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In this issue

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Drug-related deaths and deaths among drug users in Ireland: 2004–2014

The latest figures from the National Drug-Related Deaths Index (NDRDI) show that a total of 697 deaths in Ireland during 2014 were linked to drug use.[1] The NDRDI reports on poisoning deaths (also known as overdose), which are due to the toxic effect of a drug or combination of drugs, and on non-poisonings, which are deaths among people who use drugs as a result of trauma such as hanging, or medical reasons such as cardiac events.
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Sadie Grace, coordinator of the National Family Support Network, at the 18th Annual Service of Commemoration and Hope (see page 24)

HRB Health Research Board

Research. Evidence. Action.

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The policy, research and other documents covered in this issue of *Drugnet Ireland* have all been retrieved by the HRB National Drugs Library and may be accessed on its website **www.drugsandalcohol.ie**

In brief

While drugs policy in many countries moved decisively in a harm reduction direction in response to the threat of HIV/AIDS during the 1980s and 1990s, demand reduction has remained an important pillar in national policies. The emphasis that these policies place on demand reduction activities such as prevention and recovery, the subjects of a number of articles in this issue, is probably due more to support from the general public and policy-makers than to the availability of the type of high-quality evidence underpinning harm reduction practice.

The prevention of substance misuse by young people, or actions that can help delay or reduce such activity, is an essential part of any overall strategy to reduce substance-related harm. Yet, demonstrating the effectiveness of prevention interventions is problematic, as the non-occurrence of an event is the intended outcomes of such interventions. Similarly, while most English-speaking countries have adopted recovery-focused drugs policies, the recovery field has not yet built a body of evidence approaching that which supports more conventional interventions such as substitution treatment or needle exchange.

Despite the strength of the science underpinning harm reduction interventions, the approach has been criticised by those who seek more ambitious outcomes than stabilisation and retention in treatment. Recent data on drug-related deaths, presented in this issue's cover story, demonstrate that the level of mortality from both drug overdose and drug-related medical causes has changed little over the past few years. Opiate prevalence and the numbers in long-term treatment for opiate misuse remain high, giving some weight to the critique of harm reduction from the recovery perspective.

Recovery advocates emphasise the role of the individual in overcoming his or her dependency and the social context in which this dependency and recovery from it develops. There is a place for harm reduction and clinically supported treatments, but community-based groups, abstinence-based therapies, peer-led support and mutual aid all have roles to play in overcoming dependence. Recovery-focused strategies continue to support well-run and effective harm reduction interventions, but are pluralist in regard to the approaches to deal with or prevent the problems associated with dependency. Greater public understanding of the nature of effective demand reduction work, and willingness to provide resources to study it, may present the opportunity to evaluate this work more effectively in the coming years and develop the evidence base underpinning prevention, recovery and other demand reduction responses.

NDRDI data, 2004–2014 continued

In the 11-year period from 2004 to 2014 inclusive, a total of 6697 deaths by drug poisoning and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 3864 (58%) were due to poisoning and 2833 (42%) were deaths among drug users (non-poisoning) (Table 1). There were 697 deaths in 2014, similar to the number reported in 2013 (698). Many of these deaths were premature, with half of all deaths in 2014 aged 39 years or younger. Three in four (523) of all deaths in 2014 were male.

Some key findings of the report:

- Prescription drugs were implicated in 259 or three in every four poisonings during 2014.
- Two hundred and thirty-five (n=235) or two in every three people died in 2014 because they took a mixture of drugs, with an average of four drugs involved.
- Benzodiazepines were the most common drug group involved in polydrug deaths.
- Notwithstanding a small decrease in alcohol poisonings, alcohol is still implicated in one-in-three deaths and remains the single most common drug implicated in deaths over the reporting period 2004–2014.
- Opiates were the main drug group implicated in poisonings.
- Hanging was the main cause of non-poisoning deaths. There was a 21% increase in deaths due to hanging between 2013 and 2014.

Poisoning deaths in 2014

The annual number of poisoning deaths decreased by 11%, from 397 in 2013 to 354 in 2014 (Table 1). As in previous years, the majority (72%) were male. The median age of those who died was 39 years, again similar to previous years.

Prescription drugs were implicated in 259 or three in every four poisoning deaths:

- Benzodiazepines were the most common prescription drug group implicated.
- Diazepam (a benzodiazepine) was the most common single prescription drug, implicated in 115 (32%) of all poisoning deaths.
- Methadone was implicated in more than one-quarter of poisonings (n=98, 28%).
- Zopiclone-related deaths (a non-benzodiazepine sedative drug) increased by 41% from 51 in 2013 to 72 in 2014.

Table 1: Number of deaths, by year, NDRDI 2004–2014 (N=6697)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
All deaths	431	503	554	620	628	656	607	643	660	698	697
Poisonings (3864)	266	301	326	387	386	372	340	377	358	397	354
Non-poisonings (2833)	165	202	228	233	242	284	267	266	302	301	343

Figure 1: Infographic of prescription drugs implicated in deaths

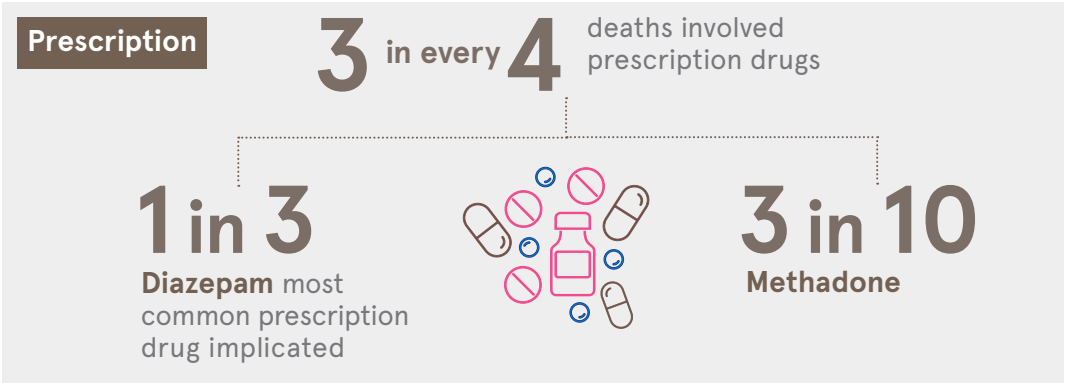
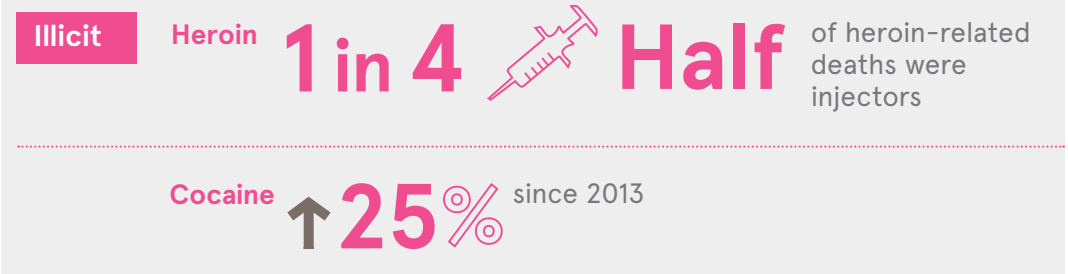
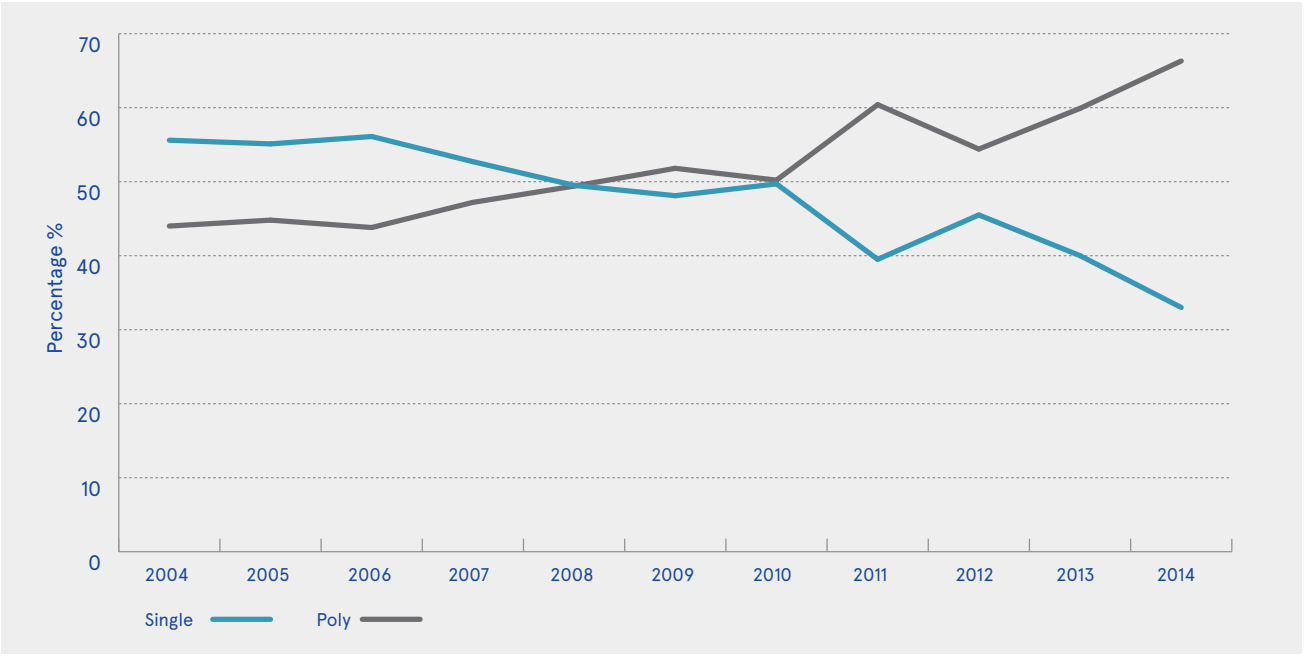


Figure 2: Infographic of illicit drugs implicated in deaths



NDRDI data, 2004-2014 continued

Figure 3: Evolution of polydrug poisonings, NDRDI 2004–2014 (N=3864)



Alcohol continues to be the single most common drug implicated over the reporting period. Alcohol was implicated in one-in-three of all poisonings, and alcohol alone was responsible for 13% of all poisoning deaths.

The number of deaths where illicit drugs were implicated increased:

- Heroin was implicated in one-in-four (n=90) deaths and 42% of these people were not alone at the time of the incident that led to their deaths.
- Cocaine-related deaths increased by 25% from 32 in 2013 to 40 in 2014.
- MDMA-related deaths continue to increase from less than 5 in 2010 to 15 in 2014.

Polydrug poisoning deaths

Polydrug use is a significant risk factor for fatal overdose. In 2004, 44% or 118 deaths were due to a cocktail of drugs, with an average of two drugs taken. In 2014, this had risen to 66% or 235 deaths, with an average of four different drugs taken (Figure 3):

- 59% of deaths where alcohol was implicated involved other drugs, mainly opiates.
- 92% of deaths where methadone was implicated involved other drugs, mainly benzodiazepines.
- 81% of deaths where heroin was implicated involved other drugs, mainly benzodiazepines.
- Almost all deaths (98%) where cocaine was implicated involved other drugs.

Non-poisoning deaths in 2014

The number of non-poisoning deaths increased by 14% from 301 in 2013 to 343 in 2014. Non-poisoning deaths are categorised as being due to either trauma (n=177) or medical causes (n=116).

- The main causes of non-poisoning deaths were hanging (27%) and cardiac events (15%).
- There was a 21% increase in deaths due to hanging between 2013 and 2014.
- More than two-thirds (67%) of people who died as a result of hanging had a history of mental health illness.

Ena Lynn

1 Health Research Board (2016) *National Drug-Related Deaths Index 2004 to 2014 data*. Dublin: Health Research Board. http:// www.drugsandalcohol.ie/26299

A number of infographics that outline key data are also available for download at http://www.drugsandalcohol.ie/26299 and http://www.hrb.ie/publications

POLICY AND LEGISLATION

Implementing a health-led approach to drug use — what does it mean?

In the Programme for Government published in May 2016, a commitment was made to 'support a health-led rather than criminal justice approach to drug use' (p. 56).[1] On 17 November 2016, CityWide Drugs Crisis Campaign held a seminar to explore what this commitment means in practice and what implementing such an approach in Ireland would involve. Decriminalising the possession of drug use was at the core of much of the discussion. There were presentations from three key speakers:[2] Ann Fordham, executive director of the International Drug Policy Consortium (IDPC); Niamh Eastwood, executive director of Release;[3] and, Aileen O'Gorman, sociologist and senior lecturer at the University of the West of Scotland.

World drug policy

Ann Fordham's presentation focused on the United Nations General Assembly Special Session (UNGASS) on the world drug problem, held in April 2016. She emphasised the move towards a much more health-led approach to drug policy in a number of countries and regions, which had manifested itself in decriminalisation and legalisation in some cases. Despite having grave reservations about UNGASS and its outcome document, she identified important progress made on a range of issues, including health, human rights, gender, and development.[4]

Decriminalisation

Niamh Eastwood's presentation, 'Decriminalisation, Moving the Debate On, Dispelling the Myths', made the case for the removal of criminal sanctions for the possession of drugs, i.e. decriminalisation. She presented evidence to debunk what she saw as two key myths in the decriminalisation debate: 'criminal justice responses and criminalisation deters drug use'; and, 'decriminalisation sends a "message" [that] drug use is ok'. Eastwood argued that reducing harms should be the primary goal of drug policy.

When noting both the number of drug-related deaths and recorded drug possession offences in Ireland, she emphasised the associated harms of both to the individual user, their families, and the wider community. The positive social and economic impacts of decriminalisation in Portugal, California and some areas of Australia were discussed to illustrate the benefits of decriminalisation. In terms of the practicalities of implementing decriminalisation, three elements that would need to be addressed by any associated policy or legislation were discussed in an international context. These were: the threshold quantity to determine personal possession; the role of the decision-makers, such as police or service providers, in assessing the quantity and the relevant course of action; and, any sanctions for those found to be in possession of a drug.

Social inclusion pillar

Aileen O'Gorman made the case for a social inclusion pillar in the forthcoming National Drugs Strategy (NDS). She spoke about how in Ireland drug use disproportionally harms people who also experience a range of problems rooted in poverty and inequality. Since the start of the economic downturn in 2008, these groups had been particularly vulnerable to what she termed 'policy induced losses'. These are the negative outcomes experienced by people as result of changes to local and national policy or a lack thereof. She argued that 'a health-led approach to drug use would provide an opportunity to address the social and structural determinants of drug-related harm'. There are a number of advantages of including a social inclusion pillar as part of the forthcoming NDS. For example, it could include a requirement that other public policies be 'drug proofed'. This would mean that policies in other areas, such as education and housing, would have to be assessed to ensure that they would not impact negatively on drug-related harms.

Lucy Dillon

1 Department of the Taoiseach (2016) *A Programme for a Partnership Government*. Dublin: Government Publications Office. Available at http://www.drugsandalcohol.ie/25508/

2 The three presentations are available at http://www.drugsandalcohol.ie/26491/

3 Release is a UK-based charitable organisation that is a 'national centre of expertise on drugs and drugs law'. http://www.release.org.uk/about

4 A summary of the IDPC's written response to UNGASS, on which this presentation was based, is available in issue 60 of *Drugnet Ireland*. http://www.drugsandalcohol.ie/26701/

Regenerating Dublin's North East Inner City

In June 2016, a Ministerial Taskforce chaired by An Taoiseach was established to support the long-term economic and social regeneration of Dublin's North East Inner City (NEIC). This was in response to a series of murders in the area which were linked to an ongoing feud between criminal gangs involved in the drugs trade and other criminal activities.

The taskforce appointed Kieran Mulvey, former chairman of the Labour Court, to prepare a report to inform this regeneration. Among the terms of reference were that Mulvey would 'recommend specific measures which would support the long-term economic and social regeneration of the area, with a ten year timeframe' (p. 6).

On 16 February 2017, *'Creating a brighter future': an outline plan for the social and economic regeneration of Dublin's North East Inner City* was published.[1]

Regenerating Dublin's North East Inner City continued

The North East Inner City

In 2011, the North East Inner City had a population of 17 580 spread across 6788 households. The report presents a picture of an area 'steeped in history' and which has a 'vibrant community'. However, it is also an area facing significant challenges in terms of social, economic, and environmental deprivation, as well as the effects of intergenerational drug use and criminal activity. Furthermore, there are high levels of 'variability' within the area. On the one hand, there are highly educated and skilled professionals living in good-quality housing in 'gated' communities, while on the other hand, parts of the community experience high levels of social deprivation characterised by low levels of educational attainment, high levels of unemployment, and poor housing. The National Economic and Social Council provided a 'view' of the NEIC and emphasised that this variability challenges the idea that 'deprivation in an area will be addressed by just attracting more investment and more (middle and upper class) workers' (p. 19). Instead, they argue, this sense of very separate 'communities' in an area tends to accentuate the sense and awareness of inequality within the community. The author summarises his view of the NEIC as being 'a community rich in assets which is not reaching its potential' (p. 15).

Place- and people-based regeneration

Extensive consultation with a wide range of stakeholders was carried out as well as a rapid review of the evidence of what has worked both nationally and internationally in terms of regeneration. The author outlines a plan for the area's regeneration that is grounded in a combination of place- and people-based approaches. 'Place-based' interventions or policies address the area's needs in terms of housing, crime, and the physical environment; 'people-based' interventions or policies address the population's needs in terms of health, education, and community participation.

Vision, guiding principles and recommendations

The vision for the outline plan is 'making the NEIC a safe, attractive and vibrant living and working environment for the community and its families with opportunities for all to lead full lives' (p. 24). To deliver on this, the author outlines specific structures and processes that should be put in place. The plan will also need to be guided by a set of core principles. It should be inclusive and take a whole community approach; present a revised narrative for the area and its identity; acknowledge that 'more of the same' is not the answer; take a tailored evidence-based approach; be locally led and community driven; and be well-connected to existing structures and policies. A number of recommendations were also made for what is required to underpin the plan's delivery, including:

- While regenerating the area will require a long-term plan, 'clear ambition' must be apparent at the outset to deliver on a number of priority actions in the first three years (2017-2020).
- There must be ongoing Government commitment to the regeneration for a minimum of 10 years.
- There will need to be a dedicated funding programme approved by Government.
- An independent executive chair should be appointed immediately to establish the necessary delivery structures and to develop and progress a detailed implementation plan.
- Progress in delivering on the project plan and any associated impact should be monitored on an ongoing basis. Baseline data linked to specific outcomes will need to be developed early on and a clear reporting structure implemented.

Key priority areas

To deliver on the plan's vision, Mulvey identified four key areas for priority action over the next three years. These are summarised in the report as follows:

> **A. Tackling Crime and Drugs:**
> Better and more visible policing with an emphasis on community policing needs to be [a] key feature in the Plan. It must be 'safe' to lead; it must be 'safe' to live, work, learn and play in the community.
>
> **B. Maximising Educational/Training Opportunities/ Creating Local Employment Opportunities:**
> There needs to be significant enhancement of the linkages between education and employment opportunity for this current generation of schoolgoers, young adults and the unemployed in local businesses and enterprises, particularly in the business/retail area of the inner city and in the Docklands Development – both in construction and business occupation stages.
>
> **C. Creating an Integrated System of Social Services:**
> Social, educational and training services to address the real problems faced by families and their children need to be planned and delivered in a far more coordinated fashion. Services should be coordinated under a single plan which is in response to the particular needs and circumstances of different communities within the area.
>
> **D. Improving the Physical Landscape:**
> The area has some of the broadest streets in the city with potential for refurbishment and revitalisation. Future regeneration needs to explore the potential within the area to renovate, make it liveable and bright with improved physical landscape; to eliminate waste, derelict sites and progress the refurbishment and replacement of the existing flat complexes. (p. 25)

Each of these priority areas is explored in detail in the report and a set of outcomes and outputs with relevant actions is laid out. A recurring theme throughout is the need for clear leadership to deliver on each priority action area to ensure a more integrated, aligned, cohesive and coordinated approach to service delivery. Mulvey argues that there has already been substantial financial investment in the area and that, while more is required, inadequate funding is not the only reason why services are not delivering for the community. Tackling the structural and coordination issues that are preventing current investment from achieving the best possible outcomes for the community across the priority areas is central to delivering on the plan. He also outlines the governance structures that need to be put in place to support the regeneration.

Regenerating Dublin's North East Inner City continued

In launching the report, Taoiseach Enda Kenny expressed the Government's ongoing support for the plan. He referred to the implementation structures and processes outlined in the report as key: 'There is a vital need to ensure there are no more "false dawns" for this community. If we want to make this happen for real this time, we need community engagement and support as a prerequisite.

The structures and processes that Kieran has proposed have that at their heart.' He also confirmed that the Ministerial Taskforce and Senior Officials Group chaired by the secretary general of the Department would maintain an ongoing oversight role. He said that 'this level of oversight has never happened before for an area-based project like this. We have to successfully harness the expertise and learning to make these types of initiatives work'.

Lucy Dillon

1 Mulvey K (2017) *'Creating a brighter future': an outline plan for the social and economic regeneration of Dublin's North East Inner City.* Dublin: Government Publications. http://www.drugsandalcohol.ie/26859/

General public attitude to drug users – CityWide survey

The findings of a survey on attitudes to drugs and drug users by the general population were published in November 2016.[1] The survey was carried out by Red C for CityWide Drug Crisis Campaign. It was an online national omnibus survey with a nationally representative sample of 1035 adults. The topics covered included respondents' own drug use, various attitudes and beliefs about drugs and drug users, their place in society, and the decriminalisation of drug use. Some key findings are presented below.

Respondents' drug use

- One-third (31%) of respondents reported that they had ever used an illegal drug.
- One per cent of respondents described themselves as 'regular users' and 17% as having used them either 'once or twice'.

Attitudes and beliefs about drugs and their use

- There were high levels of agreement that drugs are a problem in Irish society: 88% of respondents agreed that drug-related crime is a major problem in Ireland, and 87% agreed that the availability of illegal drugs poses a great threat to young people nowadays.
- Two-thirds (66%) agreed that alcohol abuse causes more problems in society than drug abuse.
- Two-thirds (66%) agreed that all illegal drugs are highly addictive and should be avoided.
- Those aged 18–34 years were more likely than the overall population to regard using cannabis once a month or less as 'not really dangerous to your health' (47% vs 34%), and that it was normal that young people will try some drugs 'at least once' (e.g. cannabis/ecstasy) (59% vs 53%).

Attitudes and beliefs about drug users

- It was a commonly held belief (91%) that drug users come from all backgrounds and classes.
- Negative views of drug users were found: one-half (51%) of respondents agreed that drug users really scare them and just under two-thirds (64%) reported that it would bother them to live near somebody who is addicted to drugs.
- However, there were also some sympathetic views expressed about users. Four out of five people (81%) agreed that all drug users should have access to the treatment they require.
- More respondents disagreed (44%) than agreed (31%) that they saw people addicted to drugs more as criminals than victims.

Decriminalisation

The public's view on the decriminalisation of drug use was captured by first providing a brief description of what it would mean and then presenting two options:

> Possession of illegal drugs, no matter how small the amount, is currently a criminal offence in Ireland. A conviction can stop a person being allowed to travel, get a visa, gain employment or access training. Many countries (including some in Europe) have decriminalised possession of small quantities of illegal drugs for personal use — which means instead of a conviction people can be fined or mandated to attend at a drug treatment programme. Production, trafficking/supply and possession of larger amounts would remain a serious criminal offence. With this in mind, which of the following comes closest to your view on the issue of decriminalisation?
>
> a) The law in Ireland should stay as it currently is so that possession of illegal drugs remains a criminal offence.
> b) The law in Ireland should be changed so that the possession of small quantities of illegal drugs is 'decriminalised' as described.

Respondents were divided almost half and half in their response. Forty-nine per cent were in favour of changing the law, whereas 51% were not. Men (56%) and younger people aged between 18 and 34 years (58%) were more supportive of a move towards decriminalisation.

Lucy Dillon

1 CityWide (2016) *CityWide: attitude to drugs and drug users.* Dublin: CityWide Drug Crisis Campaign and Red C Research & Marketing. http://www.drugsandalcohol.ie/26840/

Dr Dermot Walsh – An appreciation

Our HRB colleague Dr Dermot Walsh died recently. Following more than 30 years' service to the Health Research Board (and its predecessor, the Medico-Social Research Board, which he joined in 1969) as head of mental health research, Dr Walsh continued to work as principal investigator in the HRB's Mental Health Information Systems Unit until 2010. Dr Walsh had a highly distinguished and influential career as a clinician, researcher and policy adviser on mental health matters. He helped to establish the National Psychiatric In-Patient Reporting System (NPIRS) and continued to co-edit its annual report until he retired from the HRB. The NPIRS is an important source of data on drug and alcohol treatment and Dr Walsh had a keen interest in this area, publishing several academic papers on the topic of alcohol dependence. He will be remembered with great fondness by those who worked with him in the HRB, in particular his colleagues in mental health.

PREVALENCE AND CURRENT SITUATION

Drug, alcohol and tobacco use among the general population in Irish RDTF areas

In 2014, the National Advisory Committee on Drugs and Alcohol (NACDA) commissioned Ipsos MRBI to conduct the Drug Use in Ireland and Northern Ireland: Drug Prevalence Survey 2014/15.[1] This survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The questionnaire, based on the European Model Questionnaire, was administered in face-to-face interviews with respondents aged 15+ years. A sample comprising all households throughout the island of Ireland was randomly selected to participate, and fieldwork began in September 2014 and was completed in May 2015. Of the household members contacted, 7005 agreed to take part. The sample was weighted by gender, age and region to ensure that it was representative of the general population. The main measures were lifetime use (ever used), use in the last year (recent use) and use in the last month (current use).

The NACDA has recently published *Bulletin 2*, detailing the prevalence of illicit substance and alcohol and tobacco use by Regional Drug and Alcohol Task Force (RDTF) areas.[2] This article highlights the major findings.

Illicit substance use

Figures 1 and 2 show RDTF areas within Ireland and the prevalence of *any* illegal drug use within RDTF areas. The results from the 2014/15 survey show that the prevalence of illicit substance use varies across task force areas. Lifetime use of any illegal drug was highest in the East Coast and Northern regions (41%) and lowest in the North Western RDTF (20%) area.

Recent use of any illicit substance was highest in the South Western RDTF area (12%) and lowest in the Mid-Western region (5%). Current use was also highest in the South Western RDTF area (8%) and lowest in the Mid-Western RDTF (2%) area.

Cannabis was the most commonly used illicit substance in all areas in the year prior to the survey. After cannabis, ecstasy and cocaine were the most frequently reported drugs regarding recent use. When results were compared to the previous general population survey, which was conducted in 2010/11,[3] findings showed an overall increase in recent and current use of cannabis and ecstasy for many regions. Exceptions were noted for the Mid-Western RDTF area, which has seen reductions (or similar rates) for recent and current use of cannabis and ecstasy. Recent use of new psychoactive substances (NPS) has decreased in all regions, possibly due to the introduction of the Criminal Justice (Psychoactive Substances) Act 2010.[4]

Figure 1: Map of Ireland. Regional Drug and Alcohol Task Force (RDTF)* areas

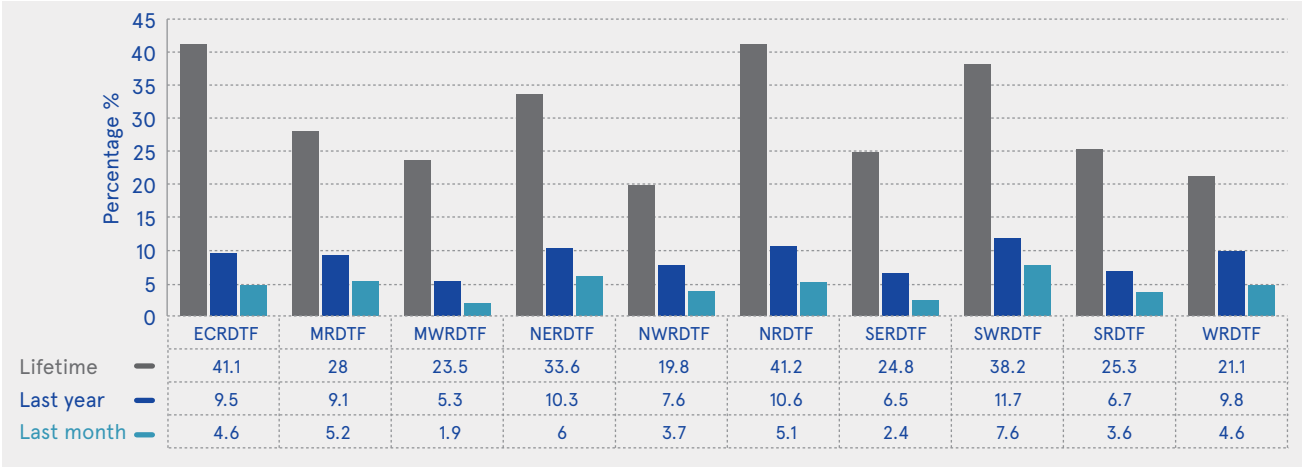
Source: NACDA, 2017

**RDTF areas: ECRDTF (East Coast), MRDTF (Midland), MWRDTF (Mid-Western), NERDTF (North Eastern), NWRDTF (North Western), NRDTF (Northern), SERDTF (South Eastern), SWRDTF (South Western), SRDTF (Southern), WRDTF (Western).*

Drug Prevalence in Task Force Areas

continued

Figure 2: Lifetime, last year and last month prevalence of any* illicit drug use in Ireland by Regional Drug and Alcohol Task Force areas, 2014/15



	ECRDTF	MRDTF	MWRDTF	NERDTF	NWRDTF	NRDTF	SERDTF	SWRDTF	SRDTF	WRDTF
Lifetime	41.1	28	23.5	33.6	19.8	41.2	24.8	38.2	25.3	21.1
Last year	9.5	9.1	5.3	10.3	7.6	10.6	6.5	11.7	6.7	9.8
Last month	4.6	5.2	1.9	6	3.7	5.1	2.4	7.6	3.6	4.6

Source: NACDA, 2017
**Any illicit drug refers to the use of cannabis, ecstasy, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, NPS, solvents, crack and heroin.*

As in previous surveys, males were more likely to use illicit substances than females, and younger adults (15–34 years) were more likely to use illegal drugs than older subjects (35–64 years), in all RDTF areas.

Alcohol and tobacco use

In 2016, alcohol prevalence ranged from 67% in the North Western RDTF area to 83% in the South Western area. Recent tobacco use was highest in the South Western region (35%) followed by the East Coast RDTF area (34%), and was lowest in the Southern RDTF area (28%). Recent and current alcohol prevalence was higher among young adults in some regions (Midland, North Eastern and North Western), whereas the opposite was the case in other regions (East Coast, Northern and Western). All of the remaining regions showed similar rates of recent and current alcohol use between younger and older adults.

For the first time, the NACDA prevalence survey included participants over the age of 65 years. In addition to showing no recent illegal drug use, the prevalence of recent alcohol and tobacco use was also lowest among this age group in all RDTF areas.

Seán Millar

1 National Advisory Committee on Drugs and Alcohol (NACDA) and Department of Health (UK) (2016) *Prevalence of drug use and gambling in Ireland and drug use in Northern Ireland. Bulletin 1.* Dublin: NACDA and Department of Health (UK). http://health.gov.ie/wp-content/uploads/2016/11/Bulletin-1.pdf and http://www.drugsandalcohol.ie/26364/

2 National Advisory Committee on Drugs and Alcohol (NACDA) & Department of Health (UK) (2017) *Prevalence of drug use and gambling in Ireland and drug use in Northern Ireland 2014/15: Regional Drug and Alcohol Task Force (Ireland) and Health and Social Care Trust (Northern Ireland) results. Bulletin 2.* Dublin: NACDA and Department of Health (UK). http://www.drugsandalcohol.ie/26901/

3 National Advisory Committee on Drugs (NACD) and Public Health Information and Research Branch (PHIRB) (2011) *Drug use in Ireland and Northern Ireland: first results from the 2010/11 Drug Prevalence Survey. Bulletin 1.* Dublin: NACD & PHIRB. http://www.drugsandalcohol.ie/16353

4 Criminal Justice (Psychoactive Substances) Act 2010. http://www.irishstatutebook.ie/eli/2010/act/22/enacted/en/html

Alcohol, tobacco and illicit substance use among 17–18-year-olds in Ireland

Growing up in Ireland is the national longitudinal study of children in the Republic of Ireland. Funded by the Department of Children and Youth Affairs (DCYA), the project is overseen and managed by the DCYA in association with the Central Statistics Office. The child cohort was recruited in 2007, when 8568 nine-year-olds were interviewed. Just over 7400 young people were re-interviewed at 13 years of age (between August 2011 and February 2012) and just over 6200 participated again at 17–18 years (between 2015 and September 2016). This article highlights key findings on alcohol, tobacco and illicit substance use in this cohort using information collected during the third wave of the study.[1] The data were collected in home-based, face-to-face interviews.

Alcohol use

Table 1 shows the prevalence of substance use in the *Growing up in Ireland* cohort. With regard to alcohol use, a majority (89%) of 17–18-year-olds reported having consumed alcohol at some stage in their lives. When study participants were asked about current drinking patterns, 5% indicated that they did not currently drink, just under one-half (48%) said they did so monthly or less, 40% drank 2–4 times per month, and 6% reported that they drank 2–3 times a week or more. In general, males were significantly more likely than females to drink frequently (52% vs 46%), whereas frequency of drinking and amount of alcohol consumed did not vary statistically by social class. It was also found that subjects who started drinking at an earlier age were more likely to be heavier drinkers at 17–18 years of age, with 62% of participants who had started drinking at 13 years of age drinking 2–4 times per month or more compared to 47% who had not.

Tobacco use

Study participants were asked to record how frequently they smoked: from a set of five precoded categories ranging from never to daily. Fifty-one per cent of 17–18-year-olds reported that they had never smoked, 25% had tried smoking once or twice, 4% of subjects used to smoke, 12% smoked occasionally, while 8% indicated that they were regular smokers. Although no significant gender differences in smoking patterns were observed, similar to findings regarding alcohol behaviours, it was noted that smoking at an earlier age was associated with heavier smoking in later adolescence. Subjects who had smoked a cigarette by 13 years were more likely to be daily smokers by 17–18 years than those who had not (31% vs 6%).

Table 1: Substance use among 17–18-year-olds in Ireland

Substance	Prevalence
Alcohol	
Ever used	89%
Don't currently drink	5%
Monthly or less	48%
2–4 times per month	40%
2–3 times a week	6%
Cigarettes	
Never smoked	51%
Tried smoking once or twice	25%
Used to smoke	4%
Smoke occasionally	12%
Smoke daily	8%
Cannabis	
Never used	69%
Used once or twice	17%
Used to but not now	4%
Use occasionally	8%
Use more than once a week	2%
Other illicit substances	
Ever used illicit drugs	9%
Ever used cocaine	4%
Ever used ecstasy	4%

Source: *Growing up in Ireland* study, 2017

Cannabis and other illicit substance use

When subjects were asked about illicit substance use, a majority (69%) of 17–18-year-olds reported that they had never used cannabis, with 8% suggesting occasional use, and a small proportion (2%) indicating weekly use. Male participants were significantly more likely to use cannabis than females (12% vs 7%). With regard to the use of other illicit substances, 9% of study participants reported that they had *ever* used other illicit drugs. Prevalence was below 1% for most of the drugs included, with cocaine and ecstasy showing the highest rates of use (4% for both).

Conclusions

The authors noted that levels of alcohol consumption, smoking and illicit substance use are clearly a concern in terms of current and future well-being of young people. A majority of 17–18-year-olds had consumed alcohol, a fifth of the cohort also smoked, at least occasionally, and a proportion had also experimented with other drugs. As the findings showed higher consumption and greater frequency of use of both alcohol and cigarettes by those who had tried them at a younger age, the authors suggest that interventions to limit risky behaviours in young people should be implemented at as early an age as possible.

Seán Millar

1 Department of Children and Youth Affairs (DCYA) and Central Statistics Office (CSO) (2016) *Growing up in Ireland. Key findings: child cohort at 17/18 years. No. 4: risky health behaviours and sexual activity.* Dublin: DCYA and CSO. http://www.drugsandalcohol.ie/26344/

National Self-Harm Registry Ireland annual report, 2015

The 14th annual report from the National Self-Harm Registry Ireland was published in 2016.[1] The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in Ireland in 2015, and complete national coverage of cases treated. All individuals who were alive on admission to hospital following deliberate self-harm were included, along with the methods of deliberate self-harm that were used. Accidental overdoses of medication, street drugs or alcohol were not included.

Rates of self-harm

There were 11 189 recorded presentations of deliberate self-harm in 2015, involving 8791 individuals. This implies that more than one in five (21.4%) of presentations were repeat episodes. Taking the population into account, the age standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm was 204 per 100 000 population. This is similar to the rate recorded in 2014 (200 per 100 000). In recent years, there have been successive decreases in the self-harm rate between 2011 and 2013. Nevertheless, the rate in 2015 was still 9% higher than in 2007, the year before the start of the economic recession (Figure 1).

In 2015, the national male rate of self-harm was 186 per 100 000, 1% higher than in 2014. The female rate was 222 per 100 000, which was 3% higher than in 2014. Since 2007, male and female rates of self-harm have increased by 15% and 3%, respectively. With regard to age, when compared to 2014, the only significant change in the rate of hospital-treated self-harm was among men aged 35–39 years, where the rate increased by 15% from 220 per 100 000 to 253 per 100 000. The authors noted that increasing rates observed in males is particularly worrying, considering the higher lethality of self-harm methods among men.

Self-harm and drug and alcohol use

Intentional drug overdose was the most common form of deliberate self-harm reported in 2015, occurring in 7319 (65%) of episodes. As observed in 2014, overdose rates were higher among women (71%) than among men (59%).

A minor tranquilliser, paracetamol-containing medicines, and antidepressants/mood stabilisers were involved in 38%, 29% and 20% of drug overdose acts, respectively. In 69% of cases, the total number of tablets taken was known, with an average of 28 tablets taken in episodes of self-harm that involved a drug overdose.

There was an 18% increase in the number of presentations involving street drugs (cannabis, ecstasy and cocaine), which rose from 465 in 2014 to 547 in 2015 (following annual decreases from 2010 to 2013). The 2015 level is the highest recorded since 2008 and the second highest ever recorded by the registry. Alcohol was involved in 31% of all self-harm presentations, and was significantly more often involved in male episodes of self-harm than female episodes. The authors reported that, as in previous years, alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, and in the hours around midnight.

The authors concluded that these findings underline the need for ongoing efforts to:

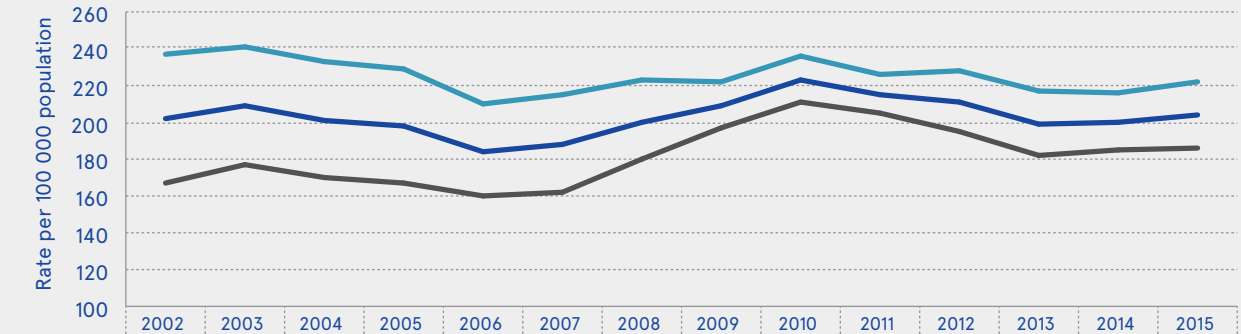
- Reduce access to minor tranquilisers and other frequently used drugs.
- Conduct further research to examine the sources of illicit drugs used in intentional overdoses.
- Enhance health service capacity at specific times.
- Intensify national strategies to increase awareness of the risks involved in the use and misuse of alcohol.
- Develop further strategies to reduce access to alcohol.

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

Seán Millar

1 Griffin E, Arensman E, Dillon CB, Corcoran P, Williamson E and Perry IJ (2016). *National Self-Harm Registry Ireland annual report 2015*. Cork: National Suicide Research Foundation. http://www.drugsandalcohol.ie/26297/

Figure 1: Person-based rate of deliberate self-harm from 2002 to 2015 by gender



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Men	167	177	170	167	160	162	180	197	211	205	195	182	185	186
Women	237	241	233	229	210	215	223	222	236	226	228	217	216	222
All	202	209	201	198	184	188	200	209	223	215	211	199	200	204

Source: National Suicide Research Foundation, 2016
'All' in the legend refers to the rate for both men and women per 100 000 population.

Incidence of hepatitis C among people who inject drugs in Ireland

Hepatitis C is an infection of the liver caused by the hepatitis C virus (HCV). The acute phase of the infection is usually asymptomatic, but approximately 75% of those infected develop chronic infection, which may cause liver cirrhosis, hepatocellular carcinoma and liver failure.[1,2] Injecting drug use is one of the main modes of transmission of HCV infection in Ireland. However, comprehensive information on the incidence and duration of HCV infection among people who inject drugs (PWID) in Ireland is lacking.

Recent research examined the incidence of HCV infection among PWID in the Republic of Ireland over a 13-year period. In this study, which was published in the BioMed Central (BMC) journal *Hepatology, Medicine and Policy,*[3] anonymised data from the National Drug Treatment Reporting System (NDTRS) were used to identify all PWID who entered drug treatment for the first time between 1991 and 2014. A curve, estimating the incidence of injecting, was created in order to plot PWID by year of commencing injecting. The curve was adjusted for missing data on PWID in treatment, and for injectors who were never treated. Additional adjustment was made to account for PWID who had never shared injecting equipment. The incidence of HCV infection and chronic HCV infection among PWID was estimated by applying published rates.

It was found that between 1991 and 2014, 14 320 injectors were registered with the NDTRS. The majority were young (median age 25 years), male (74%), lived in Dublin (73%), and injected an opiate (94%). The estimated total number of injectors up to the end of 2014 was 16 382. The authors estimated that 12 423 (95% CI: 10 799–13 161) individuals were infected with HCV, and that 9317 (95% CI: 8022–9966) of these subjects became chronically infected.

The estimated annual number of new HCV infections among PWID drugs peaked in 1998 (Figure 1). By 2014, almost 30% of injectors were estimated to have been infected for over 20 years.

Research has indicated that the prevalence of opiate use in Ireland may have stabilised,[4] and that the number of PWID entering drug treatment for the first time in Ireland has decreased slightly in recent years.[5] Nevertheless, injecting drug use remains a significant issue. As the EMCDDA recommends the collection of accurate data on the incidence of injectors entering drug treatment,[6] the study authors concluded that the analysis demonstrates the wider usefulness of routine drug treatment data collected by the NDTRS. This may help inform policy with regard to the use of highly effective but expensive new treatments for HCV that have recently become available.

Seán Millar

1 World Health Organization (2014) *Guidelines for the screening, care and treatment of persons with hepatitis C infection.* Geneva: World Health Organization. http://www.who.int/hiv/pub/hepatitis/hepatitis-c-guidelines/en/

2 Global Burden of Hepatitis C Working Group (2004) Global burden of disease (GBD) for hepatitis C. *Journal of Clinical Pharmacology*, 44: 20–29.

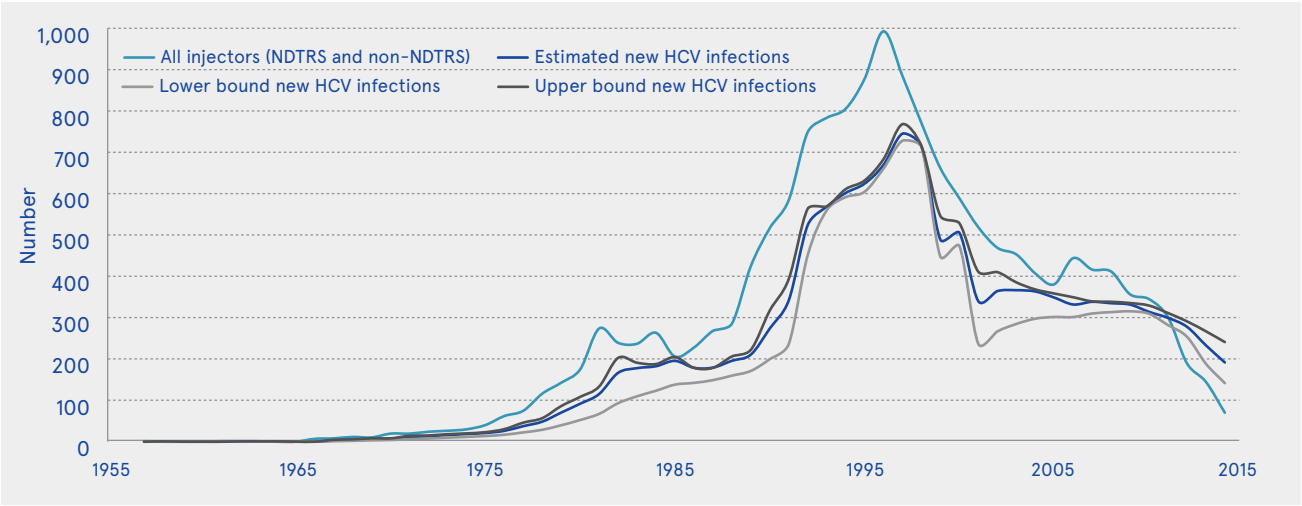
3 Carew AM, Murphy N, Long J, Hunter K, Lyons S, Walsh C and Thornton L (2017) Incidence of hepatitis C among people who inject drugs in Ireland. *Hepatology, Medicine and Policy,* 2: 7.

4 Hay G, Jaddoa A, Oyston J and Webster J (2017) *Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods.* Dublin: National Advisory Committee on Drugs and Alcohol. (Forthcoming)

5 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2011) *Statistical bulletin. Treatment demand indicator (TDI).* Lisbon: EMCDDA. http://www.emcdda.europa.eu/stats11/tdi

6 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2013) *PDU (Problem drug use) revision summary.* Lisbon: EMCDDA. http://www.emcdda.europa.eu/attachements.cfm/att_218205_EN_PDU%20revision.pdf

Figure 1: Estimates of new injectors by year commenced injecting and new HCV infections by year infected



Source: Carew AM, Murphy N, Long J, Hunter K, Lyons S, Walsh C and Thornton L, 2017

Lifting the lid on Greentown

On 13 February 2017, Dr Sean Redmond, adjunct professor of youth justice at the School of Law, University of Limerick, launched the *Lifting the lid on Greentown* report.[1,2] The report outlined a study that examined the effect of a criminal network on the offending behaviour of children between 2010 and 2011 in a regional Garda sub-district outside Dublin referred to as Greentown.

Background

Research into youth crime has been extensive and tends to focus on descriptive analysis of general populations and large offending subpopulations.[1] A tool that has been shown to increase understanding of this area is network analysis.[1] Although the literature examining associations between criminal networks and children has been slowly emerging internationally, scant attention has been given to examining this area in Ireland.

The main research questions addressed in this study were:

1. How and why did children become involved with the criminal network initially and what factors shaped and maintained this involvement?

2. How did the criminal network support the offending behaviour?

3. How easy or difficult was it for children involved in the criminal network to make and follow through on their own decisions, including quitting the network?

Methodology

The study involved a case study design and consisted of the following sequential steps:

- Burglary and drugs for sale and supply data collated on An Garda Síochána's PULSE (police using leading systems effectively) system were analysed and ranked.
- Based on the previous analysis, geographical location and other criteria, such as containment of criminal activity to the sub-district, number of young offenders, willingness of An Garda Síochána to take part in the study, and availability of facilities to undertake the fieldwork, Greentown was chosen as the most appropriate location for the study.
- A criminal network map was developed by Garda analysts using PULSE data and illustrated how offenders aged 11–36 years, who carried out burglary or drugs for sale and supply offences between 2010 and 2011 in Greentown, linked together via common offences.
- In order to ensure anonymity of individuals on the criminal network map, a blinding process, coined by the author as the Twinsight method, was utilised. Two versions of the map were developed: a 'live' version that contained personal details of the offenders involved. This was only seen by Garda members or analysts. The second version, a 'researcher' version, was similar to the first version, except that there was no identifying or personal information and was used only by the researcher. The maps shared unique identifier codes, which allowed Garda respondents (n=16) taking part in semi-structured interviews to 'ground' (p. 24) their views by linking real events to the individuals on the map via the unique identifier.
- The coding and data analysis of transcriptions were collated on NVivo and informed by grounded theory.

Results

Four key findings emerged from the analysis. First, the analysis indicated the presence of a criminal hierarchical network that differentiated between family and non-family members in Greentown. For example, at the top of the hierarchy was the network leader (A_2), his second-in-command was (Z_1), while middle management consisted of associates (D_1, E_1 and A_1). Younger family members of A_2 (B_2 and D_2) also appeared in the network.

Second, the hierarchical structure evident was supported by processes and sympathetic-embedded cultures. The study showed that A_2 and his family had an imposing effect over associates, clients and non-aligned residents. In addition, there was a mismatch between how the criminal justice system operates and the lived reality. For example, to get A_2 convicted, a complaint by someone willing to follow it through to court was necessary but the lived reality was that A_2 managed to distance himself from criminal activities, while very few would complain or act as a witness against him.

Third, the power and effect of the network was shown to be strongest on the estate where A_2 lived. A_2's influence was thought to decline with distance; however, in associates and clients, particularly those living on the same estate, the influence remained the same. Moreover, regardless of distance, having any relationship with A_2, whether by choice or circumstance, resulted in independence and privacy being taken away.

Finally, for five or more offences, child offending in Greentown (75%) was shown to be five times higher than the national average for burglary (15%). A possible explanation for this outcome is that a 'network effect' (p. 50) was present, persuading children to offend. The evidence in the Greentown study suggests that network factors differ between associates and family members. For associates, factors included how children were selected and recruited; strong pull and push dynamics; living in compliant surroundings; making deals to retain them; limiting their options and creating indecision to deter those that want to get out. However, factors for family members include 'history, expectation, family brand, legitimacy to control, emergence, succession' which suggest 'a preordained role' (p. 51). Garda respondents in this study believe that network factors are pervasive in both children that reside near A_2 and those whose family members are clients of A_2.

Lifting the lid on Greentown

continued

Limitations

The author identified a number of limitations to the study:

- The criminal network map relied on specific parameters, namely data for burglary and drugs for sale and supply offences (PULSE), which may have resulted in individuals clustering together on the map.
- Gardaí were asked to link their experiences to their interpretation of the network map, which was then interpreted by the researcher.
- 'Time' (2010–2011) and the 'offence type' parameters (burglary and drugs for sale and supply) decided who or who did not appear on the network map.
- There were also limitations and weaknesses present in the PULSE data upon which the criminal network is based.[3,4]

Conclusion

The aim of this study was to explore whether criminal networks influenced children moving into a life of crime. As acknowledged by the author, it was problematic trying to determine cause and effect; at best this study provides sufficient evidence that 'plausibly' suggests that criminal networks may influence offending in children.

However, the study increases the understanding of factors that influence offending in children under the age of 18 in an Irish context. It involved a multiagency response, which included the Department of Justice, the Department of Children and Youth Affairs, An Garda Síochána (members and analysts) and the University of Limerick. Policy and practical implications are also discussed in the report.

With the aim of extending this research further and helping vulnerable youths and children that are influenced into a life of crime in Ireland, a replication study is currently underway. The aim of this new study is to determine whether the results of the Greentown study can be generalised across Ireland. Although it will involve similar methodology, there will be slight differences, such as:

- Two additional sites instead of one
- Criminal network maps based on more recent PULSE data (2014–2015)
- Semi-structured interviews of frontline Gardaí on both sites (n=20)

Additionally, in order to broaden the data collection, juvenile liaison officers throughout Ireland will be invited to participate in the survey.

Ciara H Guiney

1 Department of Children and Youth Affairs (2016) *Lifting the lid on Greentown: why we should be concerned about the influence criminal networks have on children's offending behaviour in Ireland.* Dublin: Government Publications. http://www.drugsandalcohol.ie/26850/

2 Department of Children and Youth Affairs (2016) *Lifting the lid on Greentown: key findings.* Dublin: Government Publications. http://www.drugsandalcohol.ie/26850/

3 Central Statistics Office (2015) *Review of the quality of crime statistics.* Dublin: Government of Ireland. http://www.drugsandalcohol.ie/24887/

4 Central Statistics Office (2016) *Review of the quality of crime statistics 2016.* Cork: Central Statistics Office. http://www.drugsandalcohol.ie/26176/

Review of drug and alcohol treatment services for adult offenders in prison and in the community

In March 2016, the Probation Service and Irish Prison Service (IPS) published an independent review of alcohol and drug treatment services for adult offenders in the community and in prison.[1] The review explores current provision and sets out a model of effective practice for the treatment of adult offenders that can facilitated through a continuum of care from prison to the community. The authors argue that the prison environment provides a unique opportunity to support individuals in addressing addiction, and it is appropriate that a range of treatment and intervention options is provided in the prison estate.

Excluding direct staff and general practitioner costs, the IPS and the Probation Service have a combined expenditure of €3.33m on the provision of addiction services for adult offenders. Spending has declined in recent years in line with the fall in the number of prisoners held in the prison estate as more initiatives, such as community return, have been introduced. During the course of the review, concern was expressed about the lack of investment in health in the prison system and the absence of a clinical director or health director at senior management level. Reduced expenditure on addiction counselling has resulted in a reduction in the number of addiction counsellors provided by Merchants Quay Ireland (MQI) and changes in the types of services they provide. Some prisons only have part-time access and waiting times for addiction counsellors have increased.

Consultations with service providers, the Probation Service, the IPS and the Health Service Executive (HSE) all highlighted a number of recent changes that were affecting the capacity to treat offenders with addictions:

- There was a decline in opiate-based addiction and an increase in the abuse of benzodiazepines, novel psychoactive substances, opiate-based analgesics, and other narcotics as well as increased polysubstance abuse.

- There were increasing numbers of offenders presenting with comorbidities, most notably mental illness combined with drug and/or alcohol addiction.
- There was ready availability of drugs within the prison system;
- There were younger people with complex needs, such as drug addiction combined with chaotic personal lifestyles, homelessness, mental health issues, poor literacy, and communication skills deficits.

A cohort of offenders moving in and out of the criminal system poses significant challenges to effective treatment. Female offenders are more likely to be chaotic substance users than their male counterparts. This results in particular challenges when treating their addictions.

Model of effective practice

The review sets out a model of effective practice aligned with the principles outlined in the National Drugs Rehabilitation Implementation Committee (NDRIC) framework and refined following consultations with community-based organisations (CBOs), prison-based health teams and addiction counsellors, and a review of international literature.

The model recognises that recovery takes time and often requires several episodes of treatment, and that the person in recovery should have a broad range of options available to facilitate the process. Good communication both within the prison system and between the prison environment and the community are necessary to ensure clear treatment pathways and that the opportunity provided by time in prison to address addiction is taken. The core components of the model are pre-work and preparation, referral, assessment, care planning, case management, treatment and recovery management.

Outcomes

Apart from initial outcomes monitored by MQI in Mountjoy Prison, there is currently no robust systematic tracking of outcomes for prisoners treated in the prison estate. The review acknowledges that, while work needs to be done regarding the identification and measurement of outcomes, good progress has been made by CBOs in developing outcome models. Most of these are abstinence based but there is a recognition that other outcomes, such as completing treatment, increased social skills and behavioural change, are also valid outcomes in recovery programmes. A number of CBOs have conducted research into outcomes for clients and provide data on outcomes named in their service level agreements with the Probation Service. These outcomes included treatment completion, attending aftercare, and returning to training or education.

Recommendations

The authors recommend that the IPS adopts this model and provides the required resources and funding to support its implementation. Some of the gaps in provision identified in the review include availability of drug-free environments within the prison setting for prisoners who have completed detoxification and treatment programmes, development of non-opiate-based detoxification services, alcohol treatment services, and access to treatment for difficult cohorts such as sex offenders. Coordination of services for prisoners between the prison and outside agencies is very important in ensuring prisoners receive the services they need. Continuum of care depends on reliable referral pathways to HSE treatment services and CBOs, and this process needs to be refined through clearer protocols and mechanisms to support greater interagency information sharing. A related issue is coordination of services with a more defined role for prison addiction nurses in care planning and case management required.

The authors of the review recognise the considerable progress that has been made in recent years in the management of release planning from prisons, for instance, the involvement of integrated sentencing managers. However, prisoners with an addiction still face considerable problems on release from prison, especially if homeless. The review makes a number of recommendations that should help the coordination of pre-release planning and communication with probation and other external services. These recommendations include the involvement of relevant prison health staff and a specialised resettlement support service. As coordination and communication between services is such an important part of addiction services, the review pays particular attention to the role of service level agreements in the overall governance of external providers and CBOs.

Brian Galvin

1 Clarke A and Eustace A (2016) *Drug and alcohol treatment services for adult offenders in prison and in the community.* Dublin: Probation Service and Irish Prison Service. http://www.drugsandalcohol.ie/26569/

Irish Prison Service Strategic Plan 2016–2018

On 27 June 2016, the Tánaiste and Minister for Justice and Equality, Frances Fitzgerald TD, launched the Irish Prison Service Strategic Plan, which outlined the main strategic actions that the Irish Prison Service (IPS) will undertake between 2016 and 2018.[1] This new strategy, which builds on significant improvements the IPS made during the previous Strategic Plan 2012–2015, aims to ensure that the prison setting is safe for both prisoners and staff and is centred on dignity of care and on rehabilitation of prisoners.[2] Strategic actions to be taken include staff support, prisoner support, victim support, enhancing organisation capacity, and delivering strategy and monitoring progress.

Staff support

The IPS will aim to create a work environment where employees have a voice and are involved in the development of the organisation. It will be based on dignity and respect, and the behaviour and ethics of employees and management will be guided by well-defined standards. Central to achieving IPS organisational objectives are employee competencies.

IPS Strategic Plan continued

Thus, the introduction of a competency framework will guide and inform recruitment, training, employee performance, and continuous professional development. The IPS intends to protect and enhance the well-being of all employees, while also ensuring that employees work in a fair, inclusive setting, where they are treated equally and enjoy the same rights. Health, safety and well-being are considered essential components of a safe work environment, which the IPS is taking necessary steps to achieve. For example, the IPS intends to implement recommendations identified in a review of assaults by prisoners on prison staff,[3] avail of a multidisciplinary risk management approach, evaluate ways to reduce exposure to violent prisoners, and invest in new technologies to increase safety. To further enhance safety, procedures will be standardised and will comply with existing road safety and health and safety legislation.

Prisoner support

Prisoner rehabilitation that aids reintegration back into society remains prominent in this plan. The aim is to manage sentences by nurturing and assisting prisoners to live as law-abiding citizens that have a purpose via constructive and structured activities. The structure of the IPS Psychology Service is to be brought into line with recommendations put forward in the *New connections* report.[4] Additional resources are to be assigned to enable the service to provide a wider range of interventions. The plan also takes into consideration the needs of prisoners with mental health and addiction problems, young offenders, older prisoners, and minority groups. By building on existing collaborative arrangements with the Probation Service, and other statutory and community services, the aim is to make the transition back into society safe and effective.

Victim support

The intention is to engage with victims of crime honestly, acknowledging their fears and their right to be heard and treated in a respectful and dignified manner. Prisoners will be provided with a route to address and accept responsibility for their actions, allowing them to make amends to society. The aim is also to increase victim awareness among prisoners.

Enhancing organisation capacity

In order to achieve the main goals of the strategic plan, it is vital that the organisational structure of the IPS is fit for purpose. The intention is to ensure that systems, structures, processes, procedures, and culture are in place. Availing of a Strategic People Plan will help the vision, mission, and core values of the IPS to be realised. Additionally, the aim is to have a humane and fair penal system that participates in the rehabilitation, reintegration and reduction of offending behaviour in prisoners. The delivery of services and prisoner support, such as education, work training, healthcare, psychology services, and drug treatment, will be sufficiently resourced. While the drive to bring responsibility for prison healthcare services under the remit of the Department of Health and overseen by the Health Service Executive (HSE) will continue, it will further strengthen existing collaborative relationships with the HSE.

Delivering strategy and monitoring progress

The Strategic Plan 2016–2018 acts as a 'blueprint and roadmap' covering a three-year period. Action plans for each strategic action will be prepared to identify actions to be taken in the course of the strategy. Progress will be monitored and reported annually via the IPS annual report.

Ciara H Guiney

1 Irish Prison Service (2016) *Strategic plan 2016–2018*. Longford: Irish Prison Service. http://www.drugsandalcohol.ie/25735/

2 Irish Prison Service (2012) *Three year strategic plan 2012–2015*. Longford: Irish Prison Service. http://www.drugsandalcohol.ie/17473/

3 State Claims Agency (2016) *Review of assaults on operational prison staff by prisoners*. Dublin: State Claims Agency. http://stateclaims.ie/wp-content/uploads/2016/11/Review-of-Assaults-on-Operational-Prison-Staff-by-Prisoners-November-2016.pdf

4 Porporino FJ (2015) *'New connections': embedding psychology services and practice in the Irish Prison Service*. Ottawa: T3 Associates Inc. http://www.irishprisons.ie/wp-content/uploads/documents_pdf/porporino_report.pdf

16th European Federation of Therapeutic Communities Conference

The 16th European Federation of Therapeutic Communities (EFTC) Conference[1] will take place in Dublin Castle on 20–22 September 2017. The event is organised by Coolmine Therapeutic Community, the Department of Health, and the EFTC around the theme of 'Pathways of Care to Recovery'.

The conference will be an opportunity to learn, exchange ideas and knowledge, and network with colleagues from home and away.

Abstracts are invited from the following areas:

- Gender, women and families
- Treatment in prison and secure environments
- Mental health, well-being and intellectual difficulties

Abstracts should be submitted to **www.coolmine.ie/eftc2017/abstracts/** by 30 June 2017.

Suzi Lyons

1 EFTC is a network of international drug and alcohol treatment communities. For further information, visit http://www.eftc-europe.com/. Further information is available at http://www.coolmine.ie/eftc or by contacting eftc2017@abbey.ie

RESPONSES

'What works' in drug education and prevention? A review

In December 2016, the Scottish Government published the report by Warren on *'What works' in drug education and prevention?'*.[1] While the previous decade and a half had seen an overall reduction in substance use among young people in Scotland, there was a poor understanding of why this had happened and whether prevention activities had played any role in the decline or not. The review was the first step towards filling this knowledge gap – it aimed 'to explore the evidence of effectiveness of different types of drug prevention and education for children and young people, principally that which is delivered in schools' (p. 7). This was not a systematic review and no critical appraisal of the literature was carried out. However, the report provides a useful overview of the main issues faced by those trying to evidence the impact of drug prevention activities; the findings from key systematic reviews on drug prevention activity; and the findings of other core documents in the field.

Prevention science

Prevention science is a relatively new field, with its main aim being 'to improve public health by identifying malleable risk and protective factors, assessing the efficacy and effectiveness of prevention interventions and identifying optimal means for dissemination and diffusion'.[2] The author highlights that while the terms 'drug prevention' and 'drug education' are often used interchangeably they are in fact distinct activities. Drug prevention's primary aim is to change people's behaviour around drug use, whereas drug education is more about delivering factual information about drugs to people. There was no evidence that information provision alone changed behaviour and reduced drug use. The point was made that much of what is delivered in schools may be more drug education than prevention as such.

The report highlighted the complexities and challenges involved in carrying out research in this field, in particular in evidencing the impact of drug prevention activities: 'Evaluating prevention is difficult, in particular, measuring something that has not yet happened, and unpicking which intervention made the difference in the long term' (p. 11). These challenges included a lack of clarity around definitions of prevention; the high cost involved in measuring long-term changes in behaviour; the use of unsuitable shorter-term outcome measures concerning changes in knowledge and attitudes rather than behaviour; publication bias in favour of studies that showed positive outcomes; and, that changes presented as statistically significant could in fact be so small as to be meaningless.

Key messages

Despite these challenges, some key messages were identified from the evidence base:

- A Cochrane review[3] found that the effects of universal school-based programmes were small. It examined the effectiveness of universal school-based interventions in reducing drug use when compared to usual curricula activities or no intervention. Where an effect was found, it occurred in some programmes that were based on a combination of the social competence approach and the social influence theoretical approach. The former aimed to improve the young person's personal and interpersonal skills; the latter focused on reducing the influence of society in general on use, for example, through normative education. Knowledge-focused approaches alone did not have a positive effect on preventing drug use.
- As the effect of universal school-based programmes tended to be small, the authors of the Cochrane review concluded that to achieve population-level impact, school-based programmes should only be a part of a more comprehensive range of drug prevention strategies.
- The findings of other reviews explored by Warren (2016) suggested other components that might have contributed to an increase in programme effectiveness. These included taking an interactive approach to delivery where students had a high level of participation; having more components to the programme over and above that in the school curriculum; ensuring that the content was age appropriate; and, peers being involved, but not leading, in the delivery of the programme.
- While looking at the components of effective programmes was useful, a recurring finding was that what really mattered was the programme itself. Therefore, there was better evidence of effectiveness for specific manualised programmes as they had been rigorously evaluated. Indeed, manualised programmes tend to be highly structured and include training and implementation guidance. Fidelity to the programme design and delivery was highlighted as critical if they were to deliver similar outcomes when transferred to a new setting. Success was also dependent in part on the existence of an established national and local prevention system. Effective programmes discussed included the Good Behaviour Game and the Strengthening Families Programme.
- There was a growing body of evidence of what did not work in preventing drug use among young people. The United Nations Office on Drugs and Crime (UNODC) found that programmes that had the following characteristics had no or negative prevention outcomes: using 'ex-drug users' as testimonials; using police officers to deliver classroom sessions; providing just information about drugs, especially if used for 'fear arousal'; using non-interactive methods such as lecturing; and, focusing only on the building of self-esteem and emotional education.

'What works' in drug education and prevention? continued

- Programmes do not need to target drug use specifically to have a positive impact on drug-using behaviour.
- While the evidence base suggested that drug prevention should be embedded in strategies that take a broader approach to healthy development and well-being, there was a case for delivering more drug-specific prevention interventions for young people who are most at risk of drug-related harm or who are already using drugs. These young people were found to benefit in particular from universal programmes in which they had participated. The School Health and Alcohol Harm Reduction Project (SHAHRP) was identified as a universal programme for which there was evidence of positive outcomes for this higher risk group.

Considerations for policy-makers

In conclusion, the report's considerations for policy-makers when commissioning prevention programmes included that they should: adhere to recognised quality standards; incorporate a high-quality evaluation; ensure that ineffective or iatrogenic programmes were not funded; consider carrying out economic analysis to establish cost-effectiveness; take a wider view of the prevention system and the programme's fit; and, consider programmes that target multiple risk behaviours.

Lucy Dillon

1 Warren F (2016) *'What works' in drug prevention and education?* Edinburgh: Scottish Government. http://www.drugsandalcohol.ie/26557/

2 Society for Prevention Research (2011) *Standards of knowledge for the science of prevention.* Fairfax, VA: Society for Prevention Research. Cited in Warren (2016, p. 12).

3 Faggiano F, Minozzi S, Versino E, Buscemi D (2014). Universal school-based prevention for illicit drug use. Cochrane Database of Systematic Reviews. http://www.drugsandalcohol.ie/23203/

Launch of Recovery Academy Ireland

On 23 November 2016, Recovery Academy Ireland was formally launched by the assistant chief executive of Dublin City Council, Brendan Kenny, at City Hall, Dublin. Recovery Academy Ireland is a cooperative organisation that takes its place among a wider international network of recovery academies. Its primary focus is to promote and support active and sustainable recovery for people in addiction, their families and friends, and to advocate on behalf of those in recovery. The event was attended by Cllr Mannix Flynn, members of the Board of Recovery Academy Ireland, people in addiction, those in active and sustained recovery, service providers, academics and policy-makers. The general mood of the event was one of hope, positivity and empowerment.

Empowering people in recovery

A strong message calling for a paradigm shift in the Irish drug treatment landscape was delivered by Gerry McAleenan, chairperson of Soilse Drug Rehabilitation Project. McAleenan emphasised the need to give those in recovery a voice, empowering them to serve as role models in their communities, act as visions of hope, and champion the concept of detox and sustained recovery. In this context, Recovery Academy Ireland's mission is to begin this cultural shift of reorientating services away from simple harm reduction and towards a recovery model. The academy aims to do this by promoting a life of fulfilment, well-being and full societal participation for those in recovery, which is removed from dependence on addiction services.

Recovery principles

The establishment of Recovery Academy Ireland has grown from a strong foundation in evidence[1,2] and builds on the momentum surrounding recovery championed by mental health services and addiction services internationally. The 12 recovery principles of Recovery Academy Ireland are:

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

Recovery Academy Ireland will contribute to the growing evidence base surrounding recovery in Ireland, hold workshops and training seminars, raise awareness about recovery, and organise events encouraging those in addiction to aspire to a recovered life with the help and guidance of the academy.

Recovery Academy Ireland continued

Community-based assets audit

The launch of Recovery Academy Ireland coincided with the publication of a peer-led action research project titled 'A Community Assets Scoping Exercise in Dublin's North Inner City'[3]. The objectives of the project were to train a group of recovered individuals to undertake 'community research' and for these individuals to conduct a community-based assets audit. This project was executed by eight recovered volunteers who undertook a community participatory action research (CPAR) course facilitated by Dr Jo-Hanna Ivers and the chairperson of Recovery Academy Ireland, Dr Patricia Doyle. The course enabled the volunteers to lead and coordinate the study. Seven of the recovered individuals completed the training and subsequently conducted 100 questionnaires with people in active addiction, in different stages of recovery, members of the public, and those with a family member in recovery. The questionnaires were carried out in North Inner City Dublin. All seven also participated in personal case studies.

The research group concluded that the stigma surrounding people in recovery should continue to be challenged in the North Inner City. They demonstrated that recovery is not simply an absence of addiction but encompasses levels of personal, relationship, community and cultural recovery. The study highlighted that the language associated with recovery requires change in the North Inner City; simply replacing 'addiction' with the language of 'recovery' had an immediate effect on the community researchers and on the research participants. Other examples, such as switching words like 'dependency' to 'freedom from' or 'sickness' to 'healing/dignity/happiness', recognise that recovery is a positive and dynamic process.

The study concluded that by switching the focus from the needs of the person in recovery to the assets that the individual possesses promotes a more positive outlook. The study stated the importance of acknowledging the gifted, independent, brave and resourceful nature of individuals in recovery and promoted the idea that recovered individuals should be more visible in the community. The study added that 'healing and improving' relationships is an essential step in the recovery process, especially for women, and that building strong, supportive communities for recovering individuals helps twofold. The recovered individual can use their personal assets to become activists and pillars of social advocacy to revitalise the community traumatised by addiction. Finally, the importance of links between education and therapeutic programmes were also reinforced in the research.

Augmenting the RECOVEU initiative

The launch of Recovery Academy Ireland is a very important and poignant step to spread the message of recovery in Ireland. The work also builds on Ireland's participation in the RECOVEU initiative alongside the UK, Cyprus, Italy and Romania. Spearheaded by Soilse, the Drug Rehabilitation Programme based in Dublin city centre, RECOVEU is developing innovative learning activities for recovered adults to prepare for, and succeed in, college or university. As William L. White, author of *Let's go make some history: chronicles of the new addiction recovery advocacy movement*, outlined in the Foreword of the community research report (p. 4), the people who carried out this research were once viewed as 'part of the "problem"' but now offer living proof that:

1. Long-term addiction recovery is a reality.
2. There are many pathways to recovery and all are cause for celebration.
3. Recovery flourishes within supportive communities.

For more information about Recovery Academy of Ireland, to join the movement or to take part in their many events, visit **www.recoveryacademyireland.ie**. For more information about RECOVEU or to get involved, please visit **www.recoveu.org**

Thérèse Lynn

1 Keane M (2011) *The role of education in developing recovery capital in recovery from substance addiction.* Dublin: Soilse Drug Rehabilitation Project. http://www.drugsandalcohol.ie/16140/

2 Keane M, McAleenan G and Barry J (2014) *Addiction recovery: a contagious paradigm! A case for the re-orientation of drug treatment services and rehabilitation services in Ireland.* Dublin: Soilse Drug Rehabilitation Project. http://www.drugsandalcohol.ie/22291/

3 Brady J, Corcoran K, Ducque C, Gelston M, Murtagh J, O'Neill B, Slator K, Doyle P, Ivers JH (2016) *Peer led action research: a community assets scoping exercise in Dublin's north inner city.* Dublin: Recovery Academy Ireland. http://www.drugs.ie/downloadDocs/2016/Recovery-Peer-Led-Action-Research-2016.pdf

RECOVEU: participative approach to curriculum development for adults in addiction recovery across EU

The RECOVEU project was a three-year education initiative funded under the European Union (EU) Grundtvig Lifelong Learning Programme,[1] which was completed in December 2016. The aim of RECOVEU was to develop innovative learning activities to assist adults in addiction recovery to prepare for, and succeed in, college or university across the EU as well as starting the conversation about recovery capital. Set up in 2014, its partners comprised Soilse (Ireland), Staffordshire University (UK), the Centre for the Advancement of Research and Development in Educational Technology (CARDET-Cyprus), St Dimitrie Basarabov Program (Romania) and the Cooperativa Sociale San Saturnino Onlus (SANSET-Italy).

At the outset, a policy and practice review was carried out in each of the partner countries. This review found:

- There was a lack of consensus on the treatment of addiction and the concept of recovery across the partner countries.
- There were few specific opportunities for adults in recovery to engage with employability programmes in the five partner countries.
- There was no designated access to learning programmes designed specifically for adults in recovery and cognisant of the issues and barriers they face.
- There were differences among partner countries, and often a lack of recognition, of the way in which non-medicalised and psychosocial interventions can contribute to treatment, the development of social capital, and social reintegration of the recovered individual.

Access to Learning course

RECOVEU created a dialogue among educators, people in recovery and drug service providers that led to the development of an asset-based Access to Learning course and a range of supporting material (course pack, facilitators' pack and evaluation toolkit). Access to Learning is a sample course spread over 20 hours that demonstrates some of the main learning, insights and opportunities that must be considered to ensure any educational courses designed in the future meet the needs of those in recovery from addiction.

To develop the Access to Learning course the project involved convening 20 focus groups, which took place across the five partner countries. A total of 92 people took part in these focus groups, comprising 44 service users and 48 service providers. One-quarter of the service users (25%) and almost two-thirds (60%) of service providers were female. The data from the focus groups were transcribed, coded and thematically analysed to first identify the barriers to learning and then determine what the learning modules should contain. The barriers to accessing education programmes cited by focus group members were money, childcare, equipment, filling in forms, previous convictions, lack of ID (identity papers) and driving licences, homelessness and lack of study space.

In deciding what the modules should contain, the aim was not to repeat the failures of other programmes but to recognise that learning falls within three dimensions: the cognitive dimension of knowledge and skills, the emotional dimension of feelings and motivation, and the social dimension of communication and cooperation. This implied two learning processes: an internal psychological process and an external interaction process. It was significant that many of the service users in the focus groups grew up in systems that prioritised cognitive learning over emotional and social learning. Many of them were ambivalent about academic learning; some felt they did not fit into academic settings and others either were early school-leavers or had negative school experiences. Many were also multiply disadvantaged and saw little value in education as a means to social inclusion.

Modules developed

Following analysis of the focus group data, it was agreed to develop five modules for the course.

Module 1: Recovery and Resilience is an overarching module. It comprises:

- Online learning to create discussion of addiction and recovery
- Creation of a storyboard by each participant to show their addiction history
- Exploration of the themes of recovery capital, recovery principles and resilience
- An introduction to SMART goal techniques – specific, measurable, assignable, realistic, time-related
- Discussion of the language of recovery

Module 2: Recovery and Learning to Learn goes beyond the predictable study skills response and provides the recovering learner with insights into their own learning experiences, styles and aptitudes. It includes:

- A do's and don'ts audit
- Use of mind maps
- Kolb's model[2] on reflective learning and the use of experiential learning for the recovering person
- Challenges to learners in recovery
- An examination of orientation approaches for access to learning

RECOVEU continued

Module 3: Recovery and Digital Learning recognises the digital divide where children and teenagers are adept at using communications technology but older people in general are reluctant to engage. Participants explore online collaborative learning, knowledge sharing and blended learning, as well as face-to-face learning supported by digital skills. This module highlights that an ability to engage with online learning is vital for access to educational courses, social media, recovery websites, online meetings, and online information. Digital skills are also necessary for access to the world of work.

Module 4: Recovery and Community explores how recovery capital is generated in community settings and, by extension, educational locations. It looks at the usefulness of personal boundaries and the supportive role that trained recovery coaches can play to assist others in achieving sustained recovery.

Module 5: Recovery and Employability looks at both the barriers to work and the requirements for employment (how to find a job, put together a CV, apply for jobs, and develop interview skills). The module also examines recovery enterprises that are notable providers of work in the US and some European countries for people in recovery.

Recovery capital

RECOVEU also introduced policy-makers, educators, service providers and recovering addicts to the concept of recovery capital. Recovery capital is the sum of resources necessary to initiate and sustain recovery from substance misuse.[3]

Recovery capital comprises four elements: physical, human, social, and cultural. Physical capital refers to savings, income, accommodation, and so on; human capital means health and functioning; social capital means creating new networks and supports; cultural capital means developing new attitudes, beliefs and values. Taking part in adult learning helps people in recovery to obtain these benefits.

In conclusion, the benefit of the RECOVEU initiative is that it has identified the learning needs of those in recovery through a structured process. The Access to Learning course meets not only the educational needs of people in recovery but also enables them to initiate and sustain their recovery, maintain an independent and drug-free lifestyle, take part fully in their communities, and reintegrate with their families. The course is active in Soilse, the Drug Rehabilitation Programme in Dublin, and several other treatment centres around Ireland, where phase II of the rollout is now in train. Further information on RECOVEU, including an e-learning platform and resources on adult education and addiction recovery, can be found at **www.recoveu.org**.

Thérèse Lynn and Gerry McAleenan

1 More information about the European Union Grundtvig Lifelong Learning Programme is available at http://ec.europa.eu/education/lifelong-learning-programme_en

2 Kolb DA (1984) *Experiential learning: experience as the source of learning and development.* Englewood Cliffs, NJ: Prentice Hall.

3 Cloud W and Granfield R (2008) Conceptualizing recovery capital: expansion of a theoretical construct. *Substance Use and Misuse,* 43: 1971–1986.

EUSPR conference: sustainable prevention in a changing world

The 7th Conference of the European Society for Prevention Research (EUSPR) attracted participants from across the globe when held in Berlin between 31 October and 2 November 2016. The EUSPR was established to promote `the development of prevention science, and its application to practice so as to promote human health and well-being through high quality research, evidence based interventions, policies and practices'.[1] The cornerstones of its work are a cross-disciplinary network of scientists, policy-makers and practitioners; the development of methodologies; the promotion of higher education and career development in prevention; and the implementation of research.

The conference theme was `sustainable prevention in a changing world' - speakers covered a wide range of topics from evaluations of individual prevention programmes to much broader debates about the value and role of prevention in society today.

A recurring theme throughout the conference was how population and behavioural changes across Europe are presenting new challenges to health and well-being. Much discussion focused on how evidence-based sustainable prevention systems and structures can best be developed to meet these changing needs.

Preventing substance use was one of a range of behaviours explored at the conference. The presentations tended to focus on local evaluations of individual programmes. These included programmes unique to the locality and those more broadly recognised, such as the Strengthening Families Programme and the Good Behaviour Game.

Discussions in the sessions identified a number of issues facing those working in drug prevention. These included the challenge of gaining support for evidence-based programmes at a local level; the value of early intervention; the importance of programmes that focus on developing young people's lifeskills and resilience rather than being drug specific; and, the need to further develop training for prevention professionals.

Lucy Dillon

1 More information on the EUSPR and the conference is available at http://www.euspr.org

Update on the national rollout of LINK to replace NDTRS

What is LINK?

LINK is the new web-based system that has replaced the National Drug Treatment Reporting System (NDTRS) database. It enables service providers to enter, validate and report on their data through an online system, from any location with an internet connection and browser.

LINK changes the way in which the NDTRS collects data, enabling service providers to enter their data directly into the online database, which will allow more timely and direct access to their own data through a suite of online predefined reports, as well as providing an ad-hoc analysis tool. Data quality is ensured through a set of inbuilt validations and quality checks that are activated once a service user has been entered into the system.

As an online system, not only is LINK easily accessible and straightforward to use but the time lags involved in the previous data collection process have been eliminated. There is also greater ease of access and transparency for all parties involved.

New NDTRS questions

The NDTRS questions have been significantly amended and updated in order to comply with reporting requirements for the EMCDDA and also to improve the way in which the Health Research Board (HRB) collects data nationally. The key changes concern children of service users, self-defined sexual orientation, and treatment outcomes. Further information on the new questions is available in the new protocol.[1]

Treatment episodes

Each NDTRS form becomes a treatment episode in the LINK database. Service providers can enter multiple episodes per service user (client) and link each episode, which enables a service provider to easily view the service user's entire treatment journey over time. Reports can be run locally on the individual service provider's data or on a particular group/area, depending on user access level. Data are validated automatically by LINK as each episode is entered; this gives users the advantage of instantly seeing any issues with the data. Detailed validation messages are displayed to guide the user in making corrections and amendments. Once any serious anomalies are rectified, the system recognises the data as valid for reporting purposes and becomes available for reporting locally and nationally.

LINK validations – sample rejection

Figure 1 shows a rejection that has been raised due to conflicting information in a treatment episode. The message clearly indicates where the issue lies and is a clickable link, leading the user directly to the relevant screen where the information can be updated.

Training

The LINK system is based on the updated 2016 NDTRS questions, and all service providers and data coordinators will require training on filling in the new form accurately, as well as on how to use the new LINK features to their best advantage. As with any new system, training is important and extensive planning and preparation has therefore gone into training service providers on how to use LINK. The approach consists of a phased rollout to each area.

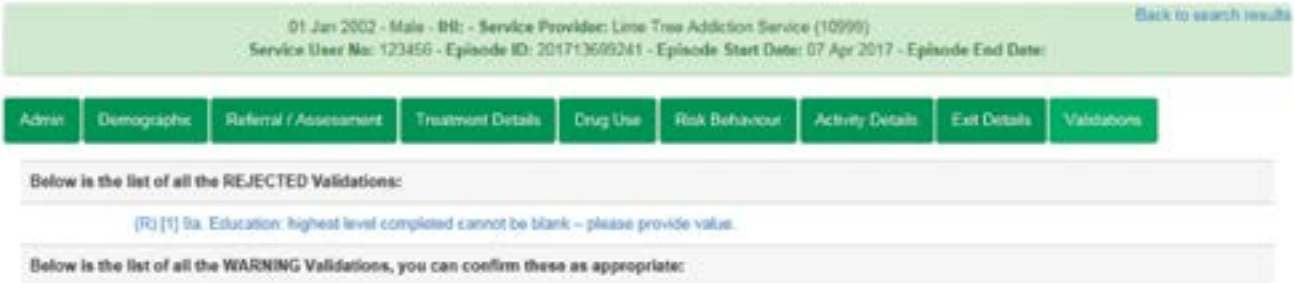
Approach to rollout and training

The first LINK training took place in July 2016 in Kilkenny and since then has been carried out in groups in the HRB office in Dublin and onsite with service providers. The phased rollout started in the South/South East and has been progressing from there. By March 2017, over 230 people from 75 service providers around the country have been trained.

Training preparation – items for action

- Each service provider will need to identify a super-user, who will be responsible for managing users, e.g. assigning passwords, setting up new users, and overseeing the quality of the data.
- Each service provider will need to assess their internet access:
  - Internet browsers: NDTRS LINK will work on Internet Explorer 9 onwards but is optimal on Internet Explorer 11. It also works on Chrome 50+, Firefox 30+ and Safari 9+.
  - Operating systems: Windows 7 minimum, Mac version 10.8, with all machines requiring 4+MB RAM.
  - Download speed: At least 3 MB.

Figure 1: A rejection raised due to conflicting information in a treatment episode



LINK system continued

- Decide which staff require training:
  - All staff who currently fill NDTRS forms or enter data will need to be trained.[2]
  - Refresher training for service providers who are already NDTRS compliant will take 3 hours.
  - Full training for service providers new to the NDTRS, or who have poor returns, will take 4 hours.

If your service provider is using eCass/Enclude, a process of consultation with them to incorporate the changes has already begun. Once the changes have been made, service providers using eCass should be able to directly upload their data to the NDTRS LINK system, and then access all the functions within LINK. Again, once the changes have been made, service providers will need to receive training on how to upload their data directly onto the new system.

Next steps

The NDTRS team has been in contact with individual service providers to plan suitable training dates and migration to the new system. If you have not yet been contacted, or have any questions at this time, email the NDTRS team at **link@hrb.ie**

Hazel Quigley

1 For further information on the protocol, visit http://www.drugsandalcohol.ie/26858/

2 To view our training video material at the LINK YouTube channel, visit https://www.youtube.com/channel/UC2_D0Cj03WwuwzVfs-kYKaQ

Launch of the National Community Action on Alcohol Network

Minister of State for Communities and National Drugs Strategy Catherine Byrne TD launched the National Community Action on Alcohol Network on 22 February 2017. The opening address was given by Kieran Doherty, CEO of the Alcohol Forum, which will coordinate the network through their Community Action on Alcohol Project (CAAP).[1] The network has been set up in response to requests from the communities engaging in CAAP to help address the harm caused by alcohol in their own areas. The network will enable the sharing of knowledge, expertise and experiences across the country, which in turn will ensure that their voices can make an impact on policy at the national level: 'The formation of the network sends a clear message that people want to see change and that communities themselves have an important role to play.'

The first two speakers on the day represented areas that had already gone through the CAAP process. David Lane (HSE Cork and Kerry) shared his experience as chair of the Cork and Kerry Alcohol Strategy Group. It was one of the initial pilot sites to go through the process and is now about to launch its own local alcohol action plans in three areas: Listowel, Youghal and North West Cork City. In particular, David acknowledged the work already done by communities in Ballymun and Galway, as learning from those experiences proved useful in their own process. He also stated they were aware that this process was a long road, indeed a marathon and not a sprint.

The next speaker was Peter Conway, chair of the North Dublin Community Action on Alcohol and a member of the North Dublin Regional Drug and Alcohol Task Force. Its members were part of the second group to go through the CAAP process. He too spoke about the positivity of community mobilisation and in particular the benefit of involving different stakeholders. He acknowledged the great help they received from the first pilot group, for example, in identifying pitfalls and 'making challenges workable'. He welcomed the formation of the network, which he felt will allow meaningful conversation about what works, comparisons, and constructive planning.

Paula Leonard from the Alcohol Forum also addressed the attendees and gave a concise overview of the alcohol situation, CAAP and plans for the future. Minister Byrne was the final speaker of the morning and spoke of the need for communities to learn from each other and their experiences in order to implement actions in alcohol harm reduction. She noted that communities need to 'be brave and make hard decisions' in this area. She acknowledged the work of the Alcohol Forum and in conclusion referenced the upcoming Public Health (Alcohol) Bill 2015 and the new National Drugs Strategy.

The network aims to:

- Promote an evidence-based approach to community action on alcohol.
- Enable the sharing of best practice and provide a space for challenges and barriers to be discussed in a positive shared-learning environment.
- Advocate for and advance the current allocation of resources to support community action on alcohol.
- Act as a learning resource between members and facilitate the exchange and development of knowledge, values, and skills in the area of community action on alcohol.
- Act as a space for members to form collective positions on issues of common concern and support collective action on these issues.
- Develop a number of shared outcomes, thereby enabling/supporting the demonstration of positive outcomes at a national level as the approach expands to other areas.

Suzi Lyons

1 Further information on CAAP is available at http://www.alcoholforum.org/community-action-on-alcohol/

18th Annual Service of Commemoration and Hope

On Wednesday, 1 February, the National Family Support Network (NFSN)[1] held its 18th Annual Service of Commemoration and Hope. This spiritual, multidenominational service is held in remembrance of loved ones lost to substance misuse and related causes and to publicly support and offer hope to families living with the devastation that substance misuse causes. Those in attendance included Commandant Kieran Carey, aide-de-camp to An Taoiseach, Garda Commissioner Nóirín O'Sullivan, Archbishop Diarmuid Martin, Bishop Eamonn Walsh, and other religious representatives, as well as family members, friends, and many people involved in substance misuse work. Music was provided by the soprano Nickola Hendy and the Gardiner Street Gospel Choir.

In her address to the gathering, Sadie Grace, coordinator of the NFSN, spoke directly to family members, stressing that they are not alone; she highlighted the latest report from the National Drug-Related Deaths Index, which showed that 697 deaths occurred in 2014, directly or indirectly due to drug use. She spoke about the increase in deaths due to heroin and cocaine use and how the majority of deaths involved young men. She also mentioned the role of naloxone in helping to prevent deaths from opiate overdose and the NFSN's support during the HSE Naloxone Demonstration Project. She stressed the importance of expanding the availability of naloxone to family members and educating families on the signs and symptoms of overdose.

Sadie spoke about the impact of compounding factors affecting bereaved families associated with drug use and drug-related deaths. These included increased financial difficulties related to funerals, increasing level of drug intimidation and threats of violence, single parents or kinship carers taking on the responsibility of caring for young children, and children dealing with the loss of parents. She called for more research in this area and support for affected families. She emphasised the importance of the NFSN being involved in the consultation process for the new National Drugs Strategy to ensure family needs are included. In her closing statement, she highlighted the necessity for ongoing financial support and investment in family support.

For many families, this service is the first time that they can openly grieve for loved ones lost to drug use and related causes. The growth of family support groups was evident, with support groups from across the island of Ireland represented at this year's service. Personal testimonies were given by members of family support groups, reflecting the vital support received through these groups. These included Maureen Penrose, a member of the Croí Cróga Peer Family Support Group, who highlighted the vital importance of peer support groups, members of whom support each other and share their heartache, hurt, fears, hopes and joys. Anne-Marie Taylor gave a very honest speech about her experience as a drug user and her journey to recovery, and encouraged people to look for support. Adrienne Sweetman acknowledged the tremendous work of the NFSN Bereavement Support Group. The NFSN runs a 10-week bereavement programme twice a year and Adrienne encouraged family members to contact the NFSN and avail of assistance from this group.

In his address, Archbishop Diarmuid Martin spoke of the importance of the annual service to reflect on tragedy and hope. He urged the audience not to lose sight of hope and the freedom and hope that comes with recovery.

Ena Lynn

1 The National Family Support Network can be contacted at 5 Gardiner Row, Dublin 1 on 01 898 0148 or info@fsn.ie or online www.fsn.ie.

National Drugs Library

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**

POLICY AND LEGISLATION

Irish general practitioner attitudes toward decriminalisation and medical use of cannabis: results from a national survey

Crowley D, Collins C, Delargy I, Laird E and Van Hout MC (2017) *Harm Reduction Journal,* 14(1): 4
http://www.drugsandalcohol.ie/26675/

Governmental debate in Ireland on the de facto decriminalisation of cannabis and legalisation for medical use is ongoing. A cannabis-based medicinal product (Sativex®) has recently been granted market authorisation in Ireland. This unique study aimed to investigate Irish general practitioner (GP) attitudes toward decriminalisation of cannabis and assess levels of support for use of cannabis for therapeutic purposes (CTP).

Conclusion: The majority of Irish GPs do not support the present Irish governmental drug policy of decriminalisation of cannabis but do support the legalisation of cannabis for therapeutic purposes. Male GPs and those with higher levels of addiction training are more likely to support a more liberal drug policy approach to cannabis for personal use. A clear majority of GPs expressed significant concerns regarding both the mental and physical health risks of cannabis use. Ongoing research into the health and other effects of drug policy changes on cannabis use is required.

Potential impact of minimum unit pricing for alcohol in Ireland: evidence from the National Alcohol Diary Survey

Cousins G, Mongan D, Barry J, Smyth B, Rackard M and Long J (2016) *Alcohol and Alcoholism,* 51(6): 734-740
http://www.drugsandalcohol.ie/26346/

One of the main provisions of the Irish Public Health (Alcohol) Bill is the introduction of a minimum unit price (MUP) for alcohol in Ireland, set at €1.00/standard drink. We sought to identify who will be most affected by the introduction of a MUP, examining the relationship between harmful alcohol consumption, personal income, place of purchase and price paid for alcohol.

Conclusion: Heavy drinkers, men and those on low income seek out the cheapest alcohol. The introduction of a MUP in Ireland is likely to target those suffering the greatest harm, and reduce alcohol-attributable mortality in Ireland. Further prospective studies are needed to monitor consumption trends and associated harms following the introduction of minimum unit pricing of alcohol.

PREVALENCE AND CURRENT SITUATION

Medicines containing codeine: perspectives of medical professionals in the Republic of Ireland

Foley M, Carney T, Harris R, Fitzpatrick E, Rapca-Veillet A and Van Hout, MC (2017) *Irish Journal of Medical Science*, Early online.
http://www.drugsandalcohol.ie/26651/

The aim of the study was to examine prescribing professional's perceptions on prescribed and OTC (over the counter) medicines, containing codeine in the Republic of Ireland. A secondary aim was to examine perceptions on codeine dependence, screening and treatment.

Conclusion: Policy should examine the need for greater public health awareness on codeine use and should examine the role of OTC and internet sales in the development of dependence. Further consideration should be given to training and support for those who prescribe addictive medicines in practice.

Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis

Popova S, Lange S, Probst C, Gmel G and Jehm J (2017) *The Lancet Global Health*, Early online.
http://www.drugsandalcohol.ie/26659/

Alcohol use during pregnancy is the direct cause of fetal alcohol syndrome (FAS). We aimed to estimate the prevalence of alcohol use during pregnancy and FAS in the general population and, by linking these two indicators, estimate the number of pregnant women that consumed alcohol during pregnancy per one case of FAS.

Conclusion: Alcohol use during pregnancy is common in many countries and, as such, FAS is a relatively prevalent alcohol-related birth defect. More effective prevention strategies targeting alcohol use during pregnancy and surveillance of FAS are urgently needed.

Oral cancer incidence and survival rates in the Republic of Ireland, 1994-2009

Ali H, Sinnott SJ, Corcoran P, Deady S, Sharp L and Kabir Z (2016)
BMC Cancer 16(950)
http://www.drugsandalcohol.ie/26605/

Oral cancer is a significant public health problem world-wide and exerts high economic, social, psychological, and physical burdens on patients, their families, and on their primary care providers. We set out to describe the changing trends in incidence and survival rates of oral cancer in Ireland between 1994 and 2009.

Conclusion: Oral cancer increased significantly in both sexes between 1999 and 2009 in Ireland. Our analyses demonstrate the influence of measured factors such as smoking, time of diagnosis and age on observed trends. Unmeasured factors such as alcohol use, HPV and dietary factors may also be contributing to increased trends. Several of these are modifiable risk factors which are crucial for informing public health policies, and thus more research is needed.

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

Davoren MP, Cronin M, Perry IJ, Demant J, Shiely F and O'Connor K (2016) *Addiction Research & Theory*, 24(4): 261-273
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.

Conclusion: 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.

Depressive symptoms, college adjustment and peer support among undergraduate nursing and midwifery students

Horgan A, Sweeney J, Behan L and McCarthy G (2016). *Journal of Advanced Nursing*, 72(12): 3081-3092
http://www.drugsandalcohol.ie/26414/

This study aimed to identify levels of depressive symptoms, social and personal college adjustment and peer support among nursing and midwifery students. The alcohol consumption of participants had a statistically significant relationship with depressive symptoms with higher consumption rates having a positive impact on symptoms.

Conclusion: The mental health of undergraduates undertaking professional healthcare studies needs to be a key research, educational and clinical priority. High rates of adjustment and mental health difficulties, particularly in the second year of the programme, need to be examined and more effective interventions developed.

New psychoactive substances (NPS) on cryptomarket fora: an exploratory study of characteristics of forum activity between NPS buyers and vendors

Van Hout MC and Hearne E (2016) *International Journal of Drug Policy*, Early online.
http://www.drugsandalcohol.ie/26618/

The continual diversification of new psychoactive substances (NPS) circumventing legislation creates a public health and law enforcement challenge, and one particularly challenged by availability on Hidden Web cryptomarkets.

Conclusion: Continued monitoring of new trends in NPS within Surface Web and cryptomarkets are warranted. A particular focus on the rising market in prescribed benzodiazepine and Z-hypnotic drugs should be included.

Association between victimization by bullying and direct self injurious behavior among adolescence in Europe: a ten-country study

Brunstein Klomek A, Snir A, Apter A *et al.* (2016) *European Child and Adolescent Psychiatry*, 25(11): 1183-1193
http://www.drugsandalcohol.ie/26347/

Previous studies have examined the association between victimization by bullying and both suicide ideation and suicide attempts. The current study examined the association between victimization by bullying and direct-self-injurious behavior (D-SIB) among a large representative sample of male and female adolescents in Europe.

Conclusion: This large-scale study has clearly demonstrated the cross-sectional association between specific types of victimization with self-injurious behavior among adolescents and what may be part of the risk and protective factors in this complex association.

Alcohol consumption among university students: a typology of consumption to aid the tailoring of effective public health policy

Davoren MP, Cronin M, Perry IJ and O'Connor K (2016) *BMJ Open*, 6(11): e011815
http://www.drugsandalcohol.ie/26485/

Tailoring public health policy to effectively tackle alcohol use is crucial. Using Q-methodology, the current study aims to develop a typology of alcohol consumption in the Irish university student population.

Conclusion: This is the first study to propose ideal types of alcohol consumption among a university student population. Further research is required to investigate the degree to which each of these ideal types is subscribed. However, this typology, in addition to informing public policy and strategies, will be a valuable analytic tool in future research.

The epidemiology of emergency in-patient hospitalisations among those with 'no fixed abode' (homeless) 2005-2014: What lessons can be learnt

O'Farrell A, Evans DS and Allen M (2016) *Irish Medical Journal*, 109(9): 464
http://www.drugsandalcohol.ie/26253/

Estimates show that homelessness is increasing in Ireland. This study analysed the epidemiology of emergency hospitalisations among those experiencing homelessness between 2005-2014.

Conclusion: The health of homeless people is a fundamental issue that needs addressing. Access to, and use of, community and preventative services is needed to reduce utilisation of emergency hospital services.

Cocaine use in young adults: correlation with early onset cannabis, alcohol and tobacco use

Smyth BP, Hannigan A and Cullen W (2016) *Irish Medical Journal*, 109(9): 468
http://www.drugsandalcohol.ie/26254/

There is ongoing debate regarding the relationship between early tobacco, alcohol and cannabis use and later cocaine abuse. We utilised data from two Irish national general population surveys.

Conclusion: Analysis indicated that being single, earlier age of first alcohol use, and history of cannabis use were significant independent predictors of lifetime use of cocaine. The substance use route to cocaine use in this Irish sample is quite typical of that seen internationally. Those who commence alcohol use in the early teenage years are more likely to use cocaine subsequently, even after controlling for early onset cannabis use and other socio-demographic characteristics. This suggests that policies which delay age of first drinking may possibly also curtail cocaine use.

RESPONSES

Smokers and ex-smokers have shared differences in the neural substrates for potential monetary gains and losses

Nestor L, McCabe E, Jones J, Clancy L and Garavan H (2016) *Addiction Biology*, Early online.
http://www.drugsandalcohol.ie/26590/

Despite an increased understanding of nicotine addiction, there is a scarcity of research comparing the neural correlates of non-drug reward between smokers and ex-smokers.

Conclusion: The results suggest that smoking may sensitize striato-orbitofrontal circuitry subserving motivational processes for loss avoidance and reward gain in nicotine addiction.

Recent publications continued

Tailoring a brief intervention for illicit drug use and alcohol use in Irish methadone maintained opiate dependent patients: a qualitative process

Darker CD, Sweeney B, Keenan E, Whiston L, Anderson R and Barry J (2016) *BMC Psychiatry,* 16 (373) http://www.drugsandalcohol.ie/26362/

The World Health Organization (WHO) recommend the tailoring of a brief intervention (BI) programme of research to ensure that it is both culturally and contextually appropriate for the country and the environment in which it is being tested. The current study developed a tailored BI for illicit drug use and alcohol use to a methadone maintained opioid dependent polydrug using cohort of patients.

Conclusion: The research team was faithful to WHO recommendations to tailor BI programmes that are culturally and contextually appropriate to the treatment cohort and clinical environment. Outcome data from the cluster RCT have demonstrated that the tailored intervention was effective.

Quality assurance in drug demand reduction in European countries: an overview

Ferri M, Dias S, Bo A, Ballotta D, Simon R and Carra G (2016) *Drugs: Education Prevention and Policy,* Early online http://www.drugsandalcohol.ie/26376/

The EMCDDA, through its network of National Focal Points, collects information on the quality assurance systems for drugs-related interventions across European countries. European National Drug Strategies include recommendations for systems and approaches for the assurance of the quality of interventions.

Conclusion: Although the evidence base for interventions in drug demand reduction is becoming available and accepted, attention needs to be given to implementation issues. The European countries are rapidly moving towards paying greater attention to the quality of interventions.

Mastery matters: consumer choice, psychiatric symptoms and problematic substance use among adults with histories of homelessness

Greenwood RM and Manning RM (2016) *Health and Social Care in the Community*, Early online. http://www.drugsandalcohol.ie/26426/

Previous research demonstrated the importance of consumer choice and mastery to residential stability and psychiatric functioning for adults with histories of homelessness. In the present study, we investigated whether these relationships hold, even in the context of problem-related substance misuse.

Conclusion: Our findings confirm that consumer choice in housing and services is important to homeless services users' recovery experiences. Because of its relationship with mastery, consumer choice in housing and services protects homeless services users' psychiatric functioning, especially when substance use-related choices have had negative consequences. Our findings suggest that if homeless services take away consumer choice when substance use causes problems, they may actually undermine, rather than foster, service users' psychiatric functioning.

Feasibility of alcohol screening among patients receiving opioid treatment in primary care

Henihan AM, McCombe G, Klimas J, Swan D, Leahy D, Anderson R, Bury G, Dunne C, Keenan E, Lambert J, Maher D, O'Gorman CSM, O'Toole TP, Saunders J, Shorter GW, Smyth BP, Kaner E and Cullen W (2016) *BMC Family Practice,* 17(153) http://www.drugsandalcohol.ie/26360/

Identifying and treating problem alcohol use among people who also use illicit drugs is a challenge. Primary care is well placed to address this challenge but there are several barriers which may prevent this occurring. The objective of this study was to determine if a complex intervention designed to support screening and brief intervention for problem alcohol use among people receiving opioid agonist treatment is feasible and acceptable to healthcare providers and their patients in a primary care setting.

Conclusion: Alcohol screening among people receiving opioid agonist treatment in primary care seems feasible. A definitive trial is needed. Such a trial would require over sampling and greater support for participating practices to allow for challenges in recruitment of patients and practices.

General practice – a key route for distribution of naloxone in the community

Klimas J, Tobin H, Egan M, Tomas B and Bury G (2016) *International Journal of Drug Policy,* 38: 1-3 http://www.drugsandalcohol.ie/26393/

Heroin use continues to drive opioid-related overdoses and mortality globally. Not-as-prescribed use of prescription opioids increases the number of victims of this epidemic. Naloxone has been shown to reduce mortality in overdose among people who use heroin and other opioids; however, its administration in a number of countries, including Ireland, is limited to paramedics and health professionals, despite proven effectiveness of overdose education and naloxone distribution (OEND) programmes by trained lay-people worldwide.

Conclusion: A key finding of this study is the very limited exposure of GP trainees to substance misuse roles during their training in GP. In Ireland, more patients with opiate dependency die from opiate overdose each year than all those who die in road accidents. The extent of this crisis is not reflected by the preparation currently offered to future GPs in their training. Re-evaluation of the role of GP postgraduate training as part of OEND must now become a priority.

The role of alcohol dependency in deaths among people with epilepsy recorded by the National Drug-Related Deaths Index (NDRDI) in Ireland, 2004-2013

Lynn E, Lyons S, Langan Y, Craig S and Doherty C (2016) *Seizure,* 45: 52-55. http://www.drugsandalcohol.ie/26487/

The aim of this study was to investigate deaths among individuals with epilepsy recorded on the National Drug-Related Deaths Index (NDRDI).

Conclusion: The high percentage of individuals with a diagnosis of alcohol dependency that died as a result of epilepsy and who have no antiepileptic drugs in their system at the time of their death highlights the need for preventative measures for this at-risk group.

Mindfulness training as a clinical intervention with homeless adults: a pilot study

Maddock A, Hevey D and Eidenmueller K (2016) *International Journal of Mental Health and Addiction,* Early online. http://www.drugsandalcohol.ie/26368/

The prevalence of mental health and addiction issues in the homeless population is very high. Mindfulness based interventions have been shown to have positive impacts on anxiety, depression and addiction in various populations.

Conclusion: The qualitative data highlighted how mindfulness skills can easily be taught to this population, and through the use of these skills, participants were able to develop enhanced coping skills, mindful traits, well-being and an improved capacity to deal with their mental health and addiction issues. This study gives support to the promising potential of mindfulness interventions being implemented by mental health care professionals with homeless service users.

Recent publications continued

A review of a GP registrar-run mobile health clinic for homeless people

O'Carroll A, Irving N, O'Neill J and Flanagan E (2016) *Irish Journal of Medical Science,* Early online.
http://www.drugsandalcohol.ie/26435/

Homeless people have excessively high morbidity and mortality rates, yet they face barriers accessing primary care. A mobile health clinic, staffed by GP registrars, was developed to provide services to homeless people, particularly rough sleepers and sex workers.

Conclusion: A GP Registrar-run Mobile Health Clinic achieved its aims of improving access to primary care for rough sleepers and sex workers, and challenging stereotypes of GP Registrars.

The effectiveness of functional family therapy for adolescent behavioral and substance misuse problems: a meta-analysis

Hartnett D, Carr A, Hamilton E and O'Reilly G (2016) *Family Process,* Early online.
http://www.drugsandalcohol.ie/26269/

A systematic review of published and unpublished English language articles identified 14 studies containing 18 comparisons between functional family therapy (FFT) and another condition in the treatment of adolescent disruptive behavior and substance use disorders.

Conclusion: Results provide support for the effectiveness of FFT compared with untreated controls and well-defined ALTs, such as cognitive behavior therapy, other models of family therapy, and individual and group therapy for adolescents.

Progressive white matter impairment as a predictor of outcome in a cohort of opioid-dependent patient's post-detoxification

Ivers JH, Fitzgerald J, Whelan C, Sweeney B, Keenan E, Fagan A, McMarrow J, Meany J, Barry J and Frodl (2016) *Addiction Biology,* Early online.
http://www.drugsandalcohol.ie/26275/

The main aims of this study were to: (1) assess the association between white matter impairment and duration of dependence; (2) examine whether this impairment correlates with treatment outcome measures in opioid-dependent patients post-detoxification.

Conclusion: The longer the subjects were dependent on opioids, the more widespread and severely the white-matter integrity was disrupted. A general linear model was used to examine patients who relapsed compared to those who were abstinent at follow-up. No statistical difference was found between groups ($p > 0.05$). Partial correlations were performed to investigate the relationship between clinical outcome measures (physical health, psychological well-being and quality of life and hope for the future) and white-matter microstructural differences. Significant correlations were found between AD in the posterior corona radiata (L) and MD in the superior longitudinal fasciculus and a clinical measure for HOPE at 9-month follow-up.

Overview of harm reduction in prisons in seven European countries

Sander G, Scandurra A, Kamenska A, MacNamara C, Kalpaki C, Bessa CF, Laso GN, Parisi G, Varley L, Wolny M, Moudatsou M, Pontes NH, Mannix-McNamara P, Libianchi S and Antypas T (2016) *Harm Reduction Journal,* 13(1): 28
http://www.drugsandalcohol.ie/26224/

This article provides a brief overview of harm reduction in prisons in Catalonia (Spain), Greece, Ireland, Italy, Latvia, Poland, and Portugal. While each country provides a wide range of harm reduction services in the broader community, the majority fail to provide these same services or the same quality of these services in prison settings, in clear violation of international human rights law and minimum standards on the treatment of prisoners.

Conclusion: Where harm reduction services have been available and easily accessible in prison settings for some time, better health outcomes have been observed, including significantly reduced rates of HIV and HCV incidence. While the provision of harm reduction in each of these countries' prisons varies considerably, certain key themes and lessons can be distilled, including around features of an enabling environment for harm reduction, resource allocation, collection of disaggregated data, and accessibility of services.

Diageo's 'stop out of control drinking' campaign in Ireland: an analysis

Petticrew M, Fitzgerald N, Durand MA, Knai, C, Davoren MP and Perry IJ (2016) *PLoS ONE,* 11(9): e0160379
http://www.drugsandalcohol.ie/26170/

It has been argued that the alcohol industry uses corporate social responsibility activities to influence policy and undermine public health, and that every opportunity should be taken to scrutinise such activities. This study analyses a controversial Diageo-funded 'responsible drinking' campaign ('Stop out of Control Drinking', or SOOCD) in Ireland. The study aims to identify how the campaign and its advisory board members frame and define (i) alcohol-related harms, and their causes, and (ii) possible solutions.

Conclusion: The 'Stop Out of Control Drinking' campaign frames alcohol problems and solutions in ways unfavourable to public health, and closely reflects other Diageo Corporate Social Responsibility activity, as well as alcohol and tobacco industry strategies more generally. This framing, and in particular the framing of alcohol harms as a behavioural issue, with the implication that consumption should be guided only by self-defined limits, may not have been recognised by all board members. It suggests a need for awareness-raising efforts among the public, third sector and policymakers about alcohol industry strategies.

Global and regional effects of potentially modifiable risk factors associated with acute stroke in 32 countries (INTERSTROKE): a case-control study

O'Donnell MJ, Chin SL Rangarajan S *et al* (2016) *Lancet,* 388(10046): 761-75
http://www.drugsandalcohol.ie/26164/

Stroke is a leading cause of death and disability, especially in low-income and middle-income countries. We sought to quantify the importance of potentially modifiable risk factors for stroke in different regions of the world, and in key populations and primary pathological subtypes of stroke.

Conclusion: Ten potentially modifiable risk factors are collectively associated with about 90% of the PAR of stroke in each major region of the world, among ethnic groups, in men and women, and in all ages. However, we found important regional variations in the relative importance of most individual risk factors for stroke, which could contribute to worldwide variations in frequency and case-mix of stroke. Our findings support developing both global and region-specific programmes to prevent stroke.

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