, sexual orientation, race, disability, religion or membership of the Traveller Community. It will draw on existing as well as new strategies, in particular the (i) New National Women's Strategy, (ii) New National Disability Inclusion Strategy, (iii) Comprehensive Employment Strategy for People with Disabilities, (iv) National Traveller and Roma Inclusion Strategy, and (v) New Action Plan for Educational Inclusion. (p. 39)¹³

Where next for social inclusion? continued

In the following article, the relationship between social inclusion policy and Ireland's national drugs strategies over the past 20 years is explored.

Brigid Pike

- 1 Pike B (2006) New social partnership agreement addresses drugs and alcohol. *Drugnet Ireland*, 19: 7. <http://www.drugsandalcohol.ie/11277/>
- 2 Pike B (2007) National Development Plan and the drugs issue. *Drugnet Ireland*, 21: 23-25. <http://www.drugsandalcohol.ie/11342/>
- 3 Pike B (2007) Where do illicit drugs fit in the new social inclusion policy framework? *Drugnet Ireland*, 23: 5. <http://www.drugsandalcohol.ie/11409/>
- 4 Pike B (2011) Inequality and illicit drug use. *Drugnet Ireland*, 38: 8-10. <http://www.drugsandalcohol.ie/15639/>
- 5 National Economic and Social Council (2005) *The developmental welfare state*. Dublin: NESC. Retrieved 1 July 2016 from <http://www.nesc.ie/en/publications/publications/nesc-reports/the-developmental-welfare-state/>
- 6 Department of the Taoiseach (2006) *Towards 2016: ten-year framework social partnership agreement 2006-2015*. Dublin: Stationery Office. <http://www.drugsandalcohol.ie/6320/>
- 7 'Consistent poverty' is the overlap of two component indicators: at-risk-of-poverty, which identifies individuals with household incomes below 60% of the median, and basic deprivation, which captures individuals lacking two or more of 11 basic necessities.
- 8 Office for Social Inclusion (2007) *National action plan for social inclusion 2007-2016*. Dublin: Stationery Office. <http://www.drugsandalcohol.ie/13378/>
- 9 For more information on *Europe 2020*, visit http://ec.europa.eu/europe2020/index_en.htm
- 10 Department of Social Protection (2012) *National social target for poverty reduction: policy briefing on the review of the national poverty target*. http://www.welfare.ie/en/downloads/2012_nptbriefing.pdf
- 11 Department of Social Protection (2016) *Updated national action plan for social inclusion 2015-2017*. Dublin: Department of Social Protection. <https://www.welfare.ie/en/downloads/Updated%20National%20Action%20Plan%20For%20Social%20Inclusion%202015-2017.pdf>
- 12 Government of Ireland (2016) *A programme for partnership government*. Dublin: Department of the Taoiseach. <http://www.drugsandalcohol.ie/25508/>
- 13 At the time of going to press, only one of the five 'new strategies' had been published. Government of Ireland (2015) *Comprehensive employment strategy for people with disabilities*. Retrieved 1 July 2016 from <http://www.justice.ie/en/JELR/Comprehensive%20Employment%20Strategy%20for%20People%20with%20Disabilities%20-%20FINAL.pdf/Files/Comprehensive%20Employment%20Strategy%20for%20People%20with%20Disabilities%20-%20FINAL.pdf>

Social inclusion and drugs policy

This article outlines how the concept of social inclusion has been incorporated into the national drugs policy framework over the past 20 years as well as issues to consider going forward.

1996-2016

As long ago as 1996, the Ministerial Task Force on Measures to Reduce the Demand for Drugs recognised the link between problem drug use and socioeconomic disadvantage.¹ The task force recommended the establishment of local drugs task forces in areas experiencing high levels of problem drug use, which coincided with areas experiencing social and economic disadvantage.

Ireland's two subsequent seven-year national drugs strategies, published in 2001² and 2009,³ both set Ireland's drug policy within the wider social inclusion policy context, to which a number of other national strategies, such as health,⁴ anti-poverty⁵ and education,⁶ had also been linked.

2001: The Group fully recognises that, notwithstanding the obvious benefits for communities affected by the drugs problem of having a specific drugs strategy, the best prospects for these communities, in the longer term, rest with a social inclusion strategy which delivers much improved living standards to areas of disadvantage throughout the country. (para. 6.1.9)

2009: The Group ... notes that the Cabinet Committee on Social Inclusion, Children and Integration deals with a wide range of social inclusion policy areas, of which drugs is one issue. While the scope for routine debate on drugs is limited, therefore, the Group acknowledges that addressing the broader social inclusion agenda ensures that the drugs issue is taken into consideration, as it is an integral aspect of many of the social inclusion priorities. (para. 6.21)

2017 and after?

How the new National Drugs Strategy will address the links between social inclusion and illicit drugs policies remains to be seen. For example:

- How will social inclusion and illicit drug policy be handled at Cabinet level?
- How will different government departments, state agencies, drugs task forces, and community and voluntary organisations be expected to address social inclusion and drug-related issues and with each other?
- How will the concepts of active inclusion, life cycle framework and integrated social inclusion framework, all mentioned in Ireland's current social inclusion policy framework, be applied in the drugs policy context?

Two articles in earlier issues of *Drugnet Ireland* on the links between social inclusion and drug policy have highlighted the importance of integrated responses.

Inequality and illicit drug use⁴

In their study of the links between health, social problems and inequality, Wilkinson and Pickett⁵ argue that policy-makers should integrate health and social problems as elements of a single policy problem - inequality - rather than approach them as separate issues:

Social inclusion and drugs policy continued

Attempts to deal with health and social problems through the provision of specialized services have proved expensive and, at best, only partially effective.... Rather than reducing inequality itself, the initiatives aimed at tackling health and social problems are nearly always attempts to break the links between socio-economic disadvantage and the problems it creates. The unstated hope is that people – particularly the poor – can carry on in the same circumstances, but will somehow no longer succumb to mental illness, teenage pregnancy, educational failure, obesity or drugs. (pp. 238–9)

Applying the life cycle approach to social inclusion policy⁶

In an article about the life cycle approach to social inclusion policy in Ireland, Whelan and Maître⁷ explain how the life cycle approach marks a shift in perceptions of the nature of risk. Traditionally, social policy interventions have focused on risks associated with unemployment, disability, and insufficient resources in childhood and old age, and have tended to redistribute resources across the life cycle, from working age groups to children and to older people. More recently, social policy interventions have begun to focus on risks faced by specific subgroups at particular stages in their lives, for example, risks associated with entering the labour market, remaining in the labour market, or managing care responsibilities. These 'new' risk perceptions have emerged in response to the greater variability and reduced stability in career and family patterns.

In essence, the life cycle approach seeks to reconcile social and economic objectives, and to emphasise the 'multidimensional' and 'dynamic' aspects of the social inclusion process: risks of being socially excluded are linked across problem areas, and difficulties experienced in any specific life cycle

stage may be a consequence of difficulties in an earlier stage or a precursor of later problems.⁶

The authors go on to comment that while the life cycle approach offers a set of lenses through which to focus on the issues, it does not offer a ready-made set of prescriptions:

...a 'general analytic framework that accounts for the dynamics and the links between events and the appropriate analytic tools' is needed. To fully understand the nature of the dynamic inter-related risks requires the mapping of social exclusion patterns across the life cycle, and an understanding of the manner in which they combine with other socio-economic characteristics.⁶

Brigid Pike

- 1 Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996) *First report of the ministerial task force on measures to reduce the demand for drugs*. Dublin: Stationery Office. <http://www.drugsandalcohol.ie/5058/>
- 2 Department of Tourism, Sport and Recreation (2001) *Building on experience: national drugs strategy 2001–2008*. Dublin: Stationery Office. <http://www.drugsandalcohol.ie/5187/>
- 3 Department of Community, Rural and Gaeltacht Affairs (2009) *National drugs strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. <http://www.drugsandalcohol.ie/12388/>
- 4 Pike B (2011) Inequality and illicit drug use. *Drugnet Ireland*, 38: 8–10. <http://www.drugsandalcohol.ie/15639/>
- 5 Wilkinson R and Pickett K (2010) *The spirit level: why equality is better for everyone*. Published with revisions and a new postscript. London: Penguin Books.
- 6 Pike B (2008) Applying the life cycle approach to social inclusion policy. *Drugnet Ireland*, 28: 19–20. <http://www.drugsandalcohol.ie/12148/>
- 7 Whelan CT and Maître B (2008) 'New' and 'old' social risks: life cycle and social class perspectives on social exclusion in Ireland. *Economic and Social Review*, 39(2): 131–156.

New psychoactive substances: legislative changes in the UK

Psychoactive Substances Act 2016

The Psychoactive Substances Act 2016 came into force in the UK on 26 May 2016. In the Act, a 'psychoactive substance' is defined as one that 'produces a psychoactive effect in a person if, by stimulating or depressing the person's central nervous system, it affects the person's mental functioning or emotional state; and references to a substance's psychoactive effects are to be read accordingly'.¹ The Act differs from the established approach to drug control under the UK's Misuse of Drugs Act 1971 in that it covers substances by virtue of their psychoactive properties, rather than the identity of the drug or its chemical structure.²

Critics of the Act argue that this focus on the psychoactive properties of the substance is too broad – it means that technically the authorities could decide that any substance which changes a person's mood could be included, irrespective of any evidence of the substance being harmful. In an effort to address this, the guidance accompanying the Act² states that the effects of the substance are to be 'as measured by the production of a pharmacological response on the central nervous system or which produces a response in in-vitro tests qualitatively identical³ to substances controlled under the Misuse of Drugs Act 1971' (p. 3).² However, the guidance also notes that the Act captures all psychoactive substances that are not controlled by the Misuse of Drugs Act or are otherwise exempt. Exempted substances include controlled drugs (within the meaning of the UK's Misuse of Drugs Act 1971), medicinal products, alcohol, tobacco products, caffeine, and food.¹

NPS: legislative changes in the UK continued

NPS come of age: a UK overview

To coincide with the introduction of the new Act, DrugWise published a report on novel psychoactive substances (NPS) – also known as new psychoactive substances. *NPS come of age: a UK overview*⁴ by Harry Shapiro provides a description of NPS from a range of angles, including the evolution of NPS in the UK; their use; how treatment services are dealing with the needs of their users; and the development of the new legislation. He compared the picture of NPS use in the UK in 2016 as ‘not dissimilar’ to that which appeared with the emergence of crack cocaine in the UK: ‘much sensational media reporting and dire predictions for the future, but ultimately finding a level in the drug scene with regular use primarily concentrated among those with existing serious drug problems and other vulnerable groups’ (p. 3).

The Internet and the lack of regulation of the substances involved were identified as enabling NPS to take their place in the global and UK drug markets. Their arrival was described as a ‘game-changer’ in terms of the Internet becoming a new route for wholesale and retail supply, distribution, and information exchange on drugs’ effects between users. In terms of the range of NPS, while Shapiro accepted that there can be ‘bewilderment’ among drugs workers at the ongoing appearance of ‘new’ substances, the difference between them was not always that significant. He described five groupings, and argued that many of the new compounds were simply variants of the first grouping:

- Synthetic cannabinoids
- Stimulant-type drugs (including mephedrone)
- Hallucinogenic-type drugs
- Opiate-type drugs
- Tranquilliser-type drugs

NPS users

NPS use has increased in the UK since 2006. However, identifying patterns and prevalence of their use in official datasets was found by Shapiro to be ‘patchy’. Among the reasons given for this was that the user groups most affected (e.g. students in student accommodation, adult prisoners, young offenders and the homeless) were unlikely to be identified in the UK’s routine official surveys that provide prevalence data. Based on his overall assessment of the evidence available, Shapiro generalised that NPS use is ‘most problematic in communities experiencing higher levels of poverty and deprivation and, where young people are involved, among those who in years gone past would have been involved in solvent use and heroin smoking’ (p. 12). He drew particular attention to the reported high levels of synthetic cannabinoid receptor agonists (SCRAs) use among prisoners in the UK. In particular, he noted the associated increases in levels of violence between prisoners and against staff, debt, intimidation, self-harm and ‘general psychotic behaviour’. The legal status of the substances and the fact that they could not be identified by the mandatory drug testing process in prisons had both contributed to the worsening situation.

Health impacts

Shapiro found a growing body of international evidence to demonstrate the potential acute and chronic health harms associated with the use of NPS. He noted in particular the ‘devastating effects’ of injecting mephedrone. While NPS were implicated in 62 fatalities in the UK in 2014, only seven deaths were as a direct result of taking an NPS in isolation. In most cases, ‘traditional’ drugs (e.g. heroin and methadone) were also implicated.

Meeting users’ needs

Relatively few people were coming forward to treatment services citing an NPS as their primary drug problem. Drug workers saw more use out in the community with clients who were not accessing treatment, for example, homeless and rough sleepers. However, those working in the community with young people reported problems with a range of NPS, especially mephedrone and synthetic cannabinoids. Shapiro emphasised the need for drug workers to ‘deal with the problem in front of you’, as the ‘whole intention’ of NPS was to mimic the effects of controlled drugs; in theory the symptoms service users present with should be similar to those already seen. He therefore recommended the clinical guidance published by Project Neptune.⁵

Legislation

Legislating for NPS is described as having provoked some of the most heated debate about UK drug law since cannabis was reclassified from Class B to Class C in 2004. The report described the legislative process gone through which culminated in the ‘blanket ban’ encapsulated in the Psychoactive Substances Act 2016. Shapiro described it as having met a ‘storm of criticism’ in the media and from drug law reform campaigners, commentators and academics. In particular, it was criticised for having turned the Misuse of Drugs Act ‘on its head’ by effectively saying that any substance that was psychoactive was harmful. It was also criticised for having removed the notion of relative harms, and there was scepticism about the legal robustness of any attempt to define ‘psychoactivity’.

Lucy Dillon

- 1 Psychoactive Substances Act 2016 (UK). Available online at http://www.legislation.gov.uk/ukpga/2016/2/pdfs/ukpga_20160002_en.pdf
- 2 *Psychoactive Substances Act 2016: forensic strategy*. Home Office Circulars 2016. London: Home Office. <https://www.gov.uk/government/publications/circular-0042016-psychoactive-substances-act-2016>
- 3 ‘Qualitatively identical to’ means that the substance interacts with the same target as a known psychoactive drug controlled under the Misuse of Drugs Act 1971.
- 4 Shapiro H (2016) *NPS come of age: a UK overview*. London: DrugWise. <http://www.drugsandalcohol.ie/25551/>
- 5 Abdulrahim D and Bowden-Jones O, on behalf of the NEPTUNE Expert Group (2015) *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances*. London: Novel Psychoactive Treatment UK Network (NEPTUNE). <http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf>



Dr Deirdre Mongan of the HRB, lead author of *Overview of alcohol consumption, alcohol-related harm and alcohol policy in Ireland*

PREVALENCE AND CURRENT SITUATION

Global Drugs Survey 2016

The findings of the world's biggest drug survey, the Global Drug Survey (GDS) 2016, were published on 14 June.¹ GDS is an 'independent global drug use data exchange hub that conducts university ethics approved, anonymous online surveys'.¹ It is made up of experts from the fields of medicine, toxicology, public health, psychology, chemistry, public policy, criminology, sociology, harm reduction and addiction. They aim to 'help people and communities reduce the harm associated with the use of drugs regardless of their legal status, by sharing information in a credible and meaningful way'.¹

The survey explored patterns of use, harms, health and well-being experienced by a range of users. The survey was translated into 10 languages and had 101,313 respondents from over 50 countries. Seven hundred and seven respondents were from the Republic of Ireland. The authors identified a number of methodological issues that should be taken into consideration when looking at their findings:

- The findings were not national estimates of drug use prevalence.
- GDS used non-random, opportunistic sampling methods to recruit large numbers of people who use drugs.
- The survey recruited younger, more involved, and often hidden drug-using populations than other surveys.

- The survey was designed to answer comparison questions that are not dependent on probability samples.
- As the data was less than six months old, the findings can help identify emerging drug trends before they enter into the general population.

Key findings

Among the key findings were:

- 9.3% of respondents reported ever buying drugs off the 'dark net'; this represents an increase on previous years. MDMA, cannabis, new or novel substances and LSD were the drugs most commonly bought.
- Synthetic cannabinoids (SCs) were more likely to lead to emergency medical treatment than any other drug. One in eight of those using weekly or more often reported seeking emergency medical treatment. The overall risk of seeking emergency medical treatment when using SCs was found to be 30 times greater than when using 'natural cannabis'.
- In terms of acute harms caused by alcohol, at 2.2% each, Ireland and Norway came in joint second to Scotland, where 2.4% of drinkers reported seeking emergency medical treatment following drinking alcohol.
- Globally, Ireland had the second highest proportion of people who would like to drink less alcohol (43.4%).
- While globally the mean price for high potency herbal cannabis was €12.48, in Ireland it was €23.

Lucy Dillon

¹ Global Drug Survey (GDS) (2016). For more information, visit <https://www.globaldrugsurvey.com/wp-content/uploads/2016/06/TASTER-KEY-FINDINGS-FROM-GDS2016.pdf>

Prisoners and infectious diseases

The Irish Penal Reform Trust launched a new report, *Improving prison conditions by strengthening the monitoring of HIV, HCV, TB and harm reduction: mapping report - Ireland*, on 23 June.¹ The report forms part of the EU co-funded project, Improving Prison Conditions by Strengthening Infectious Disease Monitoring, which was implemented under the lead of Harm Reduction International.² The project aims to reduce the ill-treatment of persons in detention and improve prison conditions through improved and standardised monitoring and inspection mechanisms on HIV, HCV and TB. This broader research informed the development of a user-friendly tool³ to help generate better informed, more consistent, and sustained monitoring of these diseases and harm reduction in prisons by national, regional and international human rights-based prison monitoring mechanisms.

The Irish report presented the findings of a national mapping exercise carried out to investigate available standards relating to human rights, infectious diseases and prison monitoring. It described the evolution in Ireland of the healthcare and prison systems; illicit drug use and the related legislative and policy context; and human rights, particularly in the context of judicial care. It then explored the situation in relation to infectious diseases among prisoners. Information was collected through a literature review, analysis of public documents, Freedom of Information requests, and consultation with experts in the prison service.

Among the key findings was that the Irish Prison Service's (IPS) provision for HIV and hepatitis C prevention measures did not meet the standards of best practice models found elsewhere in Europe and North America. Furthermore, the IPS did not fulfil its stated objective of providing primary healthcare (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to the

general population. The authors argued that the IPS's response to the HIV and hepatitis C crisis fell 'far short' of this standard.

In terms of surveillance, they noted that while the Health Protection Surveillance Centre collected and collated data on notifiable diseases nationally, it was not possible for the authors to distinguish between those identified in the prison setting and the general population. They maintained that while some progress had been made in the adoption of monitoring mechanisms for infectious diseases in Irish prisons, it was less than sufficient or consistent in meeting the standards of human rights-based prison monitoring.

The report identified a number of monitoring mechanisms for Irish prisons. These include the Inspector of Prisons, prison visiting committees, and the European Committee for the Prevention of Torture. All of these had been critical of conditions in Irish prisons. The authors also concluded that Ireland's ongoing failure to have ratified the Optional Protocol to the Convention Against Torture presented a threat to the protection of the human rights of prisoners in Ireland.

Presentations were also made at the launch by Dr Joe Barry, Clinical Professor in Public Health Medicine, Trinity College Dublin; Fergal Black, Director of Care and Rehabilitation at the Irish Prison Service; Emmett Conroy, prison nurse with the Irish Red Cross prison programme; and Judge Michael Reilly, Inspector of Prisons.

Lucy Dillon

- 1 MacNamara C, Varley L, Mannix McNamara P (2016) *Improving prison conditions by strengthening the monitoring of HIV, HCV, TB and harm reduction: mapping report - Ireland*. Dublin: Irish Penal Reform Trust. <http://www.drugsandalcohol.ie/25635>
- 2 Sander G (2016) *HIV, HCV, TB and harm reduction in prisons: human rights, minimum standards and monitoring at the European and international level*. London: Harm Reduction International.
- 3 Sander G (2016) *Monitoring HIV, HCV, TB and harm reduction in prisons: a human rights-based tool to prevent ill treatment*. London: Harm Reduction International.

Developing inside: transforming prison for young adults

Introduction

On 31 May 2016, the Jesuit Centre for Faith and Justice published a report that examined the needs, circumstances and conditions experienced by young adults (18-24 years) within the Irish prison system.¹ The report was applauded by the Irish Penal Reform Trust (IPRT) as their own report in 2015 drew similar conclusions.^{2,3}

Young adults in prison: why are they unique?

Drawing on theory and research from the fields of criminology, sociology and psychology, it is argued that young adults aged 18 to 24 form a unique but distinct group, and in consequence should be treated differently to older prisoners.

Characteristics of this cohort include:

- During the transition, biological and psychological developments can continue for some until their mid-twenties.
- They experience changes in key areas of life, such as education, occupation, finances, living arrangements and romantic relationships.
- Most grow out of crime and will have stopped altogether by the time they are 30.
- They are more malleable and susceptible to peer influence.
- They are more likely to behave in a manner that will bring them into contact with the justice system.
- There is a higher level of risk taking; impulse control does not fully develop until mid-twenties.
- Their lack of maturity diminishes their ability to understand and participate in justice proceedings.
- They are not as equipped to plan ahead, reason, think abstractly or anticipate consequences.

Developing inside: transforming prison for young adults continued

Notably, some behaviours and levels of maturity displayed by this cohort may resemble adolescence and may result in an assumption that this phase is an extension of adolescence. However, Jeffrey Arnett, who coined the term 'emerging adulthood' to represent this phase of development, defines it as a period that is 'much different from adolescence, much freer from parental control, much more a period of independent exploration' (p. 4).⁴ Proponents of the adolescent/emerging adulthood distinction argue that it is harmful to treat young adults as adults, particularly within the criminal justice system.

Young adults in prison in Ireland: historical review

The report provides an overview of the treatment of young adults within the Irish justice system since the 19th century. An important point to note is that historically there has been fluidity in the age classification of young offenders, with an acknowledgement that children on reaching the age of 18 do not become adults overnight.

Young adult prisoner: Irish context

A major finding of the report is that young adults are overrepresented in Irish prisons. Centred on data from the Irish Census of Population 2011, young adults represent approximately 11.94% of the adult population nationally. However, within prison populations young adults represent 24% of individuals committed, 20% of those sentenced to prison and 26% of prisoners on remand (p. v).¹ Notably, the overrepresentation is more apparent in young adults aged 21 to 24, who represent 14.7% of the prison population but only 5% of the general population.

International responses

Despite the existence of international standards and guidelines, countries vary in their responses to the detention of young adults.^{5,6,7} In comparison to other European countries (e.g. Germany, Northern Ireland, Scotland, Switzerland, Sweden and Turkey), Ireland does not fare well in its treatment of offenders aged 18 to 24.¹ The Committee of Ministers of the Council of Europe issued the European Rules for Juvenile Offenders Subject to Sanctions or Measures (ERJOSSM) to European states in 2009.⁸ This document provides guidance on regimes that are best suited to young adult offenders where detention is used as a last resort.

Recommendations

It is recommended that Ireland should avail of an alternative approach based on principles of education, rehabilitation and reintegration, where continuity of care of young adult offenders is guaranteed. A number of recommendations for reform have been put forward:

- There should be recognition that young adults (aged 18 to 24) are a distinct group who should be under the remit of the Irish Youth Justice Service.
- Ireland should aim to reduce the number of young adults in prison.
- Young adults should be accommodated in detention centres that are humane and designed specifically for them and their age group.

- Young adults that are detained and prison officers should be in settings where they both feel safe.
- There should be greater accessibility to specialised services within prison and upon release in the community.
- A new regime for young adults in prison should be provided.
- Extended lock-up and 'basic' regime standards should be eradicated. On committal to a prison, young adults should be placed in the 'enhanced' accommodation standard (p. 67).¹
- Young adult offenders should be included in operational decision-making of the detention centre and prison.
- There should be a reduction of remand. However, when necessary, all detention centres should have dedicated remand facilities.
- Motivation and support to abstain from drugs in the prison setting should be provided, while also providing harm reduction measures.
- Training of prison staff should be enhanced and avail of an evidence-based approach that is based on best international policy and practice.

Ciara H Guiney

- 1 Jesuit Centre for Faith and Justice (2016) *Developing inside: transforming prison for young adults*. Dublin: Jesuit Centre for Faith and Justice. Retrieved 5 August 2016 from <http://www.drugsandalcohol.ie/25588/>
- 2 Irish Penal Reform Trust (IPRT) (2016) *IPRT welcomes report by the Jesuit Centre for Faith and Justice into the needs of young adults (18-24) in prison* [online]. Retrieved 5 August 2016 from <http://www.iprt.ie/contents/2918>
- 3 Irish Penal Reform Trust (IPRT) (2015) *Turnaround youth: young adults (18-24) in the criminal justice system*. The case for a distinct approach. Dublin: IPRT. Retrieved 5 August 2016 from <http://www.drugsandalcohol.ie/23921/>
- 4 Arnett JJ (2004) *Emerging adulthood: the winding road from the late teens through the twenties*. Oxford: Oxford University Press. Retrieved 5 August 2016 from http://jeffreyarnett.com/EmerAdul_Chap1.pdf
- 5 Transition to Adulthood Alliance (2010) *Young adults and criminal justice: international norms and practices*. London: Transition to Adulthood Alliance. Retrieved 5 August 2016 from <http://www.t2a.org.uk/wp-content/uploads/2011/09/T2A-International-Norms-and-Practices.pdf>
- 6 Council of Europe (2003) *New ways of dealing with juvenile delinquency and the role of juvenile justice*. Strasbourg: Council of Europe Publishing. Retrieved 5 August 2016 from <https://www.crin.org/en/library/legal-database/council-europe-recommendation-rec200320-concerning-new-ways-dealing-juvenile>
- 7 Dünkel F and Pruin I (2012) Young adult offenders in juvenile and criminal justice systems in Europe. In Lösel F, Bottoms A and Farrington DP (eds) *Lost in transition: young adult offenders in the criminal justice system*. Abingdon: Routledge.
- 8 Council of Europe (2009) *European rules for juvenile offenders subject to sanctions or measures*. Strasbourg: Council of Europe Publishing. Retrieved 5 August 2016 from <https://book.coe.int/eur/en/children-s-rights-and-family-law/4221-european-rules-for-juvenile-offenders-subject-to-sanctions-or-measures.html>

Factors influencing reunification between NDTC service users and their children in care

Social workers from the National Drug Treatment Centre (NDTC) recently examined the issue of care admissions of children of parents attending the NDTC.¹ They outline how it is well recognised internationally that misuse of drugs by parents can have detrimental effects on child welfare, including a higher risk to the child of addiction in later life.

Previous studies in the Irish context are limited in number, but several studies have shown a high proportion of children taken into care among cohorts of drug users and homeless individuals in Dublin. The Health Service Executive (HSE) reported in 2011 that the primary reason for admission to care of 12% of children was a family member with drug or alcohol misuse. The authors also note how other studies show that drug-using parents can be motivated to provide adequate care for their children, and highlight how a combination of other factors, such as poverty, homelessness, mental health issues, and lack of family and social supports contribute to children being admitted to care.

The authors note that a primary focus of social work is maintaining family unity. Where children are admitted into care, maximising the chances of reunification is key to addressing this issue. The study consisted of two parts. Firstly, the authors retrospectively analysed data on child admissions to care for service users of the NDTC for the period 2001-2010. The NDTC cares for an average of 550 problem opiate users. Variables recorded included whether or not the placement in care was within the extended parental family; admissions shortly after birth; and whether or not the children remained in care after one year.

Secondly, the authors asked the social work team at the NDTC to identify factors that they felt contributed to reunification within the first 12 months. Service users who had their children returned within 12 months were also asked to identify the factors that assisted reunification. This was done through providing participants with a list of seven factors chosen by the authors and allowing the participants to prioritise the factors from 1 to 7.

Arrangements where children were being cared for informally within the extended family were not recorded nor were reunifications after 12 months. The authors note that these kinds of reunifications were anecdotally accepted to be low in number. The authors also point out that reunification within 12 months is not a guarantee of future family stability, and that readmissions to care do occur.

Results

Over the period 2001-2010, 142 children of service users were admitted to care. Sixty-one (43%) admissions to care came under section 36 of the Child Care Act 1991. This Act allows for children to be placed in care with a relative or family friend, assuming some initial criteria have been met. This can be done voluntarily or by court order. Interestingly, the national figures from 2011 indicate 29% of admissions to care were under section 36. While noting the potentially positive benefits of children being cared for by family members or friends, the authors warn that evidence suggests issues with these scenarios include reluctance to allow social work involvement, low levels of support offered, and carers sharing a similar background to parents.

The authors report that 46 of the 142 children were admitted to care shortly after birth. They take into account some anecdotal factors that appear associated with these early admissions to care, including illicit drug use during the pregnancy, the child exhibiting withdrawal symptoms after birth, and chaotic behaviours of the service user (e.g. address changes, not meeting appointments, etc.). The authors note the harm of separation at this early point, and how it is important to maintain frequent appropriate access to enhance the chances of reunification.

Of the 142 children taken into care during the period, 120 had not been reunified with their parent(s) 12 months later. This means that only 21 children (14.7%) had been returned to the care of their parent(s) after 12 months. This is contrasted with 34% of children taken into care nationally in 2011 being reunified within 12 months.

The social work team at the NDTC identified progress in treatment as the main factor resulting in reunifications. Only six parents were interviewed for the study, with four identifying maintaining bond/contact with children in care as the main factor in their reunifications. A full list of factors is provided in Table 1.

Table 1 Reunification factors prioritised by social workers and parents

Priority	Social workers	Parents
1	Progress in treatment	Maintaining bond/contact with child(ren) in care
2	Maintaining bond/contact with child(ren) in care	Progress in treatment
3	Support of partner/extended family	Direction and input from family court
4	Constancy of key personnel in the reunification process	Support of partner/extended family
5	Securing appropriate accommodation	Securing appropriate accommodation
6	Ongoing interagency liaison	Constancy of key personnel in the reunification process
7	Direction and input from family court	Ongoing interagency liaison

Reunifying NDTC service users and their children in care continued

The authors note that specialist interventions in the US (independent recovery coaching) and the UK (court-appointed multidisciplinary team) have been shown to raise the rate of reunification in cases like these. In Ireland, Ashleigh House, part of Coolmine Therapeutic Community, is the only residential service in Ireland for women requiring treatment and their children. Women can either live with their children or have weekend access, or work towards access, depending on their circumstances.

The authors express the hope that interventions like these could improve reunification rates and help meet the key principle of family reunion. They also highlight the need for enhanced contact between parents and children in care, believing it could increase the rate of reunification.

Martin Grehan

- 1 McGivern A and McDonnell C (2015) Vulnerable families and drug use: examining care admissions of children of parents attending an Irish drug treatment facility. *Irish Social Worker*, Spring: 17-23. <http://www.drugsandalcohol.ie/24712>

Homeless drug users: their health, perceived quality of life and use of health services

The report of a study comparing the physical and mental health, perceived quality of life, and health services use among homeless illicit drug users and homeless non-drug users was recently published.¹ The cross-sectional study was conducted with 105 participants, all of whom were recruited through Safetynet Ireland. Safetynet operates 14 clinics across Dublin, located in homeless shelters and foodhalls, which provide free primary care services, including access to GPs, nurses and drug workers, in an environment that is accessible to those who are homeless or at risk of homelessness. Study participants were recruited at four of these clinics using a gatekeeper mechanism whereby the patient was informed of the study by a staff member and, if willing to be involved, they were then introduced to the researchers.

A questionnaire consisting of 133 items was used. It included standardised tools such as AUDIT-C to measure problem drinking, GAD-7 for anxiety and PHQ-9 for depression. Quality of life was assessed using the five-point scale from the SLÁN study.² Participants were also asked if they were current, previous or never illicit drug users. Logistic regression was used to determine if drug use was associated with multimorbidity, anxiety and/or depression, poorer perceived quality of life or increased use of health services. Age, gender, alcohol use and smoking were also considered.

Of the 105 participants, 35 were current illicit drug users and 28 had used drugs in the past. The majority (75%) were male and 58% were under 40 years of age. The main accommodation type was hostel (43%) and 60% had been in their current accommodation for between 1 and 12 months. The demographic characteristics were similar for both drug and non-drug users, except that a higher proportion of current drug users as opposed to non-drug users were Irish (82% vs 70%) and were more likely to be current alcohol drinkers (94% vs 58%); fewer current drug users had completed third-level education (3% vs 13%).

The majority of participants (82%) were smokers. Of the 35 current illicit drug users, 21 (60%) were currently injecting one or more drugs intravenously, primarily heroin (95%), and had injected on average on 61 of the previous 90 days. Of the 21 injecting drug users, 81% reused their own needle/syringe and 66% shared another drug user's needle/syringe. Almost all (n=20) had used needle exchange services in the previous six months. Polydrug use was reported by 34% of all illicit drug users.

Six per cent of participants were HIV positive and this rose to 9% among current drug users. Moreover, 37% of illicit drug users were positive for hepatitis C (23% of all participants) and 3% were positive for hepatitis B. Eighty per cent of illicit drug users had been tested for HIV and hepatitis B and C. Current and previous drug users were five times more likely to have multimorbidity than those who had never taken drugs. Current drug users were four times more likely to report poor perceived quality of life than non-drug users, while there was no difference between non-drug users and previous drug users.

Uptake of primary care services was high among all participants. GP services were used by 86% of illicit drug users and Safetynet nurses by 71%. A total of 46% of current drug users were using methadone, while a further 11% were on the waiting list for methadone treatment. Current drug users were less likely to avail of mental health or dental services than those who did not use illicit drugs.

The authors highlight the high level of drug use among the homeless population and the negative impact this has on their health and perceived quality of life. They illustrate the importance of services such as Safetynet in providing accessible primary care services which meet the specific health needs of this population.

Margaret Curtin

- 1 O'Brien KK, Schuttke A, Alhakeem A, Donnelly-Swift E, Keogh C, O'Carroll A, O'Sullivan K, Galvin R and Fahey T (2015) Health, perceived quality of life and health services use among homeless illicit drug users. *Drug and Alcohol Dependence*, 154: 139-145. <http://www.drugsandalcohol.ie/24384/>
- 2 SLÁN (Survey on Lifestyle and Attitude to Nutrition) is a four-yearly survey commissioned by the Department of Health and designed to produce baseline information for the ongoing surveillance of health and lifestyle behaviours in the Irish population. For further information, visit <http://www.ucd.ie/issda/data/surveyonlifestyleandattitudetonutritionslan/>

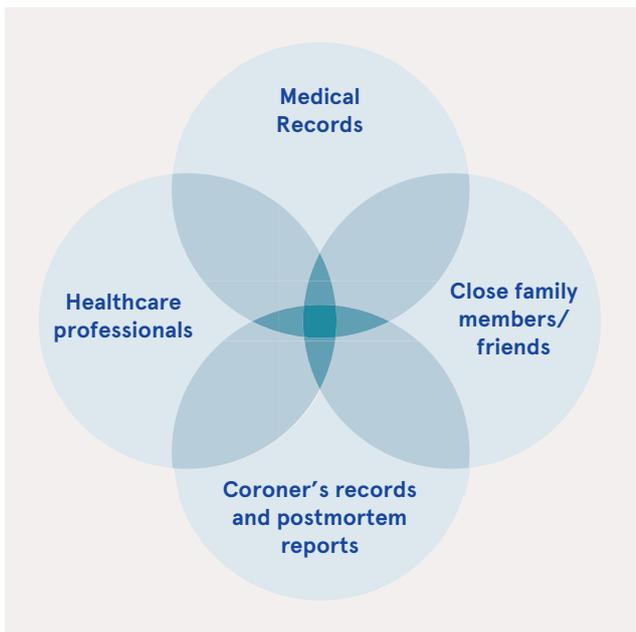
Suicide and untimely sudden deaths in the Donegal Mental Health Service

In 2014, the HSE Donegal Mental Health Service (DMHS) commissioned a study which sought insight into an increasing number of premature deaths among its service users.¹ The research, which was funded by the National Office for Suicide Prevention (NOSP) and conducted by a team from the National Suicide Research Foundation (NSRF), examined 34 deaths among those in the care of the DMHS between October 2011 and May 2015. The study has produced a number of evidence-based recommendations to improve the assessment and management of people at risk of suicidal behaviour in a mental health service setting.

Suicide Support and Information System–Psychological Autopsy Model

The Suicide Support and Information System–Psychological Autopsy Model (SSIS–PAM) used in this study was developed to prevent suicide by proactively facilitating access to support for the bereaved, while at the same time obtaining information on risk factors associated with suicide and deaths classified as open verdicts. Data were collected from multiple sources to corroborate the clinical history of the deceased as well as offering support to family members following such a tragic event. Twenty-four family informant interviews were conducted, with 21 families providing consent for the researchers to contact GPs involved in the care of the deceased. Thirteen GPs completed and returned questionnaires.

Figure 1 SSIS–PAM access to multiple sources of information



Source: A study of untimely sudden deaths and people who took their lives while in the care of the Donegal Mental Health Service (2016, p. 20, Figure 2)

Recording of deaths

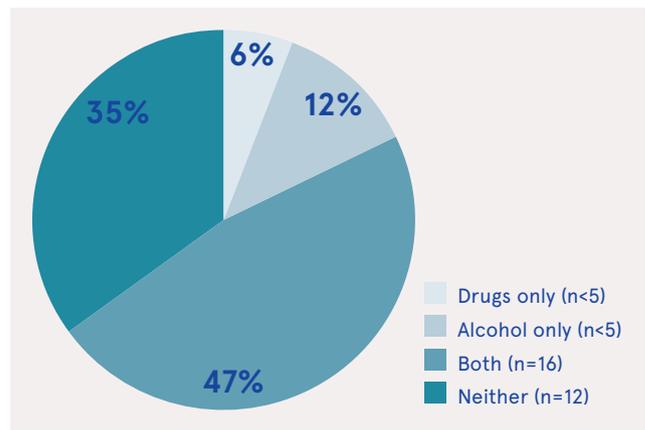
The recording of suicide and sudden unexpected deaths that may have been the result of suicidal or self-harming behaviour poses challenges to understanding the true incidence of suicide in a community at a particular time, as official figures are measured by calendar year and remain provisional for up to two years post-event. This research has provided DMHS with a 'real time' database with information on sociodemographic, psychosocial and psychiatric risk factors that may have contributed to the untimely deaths or suicides of those in its care over the period considered. The maintenance of this data will inform policy and resource planning and facilitate a targeted response to suicide contagion and emerging suicide clusters.

Key findings

Of the 34 deaths examined:

- 67.8% were men.
- The men were younger than the women, with mean ages of 41.4 years and 44 years, respectively.
- Clinical files showed cause of death as overdose of medication or drugs (n=15, 44%), hanging (n=14, 41%) and drowning (n=5, 15%).
- Of those who died by intentional overdose, the majority involved prescribed medication, with toxicology results of 10 cases also indicating substantial amounts of alcohol in both blood and urine at time of death. Most recent figures from the National Drug-Related Deaths Index (NDRDI) show that two-fifths (41%) of poisonings in 2013 involved benzodiazepines.²
- Almost half were known to abuse both drugs and alcohol prior to death (n=16, 47%) and a further six had abusive or dependent issues with a single substance.

Figure 2 Reported substance abuse of the deceased



Source: A study of untimely sudden deaths and people who took their lives while in the care of the Donegal Mental Health Service (2016, p. 30, Figure 8)

Suicide and untimely sudden deaths in the Donegal Mental Health Service continued

- 76.5% had a history of self-harm (n=26).
- The majority had a history of at least one voluntary or involuntary inpatient psychiatric admission (n=31).
- Psychiatric diagnosis was confirmed in all 34 cases, with 85% also meeting criteria for a secondary disorder; 47% had a primary diagnosis of depressive disorder (n=16) and a secondary diagnosis of substance abuse was recorded in 47% of cases (see Figure 3).
- 82% were being prescribed medication for mental illness preceding death. Information gathered on these cases included reckless behaviour, such as hoarding large supplies while requesting repeat prescriptions, and selling or exchanging prescribed medication for illegal drugs.
- The majority (n=18) had family members with known mental health issues, with depression and substance abuse the most common.
- 44% of case files contained incomplete assessments of suicidal risk, which was recorded in a way that was not considered to be informative of the service user's suicidal state. In 56% of case files, appropriate evaluation was conducted and made available in accordance with best practice principles.

Media reporting of suicides and unexpected sudden deaths

The National Media Monitoring Agency conducted a search of media outlets in County Donegal and nationally to determine the extent of media reporting of the cases of suicide and probable suicide examined in this study covering the period January 2011 to March 2015.

- Overall, journalistic reporting was mindful of the effect that oversensationalised reports can have on family and friends of the deceased and wider community.

Recommendations

The study makes six recommendations, covering 19 actions, based on its findings in relation to the characteristics of the deceased, patterns regarding contact with mental health services, and the needs of families bereaved by suicide. These can be summarised as follows:

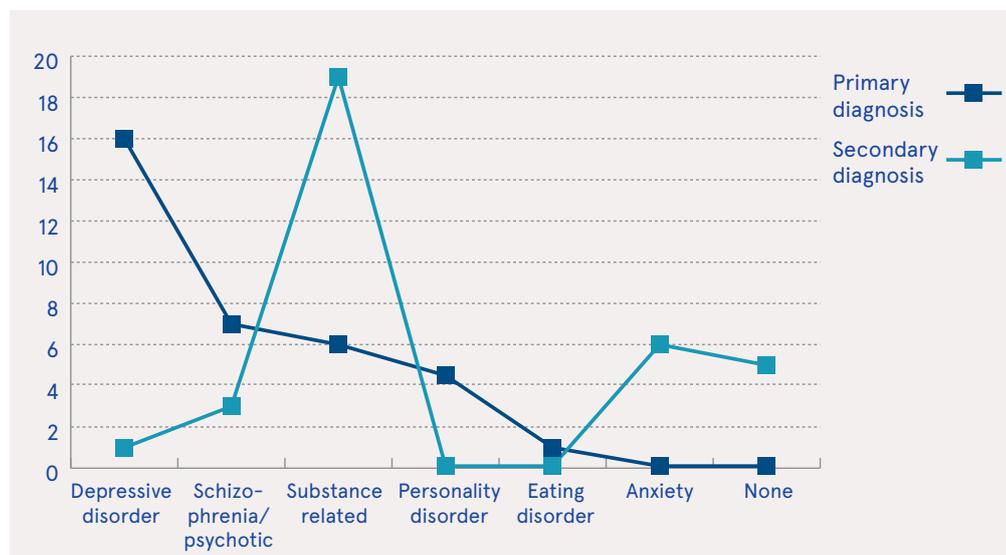
- 1 Improve clinical practice to increase understanding among mental health service staff about service user suicide and self-harm risk that is mindful of gender, age and other factors (such as cases of dual diagnosis) which may influence the risk of premature death.
- 2 Prioritise uniformity of good practice.
- 3 Foster communication and engagement with family members.
- 4 Improve the service response to family members following the death of a service user.
- 5 Improve media reporting of suicide.
- 6 Implement the Suicide Support and Information System.

According to Dr Clifford Haley, Executive Clinical Director, Donegal Mental Health Services: 'This data set of consecutive untimely sudden deaths will contribute to suicide research internationally, but most importantly it helps cast light onto what must be done to provide effective suicide prevention in Ireland.'

Sarah Fanagan

- 1 Corry C, Arensman E and Williamson E (2016) *A study of untimely sudden deaths and people who took their lives while in the care of the Donegal Mental Health Service*. Cork: National Suicide Research Foundation. <http://www.drugsandalcohol.ie/25727/>
- 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>

Figure 3 Primary and secondary psychiatric diagnoses among the deceased



Source: *A study of untimely sudden deaths and people who took their lives while in the care of the Donegal Mental Health Service* (2016, p. 37, Figure 16)

RESPONSES

Surveys reveal GPs have positive attitude towards Methadone Treatment Programme

The Methadone Treatment Programme (MTP) offers methadone maintenance treatment (MMT) to heroin addicts in Ireland and was introduced across the country in 1998. Given the central role of the GP in the delivery of care in the Irish health landscape, the MTP is regulated by the Irish College of General Practitioners (ICGP). The aim of this study¹ was to assess and compare GP perceptions of the scale of local illicit drug use, attitudes towards and obstacles in the provision of methadone treatment, and the preferred adjunct modalities alongside MMT.

To achieve this aim, two surveys were carried out with GPs in 2006 and 2015. The survey contained a series of descriptive and open-ended questions and was emailed to all GPs registered on the MTP database, irrespective of their current level of engagement in the MTP. The authors stated that, where possible, comparisons were drawn between the opinions of GPs who had patients receiving MMT in both 2006 (n=147) and 2015 (n=170).

Results

In terms of response rate, 207 out of 600 (34.5%) GPs responded in 2006 and 217 out of 949 (22.87%) GPs responded in 2015. The authors acknowledged the response rate as a limiting factor in the study but outlined that this response rate is typical of the GP population. The profile of participating GPs as predominantly male and aged between 35 and 60 remained largely unchanged between 2006 and 2015. Notably, there was an increase of 57% in the number of female participants in 2015.

Perception of the illicit drug problem and provision of MTP

When asked their opinion on the extent of illicit drug use in their area, 66.5% of GPs felt it was a major problem. This perception was worse compared with 2006 (53.2%). By linking perception to demographic location, the authors found that the majority of GPs that reported illicit drugs as a major problem were practising in urban locations. Similarly, the majority of GPs from rural areas reported minimal problems with illicit drug use in their practices. Notably, no statistical significance was observed between these two variables.

GPs that had patients enrolled in the MTP were asked to provide details about any perceived obstacles to recruiting new patients into the programme. The majority of GPs (54% 2015; 71.8% 2006) cited either no obstacles or no referrals in response to this question.

Second choices included 'have enough already' (16.3% 2015; 11.8% 2006) or that they had reached their 'protocol maximum' (27.2% 2015; 16.5% 2006). GPs that did not have patients currently enrolled in the MTP were invited to provide more information as to why this was the case. In 2015, 85% of these GPs reported that there was either no demand for the service in their area or they had never been asked to take on any patients. This was largely similar to 2006, where 83% of GPs cited the same reasons. Other reasons for not engaging with the MTP included a fear of violence, alienating private patients, a lack of knowledge, lack of community supports, and personal reasons such as a lack of empathy with addicts and discomfort with the topic of addiction.

Attitude towards the MTP and additional services

In general, the majority of GPs who had patients in the MTP in 2006 and 2015 had a positive attitude towards the programme. GPs agreed that the MTP eliminates chances of double scripting, allows for a good relationship with patients, improves the health of the patients and reduces criminality. Alongside the positive feedback for the MTP, GPs identified a lack of access to assessment and support services (including community liaison officers, literacy support, alcohol support services, and return to employment services) for patients receiving MMT. These were common issues between the 2006 and 2015 surveys. Furthermore, GPs highlighted a lack of accessible information about the types of services that are currently available and also the lack of a referral mechanism which can support the transfer of stabilised patients to primary care settings.

When asked to rank a list of services which they deemed necessary to further support the MTP, GPs in both years selected addiction counselling as their preferred choice (46.5% 2015; 51.7% 2006). GPs felt that inpatient rehabilitation detoxification beds, employment schemes and drop-in/social centres would also benefit patients in the MTP. The authors noted that the percentage of GPs who selected employment schemes and drop-in/social centres as their primary choice between 2006 and 2015 increased from 8.9% to 21.2% and 0.7% to 11.76%, respectively.

Discussion

Overall, the authors noted that this study highlighted a favourable opinion of Irish GPs towards participation in the MTP and obstacles and attitudes towards the provision of the programme. Notably, there was a perceived rise in the scale of local illicit drug use between 2006 and 2015. In addition, GPs provided a useful insight into the range of supplementary supports and services they believe are necessary for correct care of patients on the programme. By comparing survey results from 2006 and 2015, the authors found that the majority of GPs' attitudes towards the MTP have remained largely positive. The authors concluded that there is a need for greater efficiency of referral mechanisms for stabilised patients and greater implementation of psychosocial, vocational and detoxification supports warranted in the Irish primary care setting.

Thérèse Lynn

1 Delargy I, O'Shea MT, Van Hout MC, Collins C (2016) General practitioner perspectives on and attitudes toward the methadone treatment programme in Ireland. *Heroin Addiction and Related Clinical Problems*, 18(4): 43-50. <http://www.drugsandalcohol.ie/25746/>

4th International Conference on Novel Psychoactive Substances, Budapest, 30–31 May 2016

On 30 and 31 May 2016, the 4th Annual Conference on Novel Psychoactive Substances (NPS) took place in Budapest, Hungary.¹ There has been a dramatic increase in the number of NPS that have emerged worldwide in recent years. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) monitors 560 substances with approximately 100 reported for the first time in 2015. Therefore, it is imperative to share accurate, evidence-based information at an international level on the analysis of these substances and their effect on society. This conference, now in its fourth year, is a forum to foster collaboration between all those working in the area of NPS from law enforcement, forensic, clinical and toxicological analysis to research, front-line medical staff, addiction services and community workers.

Synthetic cannabinoids

A common theme in many of the presentations was the harm being caused by synthetic cannabinoids in Europe and worldwide, e.g. users reporting that the adverse side-effects far outweigh the feeling of well-being when the substances are taken initially. In addition, more negative side-effects are being experienced with synthetic cannabinoids than with other types of NPS, e.g. synthetic cathinones.

A study by Waterford Institute of Technology entitled 'Dependent user experiences of withdrawal from herbal smoking mixtures' was presented at the conference. The study was carried out in a settled Traveller community in the border counties in Ireland, where littering of herbal mixture product packaging was widespread. The packaging labelled Clockwork Orange and Happy Joker contained herbal material that was found to contain 5F-AKB-48 and 5F-PB-22. Users reported dependent use with intense cravings, compulsive behaviours and an inability to cease due to the fear of psychosis. The report recommends expedited responses from both addiction and mental health services.

New substances with potential for harm

New synthetic cathinones and cannabinoids are being identified in Europe and worldwide on a weekly basis. However, concern was raised by many speakers at the emergence of synthetic opioids and novel benzodiazepines.

The synthetic opioids are a cause for concern with many overdoses and deaths reported in the USA, Canada and Europe. Examples of such compounds are fentanyl derivatives and analogues, such as acetylfentanyl, furanylfentanyl, ocfentanil, and compounds such as W-18, AH-7921, U-47700, MT-45, all of which have a much higher potency than morphine. Users believe they are buying heroin or oxycodone but the product in fact contains a synthetic opioid, where only a fraction of the dose usually

taken is required to have an effect or cause serious harm. Many countries are now in the process of controlling these substances.

Addiction to benzodiazepines was also discussed with a warning that insufficient attention is being paid to this issue. Novel benzodiazepines, such as etizolam and phenazepam, are widely available, and in many countries are not yet controlled under drugs legislation. Many products containing these drugs are manufactured to look like legitimate pharmaceuticals, e.g. diazepam and alprazolam.

Across Europe, there is an increasing trend in injecting NPS. Hungary has reported an increase in hepatitis C infections in 2014 (24%-48.8%) with the highest prevalence rate around NPS injectors (73.9%). Many users at drug treatment centres, who were injecting, reported that their first injecting experience was with an NPS.

Guidelines for front-line staff

The EMCDDA reported on data collected across Europe with respect to current approaches and challenges in responding to NPS-related harm. Services and guidance for dealing with these substances vary from country to country with staff relying on knowledge of traditional drugs to tackle NPS. Those involved in intervention reported a need for training and NPS-specific guidance. Problems associated with drug treatment were also highlighted with services not available in rural areas or to recreational users.

In response to these issues, a guidance document published by the NEPTUNE project, entitled *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances*, is available on the EMCDDA website.² It offers information and guidelines for front-line medical staff and those working in addiction services on how to tackle NPS-related issues.

Internet forums

Since the introduction of generic and specific psychoactive substances legislation in many countries, the number of high street shops selling NPS has dramatically reduced. This in turn has resulted in a vast online market for these products. The Internet is also a place where users of NPS communicate with each other to make purchases, discuss products and dosages, and share experiences. Many researchers presenting at the conferences are using these online forums to analyse the information being shared by NPS users. This information provides a valuable insight into different groups from recreational users who are looking to experiment and relax to dependent or harmful users. Many online surveys have also been conducted across Europe, where NPS users answer specific questions on their usage and experiences. Recreational users reported taking NPS in a social setting to get high and bond with friends. However, only 50% of users had any knowledge of safe dosages.

Also discussed was the CASSANDRA project (Computer Assisted Solutions for Studying the Availability and Distribution of novel psychoActive substances), which is a multidisciplinary project that uses technology and social media to investigate the supply chain and diffusion of NPS.

NPS Conference continued

Analysis

Analysis and identification of NPS continues to pose challenges for border control, forensic and toxicological services. These include developing new analytical methods, adding new substances to existing methods and sourcing reference standards. Many speakers emphasised the need for continued collaboration between testing laboratories and academic institutions to identify new substances, whether it is providing access to standards or scientific techniques, e.g. nuclear magnetic resonance (NMR) spectroscopy. This research is also being combined with pharmacological-based studies in order to evaluate the potential for harm of newly identified compounds.

Inaugural Irish conference for nurses in addiction services

The Ireland Chapter of the International Nurses Society on Addictions (IntNSA)¹ held its inaugural conference in Dublin City University on 10 June 2016. The conference theme was 'Hot topics in addiction', where Irish and international speakers addressed several current issues, including the service user experience, chemsex, the role of the nurse in substance misuse, nurse prescribing, medically supervised injecting, and Irish and international policy developments. The conference was attended by the current president of IntNSA in the US, Dana-Murphy Parker, an Assistant Professor of Nursing at Drexel University in Philadelphia, Dr Carmel Clancy, Chair of the IntNSA International Task Force and Dr Chris Loth, President of the IntNSA Netherlands chapter, who was accompanied by two Netherlands IntNSA board members.²

Nurses play an increasingly important role in the treatment and prevention of addictive disorders across a broad range of healthcare settings. Nursing education covers a range of academic and practical subject areas, including holistic, physical and mental healthcare, psychosocial interventions, self-awareness, ethics and pharmacology. The undergraduate nursing degree prepares nurses for practice in child health, midwifery, mental health and intellectual disability as well as general practice. Many of the skills gained before undertaking specialist postgraduate training are highly relevant in terms of meeting client needs across the spectrum of addiction treatment. Nurses' professional registration also provides enhanced statutory protection for both employers and service users.

However, the diverse nature of work in the addictions field in Ireland and the lack of opportunity for specialisation outside of Dublin have meant there is some ambiguity around the role of nurses in this field and its service value. In the workplace many nurses find themselves isolated from professional support in areas where employers may

Michelle Boyle

- 1 For more information on the conference and online access to presentations and posters, visit <http://www.novelpsychoactivesubstances.org>
- 2 *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances*. Available online at [http://www.emcdda.europa.eu/attachements.cfm/att_236560_EN_UK10_NEPTUNE%20NPS%20guidance%20\(2015\).pdf](http://www.emcdda.europa.eu/attachements.cfm/att_236560_EN_UK10_NEPTUNE%20NPS%20guidance%20(2015).pdf)

be unfamiliar with their role. In 2015, nurses working in this area formed the Ireland Chapter of IntNSA, to become a part of a professional organisation founded in 1975 in the United States for nurses committed to the prevention, treatment and management of addictive disorders. These include alcohol and other drug dependencies, nicotine dependencies, eating disorders, dual diagnosis, multiple diagnosis, and process addictions, such as gambling. IntNSA's mission is to advance excellence in nursing care for the prevention and treatment of addictions for diverse populations across all practice settings through advocacy, collaboration, education, research and policy development.

IntNSA is engaged in a wide range of activities internationally, which has included hosting a symposium at the International Society of Addiction Medicine (ISAM) conference in Dundee in 2015. The Ireland Chapter was the first chapter established outside the United States and now has over 50 Irish members. It aims principally to provide a professional support network for nurses and other disciplines working in the addictions field and across other areas of healthcare in Ireland. The Ireland Chapter of IntNSA also seeks to have addiction nursing recognised as a discipline within nursing. Membership is open to nurses registered with the Nursing and Midwifery Board of Ireland (NMBI) and student nurses, while associate membership is open to other disciplines and service users.³ Service users and nurses from addiction treatment and academic disciplines are represented on the board. The board members are Ann McGuire, Deirdre Carmody, Deirdre Lynne, Dr Gerry Moore, John Flanagan, Niall O'Connell and Peter Kelly. Opportunities for international collaboration are increasing, as there are now IntNSA chapters in The Netherlands and in Brazil, with a UK chapter currently being established.

One of the main objectives of the Dublin conference, which had a capacity attendance, was to raise awareness of the value that nurses can bring right across the spectrum of treatment services and to increase dialogue with service users and other practitioners and academics in other disciplines. A panel discussion, chaired by Dr Siobhán O'Halloran, Chief Nursing Officer at the Department of Health, generated an interesting discussion around the future of addiction treatment in Ireland.

Nurses in addiction services

continued

In November 2015, representatives of the Ireland Chapter of IntNSA met with the then Minister for the National Drugs Strategy, Aodhán Ó Ríordán, and was the first nursing group to formally contribute to an Irish national drugs strategy via attendance at the Continuum of Care Focus Group. The focus for 2016/17 will be decided at our forthcoming AGM and we will explore opportunities to positively influence the nursing contribution to Irish addiction services.

Peter Kelly

- 1 Further details on IntNSA's mission, vision and values are available online at <http://www.intnsa.org/>
- 2 Information on other speakers is available at <https://www.dcu.ie/snhs/news/2016/mar/international-addictions-conference.shtml>
- 3 Information on membership of the Ireland Chapter of IntNSA and conference speakers is available online at <http://groupspaces.com/IrelandChapterofIntNSA/join/>

Ethnic data collection and monitoring

Pavee Point Traveller and Roma Centre launched its new report *Policy and practice in ethnic data collection and monitoring*^{1,2} on Monday, 21 March to mark International Day for the Elimination of Racial Discrimination. A seminar was also held on the day, chaired by Anastasia Crickley, the Vice-President of the UN Committee for the Elimination of Racial Discrimination (CERD), with presentations from Lynsey Kavanagh, author of the report, and Andrew Millard, Equalities Intelligence Manager, Scottish Public Health Observatory. Diane Nurse, HSE National Lead for Social Inclusion, Primary Care Division, provided the closing comments to the seminar. Co-directors of Pavee Point, Ronnie Fay made opening comments, while Martin Collins officially launched the report.

This report was in response to the paucity of data in official statistics on ethnic minority groups in Ireland, particularly Irish Travellers and Roma. Ethnic equality monitoring (EEM) is defined as the systematic and regular collection of data on the ethnic composition of a population. It is 20 years since the European Commission against Racism and Intolerance (ECRI) at the European Commission first recommended that ethnic data be collected to help implement policies to combat racism. Since then, many national and international organisations have stressed the importance of accurate EEM to evaluate the outcomes of policies and strategies to tackle discrimination against Travellers and Roma.

The United Kingdom is one of the few countries to have systemic EEM in place, with many other European countries slow to introduce EEM, often citing privacy, legal and moral issues as barriers. However, this report stresses that EEM data can be disaggregated and published in a manner that is appropriate and that protects the privacy of the individuals, but still provides useable data to inform policies and planning in order to provide appropriate services.

EEM is not a simple solution to eradicate discrimination. It is a powerful tool that can highlight areas of concern, specifically processes of inequality and discrimination which otherwise may go undetected (Wagman, 2002, p. 16).³

Despite this, EEM is not common practice among organisations in Ireland. The authors highlight section 42 of the Irish Human Rights and Equality Commission Act 2014,⁴ which instructs that public bodies 'have regard to the need to: (a) eliminate discrimination, (b) promote equality of opportunity and treatment of its staff and the persons to whom it provides services, and (c) protect the human rights of its members, staff and the persons to whom it provides services'. The report states that *without* accurate EEM, public bodies will not be able to demonstrate that they have met these obligations.

The report cites the national census, produced by the Central Statistics Office (CSO), and the National Drug Treatment Reporting System (NDTRS) as examples of good practice. The NDTRS has been recording ethnic identifiers since 2007. However, the report also states that often even the limited ethnic data available is not used to its full extent. While not unique to Ireland, the lack of EEM data inhibits the planning of effective services, monitoring access to them, and their outcomes.

Travellers and Roma themselves can be hesitant about disclosing their personal information for fear of discrimination and from lack of trust. However, research has shown that participation can be increased when the minority ethnic groups themselves are consulted and involved in the process of data collection itself from design, data collection and analysis. A participative and consultative approach has been shown to engender trust and increase participation in studies. Another barrier to EEM can be due to reluctance or discomfort on the part of the data collector to ask the question on ethnicity for fear of offending or from a lack of understanding the rationale for the question. This can be overcome with appropriate training, which should include cultural awareness and antiracism training.

Summary of recommendations

- 1 Ethnic equality monitoring should be endorsed, promoted and supported at a senior level within State agencies. There should be a campaign to inform people of the important, human rights rationale for collecting ethnic data.
- 2 A National Steering Committee with responsibility for developing and monitoring a comprehensive EEM framework to include all relevant stakeholders should be set up. This group should ensure that ethnic categories develop over time in consultation with the appropriate groups.

Ethnic data collection and monitoring continued

- 3 The national committee should develop an EEM strategy in consultation with ethnic groups, to incorporate key performance indicators, deadlines and sufficient funding for any actions.
- 4 All public sector organisations that collect data should provide training for staff in cultural awareness to enable them to collect ethnic data in an appropriate way and ensure that EEM is an integral part of the data collection process into the future.
- 5 Any State system or survey that collects routine data should include ethnic identifiers, using the standardised CSO classifications to ensure consistency. In particular, ethnic data should be disaggregated by gender to enable planning for appropriate services for minority women.

- 6 Timely, disaggregated data should be made readily accessible to all interested stakeholders biannually.
- 7 Resources should be available to enable collection of standardised ethnic data.

Suzi Lyons

- 1 Pavee Point Traveller and Roma Centre (2016) *Policy and practice in ethnic data collection and monitoring*. Dublin: Pavee Point Traveller and Roma Centre. <http://www.drugsandalcohol.ie/25325/>
- 2 See videos of the presentations made on the day at <http://www.paveepoint.ie/project/ethnic-data-monitoring-initiative/>
- 3 Wagman D (2002) Roma women in prisons. In Pavee Point (ed). *Traveller proofing: within an equality framework*. Dublin: Pavee Point Traveller and Roma Centre, pp. 15-17. <http://www.paveepoint.ie/wp-content/uploads/2013/11/Traveller-Proofing-Equality-Framework.pdf>
- 4 Irish Human Rights and Equality Commission (IHREC) Act (2014). Available online at <http://www.ihrec.ie/about/ihrec-act-2014.html>

LGBT service users and mental health risks

Irish research has shown that lesbian, gay, bisexual and transgender (LGBT) people, particularly younger people, are at greater risk of experiencing mental health problems than the general population. In order to increase awareness of these risks among mental health staff, the Gay and Lesbian Equality Network (GLEN) in consultation with the Mental Health Commission (MHC) developed a guidance document.¹ It aims to help mental health staff provide more inclusive services to LGBT service users. While not specifically addressing addiction issues, the guide is very relevant to staff working in addiction services.

The various steps needed to provide inclusive services to LGBT service users and their partners and families or chosen advocates are outlined in the document, which is available to download. Key considerations include the following:

- Most services have LGBT clients but their LGBT identity may or may not be related to the reason they are presenting to a service. Staff should not presume heterosexuality or predetermine a person's gender, and the language used and questions asked by staff should reflect this.
- Staff need to be familiar with the specific stressors and needs of LGBT clients, e.g. fear of coming out, isolation, lack of family support, homophobic bullying. Staff also need to be aware of the range of LGBT organisations that can support the specific needs of LGBT clients. Training can be provided for staff by LGBT organisations to facilitate this.

- To create a welcoming and inclusive environment, services should display LGBT posters where possible. LGBT issues should be included in the service ethos statement or equality policy, and in any service plans or evaluations.
- Partners and spouses of LGBT people should be included where possible and given the same consideration and rights as heterosexual partners or spouses.
- Service providers have a responsibility to ensure equal access to their service regardless of gender, sexual orientation, civil status, family status, age, disability, ethnicity, social class or religion. In order to measure equity of access, services need to monitor the ethnicity and sexual orientation of their clients. Guidance is available with regard to ethnic data collection, e.g., from Pavee Point,² and examples of how to frame questions regarding self-defined gender identity and sexual orientation are contained in the questionnaire used by the National Drug Treatment Reporting System (NDTRS).³

Suzi Lyons

- 1 Gay and Lesbian Equality Network (GLEN) (2013) *Lesbian, gay, bisexual and transgender service users: guidance for staff working in mental health services*. Dublin: GLEN. http://www.mhcirl.ie/File/LGBT_SU_Guide_for_staff.pdf
- 2 Pavee Point Traveller and Roma Centre (2016) *Policy and practice in ethnic data collection and monitoring: counting us in - human rights count!* Dublin: Pavee Point Traveller and Roma Centre. http://www.paveepoint.ie/wp-content/uploads/2016/04/Counting-Us-In-A4_WEB.pdf
- 3 Health Research Board (2016) *National Drug Treatment Reporting System Form*. For more information, visit <http://www.hrb.ie/health-information-in-house-research/alcohol-drugs/ndtrs/information-collected/>

Some key terms regarding LGBT service users

Sexual orientation refers to an enduring pattern of emotional, romantic and/or sexual attractions to men, women or both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviours and membership in a community of others who share those attractions. Three sexual orientations are commonly recognised - heterosexual, homosexual (gay and lesbian) and bisexual.

Gender identity refers to whether one feels male or female regardless of sex assigned at birth. Gender expression refers to outwardly expressing one's gender identity through mannerisms, grooming, physical characteristics, social interactions and speech.

Transgender is a term used to describe people whose gender identity or gender expression differs from the sex assigned to them at birth. Not everyone whose feelings, appearance or behaviour is gender-atypical will identify as a transgender person. Many transgender people live full-time or part-time in their preferred gender.

Transsexual refers to people whose gender identity is opposite to the sex assigned to them at birth. Transsexual people may seek medical interventions, such as hormones and surgery, to make their bodies fit as much as possible with their preferred gender. The process of changing from one gender to another is called transitioning. Biological females who wish to live and be recognised as men are called female-to-male (FTM) transsexuals or trans men. Biological males who wish to live and be recognised as women are called male-to-female (MTF) transsexuals or trans women. DSM-5 uses the term gender dysphoria instead of transsexual and this replaces the term gender identity disorder which was used in DSM-IV.

Disclosure: In Ireland the most common age at which LGBT people discover their LGBT identity is 12, and the most common age at which they first disclose this to anyone is 17. This indicates that for most there is a five-year period where LGBT young people conceal their identity from family and friends and this period coincides with puberty, school and a critical period of social, emotional and vocational development in their lives.

Source: Gay and Lesbian Equality Network (2013) *Lesbian, gay, bisexual and transgender service users: guidance for staff working in mental health services*. Dublin: GLEN

Mental health and well-being of LGBTI people

A report on the mental health and well-being of LGBTI (lesbian, gay, bisexual, transgender and intersex) people in Ireland was published on 22 March 2016.¹ The largest study of LGBTI people in Ireland to date and the first to incorporate intersex people, the research was commissioned by the Gay and Lesbian Equality Network (GLEN) and BeLonG To, funded by the National Office for Suicide Prevention and undertaken by a team at Trinity College Dublin.

In the past 25 years Ireland has made great legislative strides in achieving equality for its LGBTI citizens. Despite this progress, there is little evidence of similar progress regarding general attitudes to LGBTI people among the wider Irish population. The aim of this study, undertaken just before the same-sex marriage referendum in May 2015, was to fill this knowledge gap. The study comprised two modules: (1) to gain insight into the lives of LGBTI people, in particular young people, by examining factors which affect their mental health and well-being; and (2) to assess public attitudes towards LGBTI people and how these can impact on LGBTI people.

The selection criteria for inclusion in the first study module were any persons who lived in Ireland, identified as LGBTI, and over the age of 14. Participants were recruited mainly through social media, posters or by invitation through LGBT organisations. The vast majority completed the questionnaire online.

Module 1 findings

In total, 2,264 people met the inclusion criteria and had provided sufficient information to be included in the study. Of these, 3.6% identified as gay males, 26.5% as lesbian/gay females, 14.4% as bisexual, 12.3% as transgender, 6.3% other identity² and 2.0% as intersex.

Nearly three-quarters (72%) of participants were aged between 14 and 35 years, with a mean age of 29.6 years (range 14-71 years). Younger people were overrepresented in the study, perhaps due to the nature of the recruitment of participants mostly through social media. The study included participants from all counties of the Republic with almost half (49.6%) of participants living in Dublin. Over 80% of participants were in paid employment or education.

Self-esteem was gauged using the Rosenberg Self-Esteem Scale. Intersex, transgender and bisexual people had statistically significant lower self-esteem compared with gay males and lesbian/gay females. Younger age groups also had significantly lower self-esteem compared with their older counterparts. The life satisfaction and happiness of participants were also assessed, revealing that both improved with age. The mean scores for both satisfaction and happiness were lowest for transgender and intersex participants and highest for gay males.

The majority of participants reported incidents of verbal abuse, while 20% reported physical attacks. Participants recommended stronger legal protection and increased visibility of LGBTI identities as a means of reducing exposure to these risks. The results also showed that many LGBTI people experienced mental health issues, mainly depression, anxiety and substance misuse. Almost 60% of the sample seriously considered suicide, and one in five had attempted suicide. The mean age of those who had attempted suicide was 18.5 years (range 6-55 years).

Mental health and well-being of LGBTI people continued

Two-thirds of these people reported their suicide attempt(s) related to being LGBTI.

The Alcohol Use Disorders Identification Test (AUDIT) was used to measure alcohol use, where depending on the score the participant fell into one of four categories. These are: no alcohol problems (≤ 7); medium level alcohol problems (8–15); high level alcohol problems (16–19); and very high level alcohol problems (>20). The mean score in this study was 8.1 (range 1–33). Table 1 shows the mean audit scores by LGBTI group and age.

Table 1 Mean AUDIT scores by LGBTI group and age group

LGBTI group				
L	G	B	T	I
M=7.32 (n=455)	M=9.02 (n=710)	M=7.49 (n=241)	M=7.46 (n=185)	M=7.09 (n=35)
Age group				
14–18 years	19–25 years	26–35 years	36–45 years	46 years +
M=7.14 (n=204)	M=9.18 (n=486)	M=8.57 (n=446)	M=7.41 (n=290)	M=6.38 (n=197)

Source: Higgins *et al.* (2016)¹

Almost half (43.8%) of the AUDIT scores in the sample indicated some level of alcohol problem or dependence. This is however approximately 10% less than previously indicated in a study involving the general population. Long and Mongan (2014) found that more than half (54%) of the general population of 18–75-year-olds are classified as harmful drinkers.³

Over half (55.9%) of the participants had taken recreational drugs. This is higher than the rate of 27% found in the general population.⁴ Almost 30% (29.8%) of 14–18-year-olds had taken recreational drugs, while almost two-thirds (62.5%) of 19–25-year-olds had used recreational drugs. Cannabis, codeine-based drugs and MDMA/ecstasy were the three most commonly used drug types.

Module 2 findings

In order to gauge societal attitudes to LGBTI people in module 2, some 1,008 telephone interviews with the general public were conducted. This part of the study found mixed views among the general population. For example, 75% of participants believed that LGB people's sexual orientation was normal, 11% believed it was a phase that people would grow out of, while 17% believed that someone could be convinced to become LGB. A smaller proportion (56%) were uncomfortable with people who were transgender, perhaps due to a lack of understanding their identity. The general public were less comfortable with public displays of same-sex affection, e.g. 39% were uncomfortable with a male couple kissing in public compared with 17% for a heterosexual couple kissing in public.

While the vast majority of participants did not believe it was acceptable to discriminate against LGBTI people, 15% still believed using LGBTI slang words was not a major concern. This suggests that a section of society is unaware of the negative effects such slang can generate.

The public perception of what constitutes equal rights does not appear to match the views of the LGBTI community. One of the strongest findings from module 1 was the desire for normalisation and visibility of LGBTI relationships. However, the general population had noticeable levels of discomfort towards public displays of affection.

Recommendations

The report recommends seven strategies for achieving positive change for LGBTI:

- Reduce mental health risks and build resilience among LGBTI people.
- Support the LGBTI community to flourish.
- Protect and support LGBTI children and young people in schools.
- Increase public understanding and change attitudes and behaviours.
- Recognise the diverse needs within the LGBTI community.
- Build the knowledge and skills of professionals and service providers.
- Conduct further research and assess progress.

Derek O'Neill

- 1 Higgins A, Doyle L, Downes C, Murphy R, Sharek D, DeVries J, Begley T, McCann E, Sheerin F and Smyth S (2016) *The LGBTIreland Report: national study of the mental health and well-being of lesbian, gay, bisexual, transgender and intersex people in Ireland*. Dublin: Gay and Lesbian Equality Network (GLEN) and BeLonG To. <http://www.drugsandalcohol.ie/25323/>
- 2 Other identity: comprised participants who subscribed to another gender identity or sexual orientation outside of the LGBTI categories; see p. 39 of report.
- 3 Long J and Mongan D (2014) *Alcohol consumption in Ireland 2013: analysis of a national alcohol diary survey*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/22138/>
- 4 National Advisory Committee on Drugs (2011) *Drug use in Ireland and Northern Ireland: first results from the 2010/2011 drug prevalence survey. Bulletin 1*. Dublin: National Advisory Committee on Drugs and Public Health Information and Research Branch. <http://www.drugsandalcohol.ie/16353/>

UPDATES

Recent publications

The following abstracts are cited from published journal articles recently added to the repository of the HRB National Drugs Library at www.drugsandalcohol.ie

Estimating risk of alcohol dependence using empirically validated ordinal risk zones versus recommended binary risk zones of the RAPS4: a validation study using stratum-specific likelihood ratio analysis

Cousins G, Mongan D, Barry J, Smyth B, Rackard M and Long J (2016) *Alcoholism Clinical and Experimental Research* 40(8): 1700–1706
<http://www.drugsandalcohol.ie/25734/>

Effective treatment options for alcohol dependence exist; yet, only 10% of people with alcohol dependence receive treatment. The objective of the current study was to examine the performance of previously recommended Rapid Alcohol Problem Screen 4 (RAPS4) risk zones, based on single binary cut-points (RAPS4 ≥ 1 ; RAPS4 ≥ 2), and empirically identified RAPS4 risk zones to identify people with alcohol dependence so that further diagnostic assessment or interventions can be offered.

Stratum-specific likelihood ratio (SSLR) and receiver operating characteristic analyses were used to compare the screening performance of empirically identified 'risk zones' on the RAPS4 to previously recommended binary cut-points in a general population sample of current drinkers in Ireland (N=4,267). SSLRs were also used along with the pretest prevalence of alcohol dependence to estimate posttest probabilities of alcohol dependence for the recommended and empirically identified risk zones.

The weighted prevalence estimate of alcohol dependence among current drinkers was 6.9% (9.3% men; 4.5% women). The SSLR analysis identified multiple risk zones in the RAPS4, with each of the individual scores (0, 1, 2, 3, 4) retained as 5 separate ordinal risk zones for both men and women.

A comparison of the area under the receiver operating characteristic curve showed that the ordinal RAPS4 risk zones performed better than recommended binary thresholds for both men and women. Based on the pretest probability of 9.3% and the identified SSLRs for the ordinal risk zones, the posttest probability of alcohol dependence for men ranged from 1.6% for those in the lower risk zone (RAPS4 = 0) to 86.7% for those in the highest risk zone (RAPS4 = 4). The posttest probability of alcohol dependence for women ranged from 0.4% for those in the lower risk zone to 80% for those in the higher risk zone.

The detection of alcohol dependence may be improved using the empirically identified ordinal RAPS4 risk zones for both men and women. The application of the identified SSLRs, particularly if integrated into a clinical decision support system, may be helpful for clinicians in providing feedback to patients regarding their risk of alcohol dependence.

General Practitioner perspectives on and attitudes toward the methadone treatment programme in Ireland

Delargy I, O'Shea MT, Van Hout MC and Collins C (2016) *Heroin Addiction and Related Clinical Problems* 18(4): 43–50
<http://www.drugsandalcohol.ie/25746/>

A report on this study is presented in this issue of *Drugnet Ireland* on page 18.

Parents who use drugs: the well-being of parent and child dyads among people receiving harm reduction interventions for opiate use

Comiskey C, Milnes J and Daly M (2016) *Journal of Substance Use* Early online.
<http://www.drugsandalcohol.ie/25731/>

This article provides baseline measurement of health outcomes for parent and child dyads among people receiving interventions for opiate use. A cohort study was implemented among 171 participants with 235 children in three urban sites in Ireland in 2010/11. Adult and child outcomes were measured using the Short Form 12, the Becks Depression and Anxiety Inventories, the Strength and Difficulties Questionnaire and the Kidscreen 27.

Over 60% of adult participants grew up in a household with at least one person who used substances.

The main substance used was alcohol followed by heroin. A correlation was found between increasing adult anxiety and growing up in a home with a person using substances. Children of current parents had more difficulties with emotional and conduct problems, as compared to international norms. Correlations existed between current parental depression and anxiety and child conduct disorder. Parents who use drugs are part of the so-called 'sandwich generation'. Monitoring and evaluation of interventions that address outcomes across generations of parental and child dyads are lacking.

What is known about community pharmacy supply of naloxone? A scoping review

Nielsen S and Van Hout MC (2016) *The International Journal of Drug Policy* 32(1): 24–33
<http://www.drugsandalcohol.ie/25729/>

There is growing evidence that expanded supply of take-home naloxone to prevent opioid overdose deaths is needed. Potential routes for expansion of naloxone provision include through community pharmacies.

The aim of this scoping review is to establish what is known about community pharmacy supply of naloxone, in light of unique challenges and opportunities present in pharmacy settings. A scoping review methodology was employed using the six stage iterative process advocated by Arksey and O'Malley (2005) and Levac *et al.* (2010). Searches used key words and terms such as 'naloxone'; 'overdose prevention/drug overdose/opiate overdose'; 'community/retail pharmacy'; 'pharmacist/pharmacy/community pharmacy/pharmaceutical services'; 'professional practice/role'; 'community care'; 'attitude of health personnel'; 'training/supply/cost'. Appropriate search terms were selected for each database. After initial exploratory searches, comprehensive searches were conducted with Cochrane Database of Systematic Reviews, Medline, Medline in Process, Embase, PsycINFO and CINAHL. Eligibility criteria centered on whether studies broadly described supply of naloxone in community pharmacy or had content relating to community pharmacy supply. The search identified 95 articles, of which 16 were related to pharmacy supply of naloxone.

Recent publications continued

Five themes were presented after initial review of the data and consultation with the project Expert Group, and are: 'Pharmacists Perceptions of Naloxone: Facilitators and Barriers', 'Patient Populations: Identification and Recruitment', 'Supply Systems and Cost', 'Legal Issues', and 'Training of Pharmacists and Community Pharmacy Naloxone Recipients'. Findings from this scoping review suggest that the community pharmacy based route for distribution of take home naloxone provision warrants further consideration and development. Existing strengths include a range of established supply models, and training curricula, few direct concerns regarding legal liability of pharmacists in the supply of naloxone (once legal supply systems have been established) and the wide range of potential identifiable patient populations, which include pain patients that may not be in contact with existing naloxone supply programmes.

How do we compare with best practice? A completed audit of benzodiazepine and z-hypnotic prescribing

Rowntree R, Sweeney J, Crumlish N and Flynn G (2016) *Irish Journal of Psychological Medicine*
Early online.
<http://www.drugsandalcohol.ie/25715/>

The objective of this study was to compare benzodiazepine and z-hypnotic prescribing practices in an inpatient psychiatric unit to best practice standards. Medication charts of all inpatients in the psychiatric unit, over a 1-week period, were reviewed. Details of current benzodiazepine and z-hypnotic prescriptions were collected. Information collected included the substance prescribed, duration and administration instructions. Feedback was communicated to medical practitioners through a presentation and email. A re-audit was completed 4 months later.

There were increases in total benzodiazepine and z-hypnotic prescribing despite intervention. A reduction of 2mg occurred in the mean regular dose of benzodiazepine prescribed. Lorazepam was the most prescribed benzodiazepine throughout. In both data sets, at least 50% of regular z-hypnotics and benzodiazepines were initiated before admission.

There was an increase of 14% in regular benzodiazepines initiated in hospital exceeding 4 weeks in duration. In neither data collection did regular z-hypnotics initiated in hospital exceed this cut off. A greater number of individuals were in the process of being withdrawn from regular benzodiazepine or z-hypnotic prescriptions in the re-audit. There were minimal improvements in 'as required' prescribing as regards documentation of an indication, time limit and maximum dose.

The increase in overall prescribing, despite intervention, maybe because these medications continued to be indicated in the acute presentations needing inpatient treatment. The small improvements in 'as required' prescribing patterns suggest that the intervention was limited in effecting change in this area.

Socioeconomic differentials in mortality by cause of death in the Republic of Ireland, 1984-2008

Layte R and Banks J (2016) *European Journal of Public Health* 26(3): 451-8
<http://www.drugsandalcohol.ie/25660/>

This paper provides an analysis of relative and absolute trends in mortality by cause of death and socioeconomic group (SEG) from 1984 to 2008 among men and active women aged 30-64 years in Ireland and compares these results with recent European and US studies to give an overview of trends.

Mortality data from the Irish Central Statistics Office from 1984 to 2008 were used to calculate standardized death rates by age, sex, socioeconomic status and cause of death showing trends in SEG inequalities in mortality in Ireland. These show which specific causes of death are driving all-cause mortality trends.

SEG differentials in all-cause mortality among men and women have been increasing since the 1980s. Some of this increase reflects larger falls in cardiovascular causes among advantaged groups, but the trend is largely accounted for by increasing inequalities in mortality in digestive, neoplasm and external causes of deaths.

These findings are in line with international findings that show that socioeconomic differentials in digestive, neoplasm and external cause deaths are driving general

socioeconomic differentials in all-cause mortality. External cause deaths may have been influenced by levels of economic activity, particularly in construction, during the economic boom among manual workers. Furthermore, deaths from digestive diseases during the 1990s and 2000s may well be the result of increases in liver disease associated with excessive alcohol consumption.

'Trip-sitting' in the black hole: a netnographic study of dissociation and indigenous harm reduction

Hearne E and Van Hout MC (2016) *Journal of Psychoactive Drugs*
Early online.
<http://www.drugsandalcohol.ie/25845/>

An array of dissociative novel psychoactive substances, including 'methoxetamine', '3-MeO-PCP', and 'methoxphenidine', have emerged as substitutes for the illicit substance 'ketamine'. A netnographic research methodology aimed to describe online, dissociative novel psychoactive substance users' perceptions of risk, informed knowledge around use, and indigenous harm-reduction practices as advocated within online drug fora, so as to provide credible information which can be used to inform public online health education and drug prevention. Systematic Internet searches were performed using the terms 'synthetic dissociative', 'methoxetamine', 'methoxphenidine', 'diphenidine', '3-MeO-PCP', '4-MeO-PCP', '2-MDP', and 'dissociative research chemical' in combination with 'forum'. Following screening of 3,476 forum threads with removal of duplicates and exclusion criteria, 90 user trip reports and 115 fora threads from seven drug fora websites were analyzed by conducting content analysis. Five themes emerged with 43 categories. The findings illustrated how forum activity within the cyber drug user community disseminated and exchanged 'communal folk pharmacology' relating to the use of dissociative novel psychoactive substances. Further research and consistent monitoring of Internet drug fora are advised to explore variations in harm-reduction tactics throughout dissociative NPS populations, and to consider how existing harm-reduction initiatives are influencing these hard-to-reach groups.

Recent publications continued

The changing landscape of Irish Traveller alcohol and drug use

Van Hout MC and Hearne E (2016)

Drugs: Education, Prevention and Policy

Early online.

<http://www.drugsandalcohol.ie/25843/>

The aim of this commentary is to illustrate how the changing social situation and fragmentation of Traveller culture overtime which once offered resilience and protection against alcohol and drug abuse has contributed to a rise in associated problems and addiction within Traveller communities in Ireland. We present here extant available literature on this issue.

Forensic analysis of P2P derived amphetamine synthesis impurities: identification and characterization of indene by-products

Power JD *et al.* (2016) *Drug Testing and Analysis*

Early online.

<http://www.drugsandalcohol.ie/25869/>

1-Phenyl-2-propanone (P2P) is an internationally monitored precursor that has become increasingly difficult for illicit amphetamine producers to source, which means that alternative routes to its preparation have become increasingly important. One such approach includes the hydrolysis of alpha-phenylacetone nitrile (APAAN) with sulfuric acid. Previously, we reported the identification of 4,6-dimethyl-3,5-diphenylpyrid-2-one following implementation of hydrolysis conditions and it was proposed that this compound might serve as one route specific by-product in the APAAN to P2P conversion.

This study continued to explore the presence of impurities formed during this conversion and expanded also into a second route of P2P synthesis starting from alpha-methylstyrene (AMS). All P2P products underwent the Leuckart procedure to probe the presence of P2P-related impurities that might have carried through to the final product. Two by-products associated with the APAAN hydrolysis route to P2P were identified as 2,3-diacetyl-2,3-diphenylsuccinonitrile (1) and 2-methyl-1-phenyl-1,3-dicarbonitrile-1H-indene (2), respectively. Two by-products associated with the AMS route to P2P and subsequent Leuckart reaction were 1,1,3-trimethyl-3-phenyl-2,3-dihydro-1H-indene (3) and 1-phenyl-N-(phenylethyl)propan-2-amine (4), respectively.

The two indenes (2 and 3) identified in synthesized amphetamine originating from P2P suggested that it might be possible to differentiate between the two synthetic routes regarding the use of APAAN and AMS. Furthermore, the association of these compounds with amphetamine production appears to have been reported for the first time. The presence of compounds 1-4 in seized amphetamine samples and waste products could facilitate the suggestion whether APAAN or AMS were employed in the synthesis route to the P2P.

Buprenorphine-naloxone in the treatment of codeine dependence: a scoping review of clinical case presentations

Van Hout MC, Hearne E and Bergin M

(2016) *International Journal of Mental Health and Addiction*

Early online.

<http://www.drugsandalcohol.ie/25842/>

Misuse of prescribed and over the counter (OTC) codeine containing medicines is an increasing public health concern in recent times. Studies have called for low threshold treatment services for individuals experiencing codeine dependence using buprenorphine naloxone therapy. We present a scoping review of clinical case presentation literature on the use of buprenorphine-naloxone in the treatment of codeine dependence. Seven records (four single case studies and three case series) on codeine dependence treated with buprenorphine-naloxone were included. Five themes emerged following a review of the cases for the treatment of codeine dependence with buprenorphine-naloxone. They are: (1) Patient Profiles; (2) History of Codeine Misuse; (3) Medical Problems; (4) Use of Other Substances; and (5) Buprenorphine-naloxone in the treatment of Codeine Dependence. The review highlights the complexities of patients with regards to pain, psychiatric illness, poly substance use and iatrogenic dependence, with findings encouraging in terms of patient stabilisation and recovery.

Test purchase, synthesis, and characterization of 2-methoxydiphenidine (MXP) and differentiation from its meta- and para-substituted isomers

McLaughlin G *et al.* (2016) *Drug Testing and Analysis* 8(1): 98-109

<http://www.drugsandalcohol.ie/25870/>

The structurally diverse nature of the 1,2-diphenylethylamine template provides access to a range of substances for drug discovery work but some have attracted attention as 'research chemicals'. The most recent examples include diphenidine, i.e. 1-(1,2-diphenylethyl)piperidine and 2-methoxydiphenidine, i.e. 1-[1-(2-methoxyphenyl)-2-phenylethyl]piperidine (MXP, methoxyphenidine, 2-MXP) that have been associated with uncompetitive N-methyl-D-aspartate (NMDA) receptor antagonist activity. Analytical challenges encountered during chemical analysis include the presence of positional isomers. Three powdered samples suspected to contain 2-MXP were obtained from three Internet retailers in the United Kingdom and subjected to analytical characterization by gas chromatography (GC) and high performance liquid chromatography (HPLC) coupled to various forms of mass spectrometry (MS). Nuclear magnetic resonance spectroscopy, infrared spectroscopy and thin layer chromatography were also employed.

This was supported by the synthesis of all three isomers (2-, 3- and 4-MXP) by two different synthetic routes. The analytical data obtained for the three purchased samples were consistent with the synthesized 2-MXP standard and the differentiation between the isomers was possible. Distinct stability differences were observed for all three isomers during in-source collision-induced dissociation of the protonated molecule when employing detection under HPLC selected-ion monitoring detection, which added to the ability to differentiate between them. Furthermore, the analysis of a 2-MXP tablet by matrix assisted inlet ionization Orbitrap mass spectrometry confirmed that it was possible to detect the protonated molecule of 2-MXP directly from the tablet surface following addition of 3-nitrobenzotrile as the matrix.

Recent publications continued

A typology of alcohol consumption among young people: a narrative synthesis

Davoren MP *et al.* (2016)

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.

User experiences of development of dependence on the synthetic cannabinoids, 5f-AKB48 and 5F-PB-22, and subsequent withdrawal syndromes

Van Hout MC and Hearne E (2016)

International Journal of Mental Health and Addiction

Early online.

<http://www.drugsandalcohol.ie/25835/>

Emergence of synthetic cannabinoids (SCBs) in herbal smoking mixtures is a public health concern. New SCB's such as 5f-AKB48 and 5F-PB-22 have been detected in French seizures and in sudden death post mortems in the US. The aim was to describe development of dependence on herbal smoking mixtures containing the SCB's, 5f-AKB48 and 5F-PB-22 and subsequent withdrawal syndromes. Dependent users of herbal smoking mixtures known to contain the SCB's 5f-AKB48 and 5F-PB-22 with an average Severity of Dependence Score (SDS) of 13 were interviewed using a structured guide (three males/three females). Narratives were analysed using the Empirical Phenomenological Psychological (EPP) five step method. Six themes with 68 categories emerged from the analysis. Themes are illustrated as 1) Networks and Product Availability; 2) Drivers and Motives for Use; 3) Effect and Pathways toward Dependence; 4) Poly Substance Use and Comparisons to Natural Cannabis; 5) Dependence and Withdrawal and 6) Self-detoxification Attempts. Two higher levels of abstraction above these theme-levels emerged from the data, with sole use of herbal smoking mixtures containing 5f-AKB48 and 5F-PB-22 centering on the interplay between intense cravings, compulsive all-consuming seeking, use and re-dose behaviours, and fear of the psychiatric and self-harms caused when in withdrawal. This is the first study describing dependence and withdrawal experiences in users dependent on 5f-AKB48 and 5F-PB-22. Given the potential for adverse psychiatric and physical consequences of dependent use, further development of specific clinical responses and clinical research around toxicity and withdrawal severity are warranted.

Prevalence and risk factors for Hepatitis C viral infection amongst a cohort of Irish drug users attending a drug treatment centre for Agonist Opioid Treatment (AOT)

Keegan D, Crowley D, Laird E and

Van Hout MC (2016) *Heroin Addiction and Related Clinical Problems*

Early online.

<http://www.drugsandalcohol.ie/25815/>

Injecting drug use (IDU) is a major driver of the European hepatitis C virus (HCV) epidemic. National data on prevalence of HCV amongst Irish drug users remains confined to certain treatment sites and prison settings. The aim of the study was to examine the prevalence of HCV infection and risk factors associated with infection among the 228 patients attending Opioid Substitution Treatment (OST) in a clinic in Dublin.

A retrospective cross-sectional study was conducted using data collected from Health Research Board (HRB) forms and standardised written and electronic assessment forms routinely completed on OST initiation. The prevalence of HCV infection was 63.6% (n=145) with no significant gender difference (p=0.717). Patients who were infected with HCV were older than those uninfected (41.1 ± 7.5 years versus 37.5 ± 8.5 years; p=0.001), with prevalence significantly lower in younger adults (p=0.002). Multivariate analysis identified age of first drug use (p=0.002) and first injection (p=0.001), type of first drug used; cannabis (p=0.015), heroin (p=0.014) and cocaine (p=0.018) and early age of OST entry (p=0.001) as the most significant risk factors for HCV infection in this cohort. Those with no IDU had decreased odds of being HCV positive by 91.1%. Data for this Irish sample indicates high prevalence of HCV infection, and the need to consider age of first drug onset and injecting use, particular drug types and earlier commencement of OST to inform targeted HCV treatment and prevention interventions in Ireland.

Drugnet Ireland is the quarterly newsletter of Ireland's focal point for the EMCDDA and is produced in collaboration with the HRB National Drugs Library. *Drugnet Ireland* is published by the Health Research Board.

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