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## European drug trends 2017

In May 2017, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published the *European drug report 2017: trends and developments* summarising the latest trends across the 28 EU member states, Norway and Turkey.<sup>1</sup>

The report highlights the findings a major school survey in 2016 that showed that last-month cannabis use among European school students was around half the level reported in a similar study from the US. Cannabis use among school students in Europe appears to be stable while smoking and drinking is declining. The percentage of European students reporting last-month alcohol use was more than double (49%) that reported by their American peers (21%).<sup>2</sup>

An estimated 8,440 people died from drug overdose, mainly related to heroin and other opioids, in 2015. This is the third year in a row that overdose deaths in Europe have increased. Methadone-related deaths exceed heroin-related deaths in four European countries, including Ireland. Supervised drug consumption facilities are available in seven European countries and ten countries are running take-home naloxone programmes. Naloxone is an opioid overdose-reversal drug.



L to R: Alexis Goosdeel, Director EMCDDA, Commissioner Dimitris Avramopoulos, Laura d'Arrigo, Chair EMCDDA Management Board at the launch of the *European Drug Report* in Brussels

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# In brief

## The Steering Committee appointed by the Minister with responsibility for the National Drugs Strategy to provide guidance and advice in the development of the new strategy finished their deliberations in June.

The members of the committee considered how the new strategy should address problem drug use and what structural arrangements were needed to support this task. The work of the Steering Committee was informed by a report from an international expert review group, a review of international evidence on responses to problem drug use, an overview of trends over a 10-year period, reports from focus groups dealing with the themes of education and prevention, the continuum of care, supply reduction and evidence and best practice, and a report on a public consultation process.

In 2016, *Drugnet Ireland* looked at a selection of drugs strategies from different countries and outlined the range of strategic approaches that are being taken to deal with the challenge of problem drug use. This is the international context in which Ireland's new strategy is being developed.

Many recent national strategies have included illicit substances. Australia, New Zealand, Sweden and Spain cover alcohol in their strategies, while Cyprus and the UK deal with the harmful use of alcohol in their strategic approach. The Czech Republic, Croatia, France and Germany include addictive behaviours, such as gambling, as well as substances in their strategies.

A further strategic development in recent years has been the setting of national drugs strategies within the framework of wider governmental objectives, such as societal wellbeing or economic development. The countries that illustrate this shift most clearly are New Zealand and Scotland. Another recent change in emphasis has been the prominence given to instrumental guiding principles over the more traditional strategic objectives of reducing supply and demand and minimising harm. These principles include long-term and comprehensive planning, realistic decision-making – using evidence and evaluation of effectiveness, rational funding and service quality guarantee, and social participation as a way of raising awareness in society at large. Several European strategies explicitly mention 'European values' such as human dignity, freedom, equality, solidarity, democracy and the rule of law.

In this issue of *Drugnet Ireland*, we look at the report of the expert review group who visited Ireland last year and undertook a high-level review of the current National Drugs Strategy, and reported to the Steering Committee on their findings and observations. The group's terms of reference enabled it to provide an objective assessment of the current strategy and present options, based on analysis of international trends, that the Steering Committee could consider in the development of Ireland's new strategy. This review, along with the other information resources prepared for the Steering Committee, comprise a rich source of knowledge that will continue to be used to inform policy and practice as the new strategy progresses.

## European drug trends 2017 continued

While the number of new substances being introduced to the drug market has declined, the overall number of substances now available continues to grow. In 2016, the EMCDDA monitored more than 620 new psychoactive substances (NPS), compared with around 300 monitored in 2013. The slower rate of detection of new substances may be due to a more restrictive legal environment in some member states and operations against NPS laboratories in China.

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

The impact of the drugs problem continues to be a significant challenge for European societies. Over 93 million Europeans have tried an illicit drug in their lives and overdose deaths continue to rise for the third year in a row. I am especially concerned that young people are exposed to many new and dangerous drugs. Already 25 highly potent synthetic opioids have been detected in Europe between 2009 and 2016, of which only small volumes are needed to produce many thousands of doses, thus posing a growing health threat.

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

### Cannabis

- The EMCDDA estimates that around 17.1 million (13.9%) of young Europeans (15–34 years) used cannabis in the last year, 10 million of whom (17.7% of this age group) are aged 15–24 years.
- The most recent survey results show that countries continue to follow divergent paths in last-year cannabis use. Of the countries that have produced surveys since 2014, nine reported higher estimates, six were stable and two reported lower estimates than in the previous comparable survey.
- Levels of lifetime cannabis use in 2014 among school-aged children was, on average, 18%, with the highest levels reported by the Czech Republic (37%) and France (31%).
- The number of first-time treatment entrants for cannabis as their main problem drug increased from 43,000 in 2006 to 76,000 in 2015. It is estimated that around 1% of European adults are daily or almost daily cannabis users.
- In 2015, 703,000 seizures of cannabis were reported in the European Union (EU) (416,000 of herbal cannabis, 287,000 of cannabis resin). There were a further 21,000 seizures of cannabis plants. The quantity of cannabis resin, transported in large quantities and over long distances, seized in the EU is much higher than that of herbal cannabis (537 tonnes vs 73 tonnes).

### Opioids (mainly heroin)

- There was an estimated 1.3 million high-risk opioid users in Europe in 2015.
- Of the 191,000 clients entering specialised treatment and reporting opioids as their primary drug in 2015, 29,000 were first-time entrants. The numbers of new entrants to treatment had declined from 56,000 in 2007, when they accounted for 36% of all new clients, to 23,000 in 2013.
- In 2015, 17 European countries reported that more than 10% of all opioid clients entering specialised services presented for problems primarily related to opioids other than heroin, including methadone, buprenorphine, fentanyl, codeine, morphine, tramadol and oxycodone.
- Among first-time clients entering drug treatment in 2015 with heroin as their primary drug, 29% reported injecting as their main route of administration, down from 43% in 2006.
- The EMCDDA estimates that at least 7,584 overdose deaths occurred in the EU in 2015, an increase from the 6,800 figure recorded in 2014. The reported number of overdose deaths increased among older age groups between 2007 and 2015, while those among younger age groups decreased.
- Viral hepatitis, particularly infection caused by the hepatitis C virus (HCV), is highly prevalent among injecting drug users across Europe, with 5 of the 13 countries with national data reporting a prevalence rate in excess of 50% in 2014–15. Drug injection is a risk factor for other infectious diseases, including hepatitis B, tetanus and botulism.
- The quantity of heroin seized within the EU had been declining steadily between 2002 and 2013 when 5.6 tonnes were seized. A total of 8.9 tonnes were seized in 2014, but in 2015 some 4.8 tonnes were seized, a return to the levels registered in the early 2010s. The reversal in trends in 2015 was largely due to an increase in large seizures (above 100 kg) in several countries.

### Cocaine

- Cocaine is the most commonly used illicit stimulant drug in Europe. Its use is more prevalent in the south and west of Europe. It is estimated that about 2.3 million young adults aged 15 to 34 (1.9% of this age group) used cocaine in the last year. Only Ireland, Spain, the Netherlands and the United Kingdom (UK) reported last-year prevalence of cocaine use among young adults of 2.5% or more.
- The decreases in cocaine use reported since 2008 had not been observed in the most recent surveys; of the countries that have produced surveys since 2014, three reported higher estimates, 12 reported a stable trend and one reported lower estimates than in the previous comparable survey.
- Overall, cocaine was cited as the primary drug by 63,000 clients entering specialised drug treatment in 2015, with the UK accounting for almost three-quarters of all reported treatment entries for cocaine. After a period of decline, the overall number of cocaine first-time treatment entrants has been stable since 2012 and there were 28,000 first-time clients in 2015.

## European drug trends 2017 continued

- In 2014, almost 7,400 clients entering treatment in Europe reported crack cocaine as their primary problem drug, with the UK accounting for more than half of these (4,800), and Spain, France and the Netherlands most of the remainder (1,900).
- In the UK, deaths involving cocaine increased from 169 in 2013 to 320 in 2015. In Spain, where cocaine-related deaths have been stable for some years, the drug continued to be the second most-often cited drug in overdose deaths in 2014 (269 cases).
- In 2015, around 88,000 seizures of cocaine, amounting to 68.7 tonnes, were reported in the EU. The situation has remained relatively stable since 2007, although both the number of seizures and the quantity seized has increased between 2014 and 2015.

### Other stimulants and new psychoactive substances

- Data on new psychoactive substances are based on notifications by member states to the EU Early Warning System (EWS). In 2016, 66 new substances were reported for the first time (98 in 2015). By the end of 2016, the EMCDDA was monitoring more than 620 NPS, compared with around 300 monitored in 2013.
- In 2015, almost 80,000 seizures of NPS were made across Europe, more than double the number reported in 2014. Together, synthetic cannabinoids and cathinones accounted for almost 60% of the total number of all seizures of NPS.
- In 2015, synthetic cannabinoids accounted for just over 24,000 seizures. This represents an increase of almost 7,000 seizures compared to 2014 figures. Since 2008, 169 synthetic cannabinoids have been detected in a range of different products – including 11 new cannabinoids reported in 2016, and these continue to be the largest group of new drugs monitored by the EMCDDA.

- Synthetic cathinones are the second largest group of new drugs monitored by the EMCDDA. In total, 118 synthetic cathinones have been identified since 2005, with 14 reported for the first time in 2016, a decrease from the 31 reported in 2014.
- The number of detections of new opioids and benzodiazepines rose markedly in 2016. Nine new opioids were detected for the first time in 2016. Over 60% of the 600 seizures of new synthetic opioids reported in 2015 were fentanyl derivatives. Over 300,000 tablets containing benzodiazepines, such as clonazepam, diclazepam, etizolam and flubromazolam were seized in 2015. This figure was almost twice the number reported in 2014.
- The EMCDDA estimates that 2.3 million young adults (15–34 years) used MDMA/ecstasy in the last year (1.8% of this age group), with national estimates ranging from 0.3% to 6.6%. These figures suggest an increase in use following a number of years of decline.
- Around two-thirds of European countries (19) reported some level of use of new psychoactive substances among their populations of high-risk opioid and stimulant users. The injection of synthetic cathinones among these groups was reported, with the substance used often varying by country.

Accompanying the *European drug report 2017* will be Perspectives on Drugs (PODs), online interactive articles providing insights into specific issues in the drugs field. A number of these PODs have been updated and are published today alongside the report. The themes covered are cannabis resin market, drug consumption rooms, preventing overdose deaths in Europe, synthetic cannabinoids in Europe, and wastewater-based epidemiology.

1 European Monitoring Centre for Drugs and Drug Addiction (2017) *European drug report 2017: trends and developments*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/27401/>

2 For further information, visit <http://www.emcdda.europa.eu/edr2017>



L to R: HRB librarians, Mairea Nelson, Louise Farragher (conference organiser) and Mary Dunne at the ICML/EAHIL conference in Dublin Castle in June

# Rapid expert review of Ireland's National Drugs Strategy

The Cabinet Committee on Social Policy and Public Service Reform in 2015 mandated the Department of Health to develop the new National Drugs Strategy (NDS) to follow on from that which ran from 2009 to 2016. Late in 2015, the then Minister of State with responsibility for the NDS, Aodhán Ó Ríordáin TD, established a Steering Committee to provide him with guidance and advice in the development of the new NDS covering the period 2017–2024. The work of this committee has been informed by a number of inputs, including a report from a group of international experts<sup>1</sup> who undertook a high level review of the National Drug Strategy 2009–2016.<sup>2,3</sup>

The *Report of the rapid expert review of the National Drugs Strategy 2009–2016* was completed in August 2016.<sup>4</sup> It aimed 'to inform the development of the next National Drugs Strategy by providing a "helicopter view" of and capturing some key learning points from the experiences of the National Drugs Strategy 2009–2016' (p. 1). The review highlights the complexities involved in developing a drugs strategy in a landscape that is always evolving and in which 'articulation between social, criminal, and health policy areas is vital' (p. 31). The group's terms of reference were:

- To examine the progress and impact of the 2009–2016 NDS in the context of the objectives, key performance indicators and actions set out in the strategy.
- To identify deficits in the implementation of the strategy.
- To summarise success factors or barriers to success.
- To comment on Ireland's evolution in tackling the drug problem in the light of international trends.
- To identify key learning points arising from the strategy and to highlight areas to consider for development in the new NDS.

The review was based on documentary evidence, meetings and site visits held during a week-long visit to Ireland in January 2016. The review team met with a range of stakeholders, including Government officials, statutory and voluntary sector service providers, community members, and service users. It is important to note that this was not an evaluation of the NDS. This article presents just some of the key findings from the review.

## National Drugs Strategy 2009–2016

The 2009–2016 NDS was described by Griffiths *et al.* as a 'well-crafted and comprehensive version of a contemporary EU drugs strategy' (p. 2) of its time. Overall, those they consulted considered it to have been 'a valuable instrument, both in respect to the structures and coordination

mechanism it established, and in respect to its content which allowed priorities to be identified and targeted' (p. 6). It helped 'facilitate multiagency working, encouraged stakeholder buy-in, and helped galvanise political support for drug issues' (p. 7). Over the course of the strategy, progress had been made on many of the priority areas. In particular, it had been successful in targeting resources and developing services for opiate users.

However, the review also found that while delivery of the strategy got off to a good start, over time some of the positive changes delivered in the initial phases 'became less apparent' (p. 6) and the 'usefulness and appropriateness of the instrument declined' (p. 8). Areas that became problematic included: '[meeting] changing needs, stakeholder participation, sustaining appropriate coordination mechanisms, and follow up and continuing relevance of actions' (p. 6). Griffiths *et al.* argued that it was inevitable that changes would occur over the period of a drugs strategy and it was therefore important that the strategy would adapt to meet these changes. The review discussed a number of areas in which the NDS had lost its momentum over time, including:

- The 'strong role of community organisations' in both strategy development and delivery was identified as one of the key features of the Irish context (p. 9). In the course of the review, they found that in some areas of the NDS the **coordination between local, regional and the national level** became less effective over time. Roles and responsibilities became less clear and lines of communications blurred. This impacted on progress in a number of ways. One of these was that it meant opportunities to identify and adopt effective interventions were sometimes missed: 'The need for effective engagement with local communities, needs based service provision, and mechanisms to ensure the quality of services delivered across locations, came up repeatedly during discussion on the current strategy' (p. 10).
- The impact of the strategy appeared to vary across **geographical areas** – in particular the impact on local structures, services and practice. This was influenced by 'changes in the location of needs since the drafting of the last strategy; the difficulty of reconfiguring delivery structures in response to these changes; and practical and resource issues related to developing service models suitable for areas where the target population is more geographical dispersed' (p. 9).
- The **policy and operational landscape** changed a lot over the course of the strategy. New strategies and structures had been developed across related fields. This had brought about 'some corresponding lack of clarity on the purpose and/or role of different structures or actors working in the area' (p. 6).
- The commitment to **research, monitoring and evidence-based interventions** in the NDS was seen as one of its strengths. However, momentum in this area had faded over time. It was seen as having faced some 'problematic coordination and structural issues' (p. 11), including inadequate resourcing, a lack of standardisation for data collection, and a lack of capacity to analyse data collected and use it to inform strategic decisions.

## Rapid Expert Review continued

### Structure of the NDS

To take learning from the experience of the NDS, the review discussed the effects of three elements of the NDS structure:

- The topic areas of the **five pillars** were described as 'well chosen', as they contained all the main elements of a 'modern balanced drug strategy' (p. 8). There were pros and cons to structuring the NDS around the pillars. By keeping similar areas together, it gave clarity to the main tenets of the strategy. Having a 'point of focus' (p. 7) encouraged joined up working in some areas. However, it also impeded cross-pillar coordination at times, in particular when resources were limited or reduced. Where issues cut across more than one pillar, they sometimes lacked ownership and failed to be addressed. However, the overall view was that the benefits of the pillar approach outweighed the costs of it. Griffiths *et al.* suggest that the new strategy could be designed in a way to maintain the clarity that comes from keeping similar areas together but also facilitates better cross-area working.
- **Actions were embedded** in the seven-year strategy. Doing so was found to have particular limitations. The actions could not be reactive to change in the drug situation over time, and this contributed to an overall perception of a decline in the NDS's 'relevance and momentum' (p. 6) over its timeframe.
- The NDS included a set of **key performance indicators** (KPIs). These were to be used to measure progress over time. Their appropriateness as measures for both changes over time and the strategic goals they were linked to was not always clear. Furthermore, the data needed to measure them were not always available and investment in monitoring the KPIs 'appeared to decline' (p. 6) over the course of the strategy. They therefore did not fulfil their intended role. The authors suggested that the objectives, actions and KPIs need to be more clearly linked together and better sequenced to ensure they are achievable.

### New NDS

Based on their findings, the authors made a number of suggestions for the development of the new NDS. These included:

- **Separate the actions from the strategy:** Given the relatively long period of time covered by Ireland's current and forthcoming strategies, Griffiths *et al.* argued strongly for separating the strategy from the actions. The strategy document could lay out the vision, objectives and structure for the seven years; and a separate time-bound (e.g. three years) action plan could support the strategy. This approach would allow for an opportunity to reflect on progress and changes in the landscape at a midpoint in the strategy's timeframe and to make appropriate changes to the action plan.
- **Synergise with other strategies:** To minimise duplication, the waste of scarce resources and to maximise the impact of strategies, the authors emphasised the importance of having clear 'synergy and complementarity' (p. 31) between the new NDS and other related strategies. This would include strategies dealing with other substances (in particular alcohol), the needs of specific populations, areas, or social issues where drug use is an issue.

- **Ensure equality of access to provision according to need:** They argued that this is a concept that should cut across the strategy. High-quality interventions, of proven effectiveness, need to be universally available, irrespective of the types of drugs being used, where the user lives, or which community the user belongs to.
- **Identify and roll out good practice:** In the course of the review, the authors were presented with numerous examples of good practice, but it appeared there were barriers to them being implemented nationally. They argued for 'a clear mechanism for identifying good practice, supporting programme evaluation, and encouraging wider implementation where this is appropriate' (p. 10). They suggested drawing on national and international practice and programmes to develop a suite of approved interventions that have been proven to work and from which partners could draw.
- **Monitor, research and evaluate:** These are considered 'an essential element of any strategic response in this area' (p. 31). This would help ensure that the strategy is responsive to changing needs and will deliver on the goals. Following on from this, there needs to be mechanisms in place to facilitate the analysis of what is found and the provision of advice based on this evidence to relevant stakeholders. Stakeholders would therefore be able to spread good practice and identify problem areas.
- **Clarity of structural functions for implementation and delivery:** The strategy should have a clear focus on how it is to be implemented and delivered, including the organisational structure and roles and responsibilities of the various stakeholders. To facilitate the delivery of the strategy, they highlight the importance of leadership (ideally at a ministerial level with the support of a committee) to provide drive, direction/prioritisation and to ensure resources are made available.
- **Alcohol:** The authors gave special mention to alcohol as a theme that recurred throughout the review – the high prevalence of problems associated with it, the 'interactions' (p. 6) between alcohol and other drug problems, and its place in the forthcoming strategy. While Griffiths *et al.* do not identify a specific model to follow, they note that what is important in areas like prevention and treatment, where a 'cross-substance approach is essential' (p. 12), is that they are adequately supported.

### Specific issues for new NDS

Section 4 of the review identified a long list of specific issues that the team considered important for inclusion in the new strategy. Replicating the full list is beyond the scope of this article. However, current issues in Ireland that reflect those in other EU states included: meeting the needs of an ageing cohort of opiate users; new psychoactive substances; concern about cannabis in its various forms, in particular high potency products; and, the negative impact of criminalising users, especially young cannabis users. Issues that appeared to be of particular relevance to Ireland were problematic prescription drug use, the spread of opiate use to rural areas, drug-related intimidation, and homelessness and housing insecurity.

As mentioned above, this report is not an evaluation of the NDS, rather it sets out to take lessons from its delivery to inform the new NDS. This article presents just some of its key findings with far more detail available in the full report.

## Rapid Expert Review continued

Lucy Dillon

1 The expert review group included: Paul Griffiths, scientific director of the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA), who chaired the group; Nicola Singleton, scientific analyst with the EMCDDA; and Professor John Strang, director of the National Addiction Centre, King's College London.

2 Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. <http://www.drugsandalcohol.ie/12388/>

3 Throughout this article, the National Drugs Strategy 2009–2016 will be referred to as the NDS. The National Drug Strategy 2017–2024 will be referred to as the 'new NDS'.

4 Griffiths P, Strang J and Singleton N (2016) *Report of the rapid expert review of the National Drugs Strategy 2009–2016*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27289/>

## Dublin Drug Policy Summit

The Dublin Drug Policy Summit was held on 20 January 2017. It was organised by the Ana Liffey Drug Project and attended by national and international experts on drug policy, including policy-makers, practitioners, and academics. Among the delegates were Minister of State for Communities and the National Drugs Strategy Catherine Byrne TD and Ruth Dreifuss, chair of the Global Commission on Drug Policy (GCDP).<sup>1</sup> The summit focused on two issues: supervised injecting facilities and the decriminalisation of possession of drugs for personal use. This article is based on the published proceedings of the event, which present a thematic analysis of the issues discussed.<sup>2,3</sup>

### Supervised injecting facilities

It is Irish Government policy to introduce a supervised injecting facility.<sup>4</sup> The summit focused on discussing how best to operationalise the facility. The key points discussed were grouped under the broad themes of people, place, and policing.

### People

**Access criteria:** There was general agreement among participants that any access criteria should be as broad as possible and that any related legislation should not extend to defining which groups could access the service. The two groups noted in particular were pregnant women and those aged under 18. However, it was agreed that access should only be given to people who are already injecting drug users. Specialised protocols could be put in place for particular groups, and practitioners would have the flexibility to make decisions on a case-by-case basis to best meet the service user's needs.

**An appealing service for potential service users:** Having a service that appeals to users was considered critical. A number of themes were raised on this issue. First, there was both curiosity and apprehension among potential service users about what the service would be like and how it would work. Second, a good atmosphere and person-centred approach that builds positive relationships between staff and service users is what would truly make the service appealing. Third, the service needs to be accessible, and the importance of its proximity to where people buy their drugs was noted. While NIMBYism – Not in My Back Yard – may present challenges, evidence from other jurisdictions did not show a 'honeypot effect' for supervised injecting facilities, i.e. they have not drawn in more dealers and users to an area. Finally, there were issues relating to the staffing of the facility.

The attitude of staff members is key; they need to be able to deal with the paradox of being healthcare professionals (in some cases), while also supervising injecting, which is an 'inherently dangerous activity' (p. 14), as well as always treating service users humanely.

### Place

**The building:** It was suggested that the building should not be overly clinical. Instead, it should be a safe place for people suited to the development of therapeutic relationships. For accessibility, it should be in the city centre. A mobile facility could be considered, as it could follow the flow of the target population.

**Engaging the community:** The location of the facility has attracted a lot of interest in the broader community and it was expected that NIMBYism would be an issue. First, it was suggested that the supervised injecting facility would need to follow the practice of existing drug services in Dublin of engaging proactively with the community. Based on international experience, this would be an important element of the ongoing management of the facility. Second, communities elsewhere were reported to have been ultimately welcoming of these facilities despite initial opposition. They had a positive effect on an area, and the need to collect good baseline data to be able to evidence any such changes was noted.

**Integration with other services:** Supervised injecting facilities need to be embedded in the wider service landscape. First, there is a need to offer users access to other related services. This would require providers to identify and define pathways through the service and on to other services. Second, the provision of suitable ancillary services at the facility can be important, for example, access to food and showers.

### Policing

**Impact on drug markets and crime levels:** As these facilities are not a criminal justice intervention, it was noted that they should not be expected to impact significantly on crime, either positively or negatively. The impacts will be in terms of the service user's health and the public amenity. However, international examples show that these facilities are not associated with increases in crime. Similarly, they do not affect any change in the drug market.

**Role of policing:** There was much discussion about the complexities involved in the policing of the centre and a number of key points were identified. First was that the role of law enforcement agencies should not be underestimated in the successful delivery of the service. Establishing a positive and transparent relationship between police and the facility's management was identified as crucial.

## Dublin Drug Policy Summit continued

Second were the complexities involved in the approach taken to the policing of service users. Experiences in other jurisdictions highlighted these in terms of decision-making on whether to stop and search people in the vicinity of these facilities, for example. Overall, it was noted that Irish police are 'aware of the complexities of policing in the context of social and health issues and take a very pragmatic approach to dealing with people on the street every day' (p. 19). While there was no clear answer as to what was the best approach, there was a clear call for discretion on the part of the police and for it to be applied consistently. This would be facilitated by legislative clarity.

### Decriminalisation

The decriminalisation of the possession of small amounts of drugs for personal use is not Government policy but an issue of growing debate. The discussion at the summit in this regard fell into three broad themes: general discussion, responses, and threshold limits.

### General discussion

A number of key points were made during the general discussion on decriminalisation. First, it was important not to overstate its benefits – it was not a panacea and it alone would have little or no impact on levels of drug use. Where changes in the law have led to better outcomes for users (e.g. in Portugal), this was likely related to a broader shift in policy and investment in services, rather than a change in the law as such. Second, criminalisation causes harms. For example, it might mean users are less likely to access services, and labelling someone as a criminal can have a sustained negative effect on their life and opportunities. Third, the language used around the debate requires consideration; 'decriminalisation needs to be framed as a health and social issue rather than a criminal one' (p. 21). Fourth, while some stakeholders were convinced about decriminalisation, others were not and concerns remained. These included concerns about the message it might send to (particularly young) people about drug use, and the new challenges it might present for law enforcement agencies. Finally, the importance of balance in drug policy generally was noted – 'going too far either way on a restrictive/permissive spectrum is likely to result in significant harms and be unhelpful as a policy approach attempting to minimise harm' (p. 21).



Minister of State for Communities and the National Drugs Strategy Catherine Byrne TD with Tony Duffin, Ana Liffey Drug Project, at the Dublin Drug Policy Summit. (See report p. 7)

### Responses

Some of the discussion focused on what would be the most appropriate responses if someone were found in possession of drugs where it had been decriminalised. First, it was noted that decriminalisation does not mean the absence of any consequences for being found in possession of a controlled substance. Instead, these could take the form of a civil rather than a criminal sanction. Portugal's experience was highlighted, with a focus on the benefits of having sanctions for possession that do not come with a criminal record, stigma or the expending of a large amount of resources. There was also a call for research on what would be the most appropriate responses in the Irish context.

### Threshold limits

Threshold limits were also discussed, i.e. the amount of drugs that a person could possess before they were considered to be in possession for supply. While it was recognised that there was a need for thresholds to be established, it was also suggested that they should be carefully selected and should not be rigid. Instead, there should be flexibility to allow for the needs of the individual to be considered. By doing so, the courts could refer to the health authorities and vice versa.

### Lucy Dillon

- 1 The Global Commission on Drug Policy is 'an international reference regarding the impacts of the current drug control strategy, proposing policy recommendations that protect human rights, scale-up harm reduction and promote development'. It is made up of 23 political leaders and leading thinkers from across the political spectrum. For more information, visit <http://www.globalcommissionondrugs.org/>
- 2 Ana Liffey Drug Project (2017) *Dublin Drug Policy Summit*. Dublin: Ana Liffey Drug Project. <http://www.drugsandalcohol.ie/27186/>
- 3 To facilitate a more open discussion, the summit followed the Chatham House Rule, whereby any reported views or comments from the session are not attributed to any particular individual or organisation. It is not suggested that all delegates agreed with or supported the statements reported in the proceedings document.
- 4 The Misuse of Drugs Act (Supervised Injecting Facilities) Bill 2017 was published in February 2017.

# Cannabis for medical use: a scientific review

*Cannabis for medical use: a scientific review*<sup>1</sup> was launched by Minister for Health Simon Harris TD on 10 February 2017. He described the review as a 'milestone' in the development of policy on medicinal cannabis in Ireland.<sup>2</sup> The review was carried out by the Health Products Regulatory Authority (HPRA) in response to a request from the Minister in November 2016 for expert scientific advice on the use of cannabis for medical purposes.

HPRA defined the medical use of cannabis<sup>3</sup> as 'a situation where a doctor prescribes or recommends the use of cannabis for treatment of a medical condition in a patient under his/her care' (p. 9). It convened a group of clinical experts and patient representatives to assist them in carrying out the work. They did not undertake a systematic review of the data on cannabis for medical use. Instead, they reviewed a selection of what they considered to be the 'main scientific reviews and relevant publications' (p. 2).<sup>4</sup> They also carried out a survey of HPRA's global regulatory counterparts to explore the situation in other jurisdictions and their policies on access to cannabis for medical use.<sup>5</sup>

The review covered four main themes:

- The cannabis products available
- The regulatory regimes in countries where cannabis was allowed for medical purposes
- The research on new indications and evidence of efficacy of cannabis for various medical conditions
- The current legal situation in Ireland and legislative changes required for cannabis to be made available for medical purposes here

This article focuses on elements of the last two themes.

## Evidence of effectiveness

Overall, the team found an absence of scientific data demonstrating the effectiveness and safety of cannabis products (p. 1). They also found that most cannabis products available through international access programmes did not meet 'pharmaceutical quality requirements' (p. 1). As the regulator of medicines and other health products in Ireland, HPRA's role is to ensure that any medicines available on the Irish market are 'safe, effective and of an appropriate quality based on clinical and scientific data' (p. 7). The authors found insufficient evidence to allow for cannabis products to be authorised as medicinal products (medicines) under this regulatory requirement.

There were a number of complexities involved when examining the evidence base. For example, 'a major limitation' (p. 13) was the variation in the formulations of cannabis that had been studied, particularly in relation to the tetrahydrocannabinol (THC) and cannabidiol (CBD) ratio.<sup>6</sup> Another was the variety of medical conditions under examination. The potential benefits and risks of cannabis products depend on the product, dose and duration of use,

and the patient population. Given the variation in what was explored in the studies, the team found it challenging to draw conclusions regarding the effectiveness of treatment.

Despite these limitations, the team found three medical conditions for which there was 'some scientific evidence to support the use of cannabis or cannabinoids as a medical treatment in patients who have failed available treatments' (p. 16). These were:

- Spasticity associated with multiple sclerosis
- Intractable nausea and vomiting associated with chemotherapy
- Severe, refractory (treatment-resistant) epilepsy

However, there was insufficient evidence to support their use for other conditions, including chronic pain.

## Access programmes

At the core of the review's findings is HPRA's acknowledgement that the Government may decide to make cannabis more readily available on a medicinal basis: 'The decision to permit access to cannabis for medical use is a societal and policy decision due to the paucity of scientific research, the recreational use of the product and the strong public and patient demand' (p. 1). Any products or preparations extracted from the cannabis plant that are psychotropic are currently controlled under the Misuse of Drugs legislation and their medical use is therefore not permitted.<sup>7</sup> However, if the Minister for Health considers it to be in the public interest, a specific licence can be granted which allows a doctor to prescribe products containing THC. Any application for a licence must be accompanied by an endorsement from a medical consultant who is responsible for the care of the individual applicant.

The authors argued that if cannabis were to be made more readily available for medical use in Ireland, then it should only be permitted under a controlled access programme for the treatment of patients with a selection of medical conditions. Any programme should be part of a 'structured process of formal on-going clinical evaluation in a limited number of clearly defined medical conditions' (p. 6). They advised that the programme be run for an initial period of 5 years and be limited to the medical conditions outlined above. The programme should have the following features:

- Patients treated with cannabis should be under the care of a medical consultant who has expertise in the condition being treated. He/she would be responsible for the ongoing monitoring of the patient.
- There should be a central register for patients, doctors and pharmacists involved in the programme, with data collected on the use of cannabis by these patients.
- Authorised cannabis-based medicines should be the products considered first. If unsuitable, then cannabis products from other countries that have been subject to quality control requirements could be used.
- Patients should be educated about the correct use of any cannabis product provided, the benefits and risks involved, how to report any side-effects, and the care and safe disposal of cannabis products.
- Doctors and pharmacists should be supported in their prescribing and dispensing of the products (p. 6).

## Cannabis for medical use continued

### Ministerial response to the review

Following the publication of the report, the Minister for Health gave a commitment to establish a 'compassionate access programme for cannabis-based treatments'.<sup>2</sup> His decision was based on the advice of HPRA and the programme will therefore only be accessible to people with one of the three medical conditions outlined above and will require the support of a medical consultant. In addition, the Department of Health has established an Expert Reference Group responsible for developing operational guidelines to facilitate the prescription and supply of medicinal cannabis to qualifying patients.<sup>8</sup>

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- 1 Health Products Regulatory Authority (2017) *Cannabis for medical use: a scientific review*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/26784/>
- 2 Department of Health (2017) Minister Harris publishes 'milestone' report on cannabis for medical use. Available online at <http://health.gov.ie/blog/press-release/minister-harris-publishes-milestone-report-on-cannabis-for-medical-use/>
- 3 For the purpose of the report and this article, 'references to cannabis include cannabis resin and other derivatives from the plant such as oils and other processed plant parts' (p. 8).

- 4 The main documents used were: Barnes MP and Barnes JC (2016) *Cannabis: the evidence for medical use*. London: All-Party Parliamentary Group for Drug Policy Reform; Whiting PF, Wolff RF, Deshpande S, Di Nisio M, Duffy S, Hernandez AV, Keurentjes JC, Lang S, Misso K, Ryder S, Schmidkofer S, Westwood M and Kleijnen J (2015) Cannabinoids for medical use: a systematic review and meta-analysis. *JAMA*, 313(24): 2456–73; Hill KP (2015) Medical marijuana for treatment of chronic pain and other medical and psychiatric problems: a clinical review. *JAMA*, 313(24): 2474–83; National Academies of Sciences, Engineering and Medicine (2017) *The health effects of cannabis and cannabinoids: the current state of evidence and recommendations for research*. Washington DC: National Academies Press.
- 5 Forty countries were contacted and responses received from 28 EU member states and seven non-EU states.
- 6 The cannabis plant is reported to contain more than 100 plant cannabinoids; those thought to be the most important in terms of their clinical effects are tetrahydrocannabinol (THC) and cannabidiol (CBD). THC is the main psychotogenic component of cannabis.
- 7 One cannabis-based medicine (Sativex®) has been authorised by HPRA for use with adult patients with moderate to severe spasticity due to multiple sclerosis (MS). Two other medicines based on the structure of THC were reported to be listed under Schedule 2 of the Regulations: nabilone and dronabinol. As CBD does not have any psychotogenic effects, products containing it alone do not fall under the Misuse of Drugs legislation and its restrictions.
- 8 Department of Health (2017) Minister Harris announces 'pivotal step' on medicinal cannabis access programme: prescribers, patients and pharmacists to draw up guidance for the safe use of cannabis-based treatments for qualifying patients. Available online at <http://www.drugsandalcohol.ie/27104/>

## Cannabis legislation in Europe: an overview

A recent study by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) carried out an overview of cannabis legislation in Europe focusing primarily on 'recreational' use.<sup>1</sup> In Europe, cannabis is the most commonly talked-about drug referred to in drug law offences reports (57%), and the most frequently used illicit drug in young adults (aged 15–34 years).<sup>2</sup> Debates on the prohibition and permissance of cannabis use and supply are ongoing. This study aimed to provide answers to commonly asked questions that arise when cannabis legislation is being discussed.

### What is cannabis?

Cannabis is defined as 'any plant of the genus *Cannabis*', which includes *Cannabis indica*, *Cannabis sativa* and any other species that is created in the future (p. 24).<sup>3</sup> In most European Union (EU) countries, legal control occurs if the plant is able to produce a usable psychoactive substance called delta-9-tetrahydrocannabinol (THC). A higher concentration of THC ( $\leq 20\%$ ) is found in female flowers and resin-producing trichomes (plant hairs). Recreational cannabis is sold as herbal cannabis (i.e. resin-coated flowers) or cannabis resin (i.e. resin extracted and sold on its own). Between 2006 and 2015, mean potency of European samples of resin and herb rose by 90% and 80%,

respectively. In 2015, the national mean THC potency in cannabis resin ranged from 4% to 28%, while national mean THC potency in cannabis herb ranged from 3% to 22%.<sup>1</sup>

### Obligations by countries to control cannabis

In accordance with international treaties, national drug laws are required to control the whole plant. However, in some EU member states, allowances are made for plants grown for fibre that have low THC content ( $<0.2\%$ ). National control is not required for cannabis seeds. By law cannabis or cannabis-based products may be used for medicinal purposes in EU member states, for example, THC in capsules, cannabis extract (e.g. Sativex®), a mouth spray used to treat multiple sclerosis), and dried cannabis flowers for vaporising or making tea. No EU member state allows cannabis to be smoked for medicinal purposes.

The control of cannabis and other drugs comes under United Nations conventions and stipulates that all controlled drugs must be restricted to medicinal or scientific purposes.<sup>3</sup> Any unlawful behaviour (e.g. possession, acquisition, distribution or offering for sale, etc.) must be penalised, with serious offences being punished by withdrawal of freedom. With regard to cannabis use, the EU provides no 'harmonised' law to control cannabis usage (p. 9);<sup>1</sup> the responsibility for responding to drug use offences is placed solely with EU member states. However, EU law does exist for crimes related to the trafficking of cannabis.<sup>4</sup> With the aim of having a common approach to tackling drug trafficking throughout the EU, minimum provisions have been outlined for basic offences and penalties since 2004 (p. 1).<sup>4</sup> Possession for personal consumption was not included in these provisions.

# Cannabis legislation in Europe

continued

## Laws and associated guidelines

Within EU member states, penalties applied to cannabis offences can be grouped in two ways. In some member states (e.g. Italy, UK and Portugal), cannabis is not treated like other drugs in that the level of penalty applied is linked to the level of harm caused. In this instance, penalties obtained for cannabis-related offences are less severe than those provided for other drugs, whereas in other member states, the same penalties, which tend to be more severe, are applied to all drugs. Where cannabis use is viewed as a minor offence, penalties are lower than that for other drugs (e.g. Ireland, Belgium and Luxembourg).

A positive drug test for drug use is not viewed as an offence under UN conventions; however, in some member states drug use is considered a serious offence and can result in police arrest (e.g. France, Norway and Cyprus). Nonetheless, how the law is enforced differs between countries; for instance, it can be used to enforce public order or to apprehend drug users, or can act as a road safety policy, for example, in tests for drug-related driving.

The penalty for possession of cannabis for personal use varies across the EU. The probability of being imprisoned for 'small amounts' has been declining since 2000 (p. 13). However, the definition of a small amount varies in EU member states; for example, in Belgium, imprisonment can occur for being in possession of small amounts of cannabis, yet police have been advised to record non-problematic cases locally instead of centrally. While in other EU member states (e.g. Denmark, France and UK), police and prosecutors are allowed to apply either a non-custodial penalty or dismiss the case.

Penalties for selling or trafficking cannabis vary substantially among EU member states, which makes comparison problematic between countries. For example, where cannabis supply is viewed as minor, in countries such as Denmark and Spain, maximum penalties can range from two to three years where as in Ireland and Cyprus the maximum penalty is life imprisonment. Other factors can also influence the outcome, such as whether the offender was involved with organised crime or gangs, the motive for the offence, or which court the offender was tried in.

Driving under the influence of cannabis is considered illegal across all EU member states; however, how laws are phrased or interpreted varies considerably.

## Cannabis offenders in practice

An examination of legislation in EU member states does not provide an insight into how it is applied. This is the responsibility of law enforcement agencies, which may or may not be authorised to enforce legislation or may have to adhere to local or national directives that lay down how different offences should be responded to. Punishments for cannabis use provided by EU member states include fines, warnings, and community work orders, and in some cases suspended prison sentences. More often than not, the type of drug implicated has not been identified.

The route taken by most member states to penalise cannabis use is via decriminalisation or depenalisation of offences by using non-criminal punishments or closing the case as minor. However, some member states use alternatives to punishment, for example, diverting offenders to rehabilitative or treatment services instead.

## Future of cannabis legislation

In the previous two decades, the aim of legislation has been to decrease or remove prison penalties for minor cannabis possession offences. Primarily, legislative changes were applied to the level of penalty to ensure that the sentences were consistent, their severity corresponded with the health risks associated with different drugs, and to ensure that rehabilitation/treatment was given precedence ahead of punishment. No EU member state has removed all penalties nor have they made the supply of cannabis legal. More recently, decriminalisation or legalisation of recreational cannabis use is being debated among a number of EU member states. Although not discussed in this study, medicinal and industrial use of cannabis is also being debated.

## Conclusion

This study provided an overview of legislative approaches to cannabis across EU member states. There is no common approach to targeting cannabis offences. In fact, considerable disparities were illustrated in how countries discern laws and penalties for cannabis sale or use. For legislative purposes, EU member states either treat all drugs the same, or view cannabis offences as less serious, or in some cases harsher penalties are applied. In the previous two decades, nearly 50% of EU member states altered legislation that targeted cannabis use. The impact on cannabis use is unclear, as no rigorous scientific evaluations were carried out to determine the effectiveness of the legislative changes. To date, cannabis policy is a topic of ongoing debate throughout EU member states and its development is being monitored by the EMCDDA.

## Ciarra H Guiney

- 1 European Monitoring Centre for Drugs and Drug Addiction (2017) *Cannabis legislation in Europe: an overview*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/27071/>
- 2 European Monitoring Centre for Drugs and Drug Addiction (2016) *European drug report 2016: trends and developments*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/25579/>
- 3 United Nations Office on Drugs and Crime (2013) *The international drug control conventions*. Vienna: United Nations Office on Drugs and Crime. Available online at [http://www.unodc.org/documents/commissions/CND/Int\\_Drug\\_Control\\_Conventions/Ebook/The\\_International\\_Drug\\_Control\\_Conventions\\_E.pdf](http://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Ebook/The_International_Drug_Control_Conventions_E.pdf)
- 4 Council of the European Union (2004) Council framework decision 2004/757/JHA. *Official Journal of the European Union*, 11 Nov 2004, L 335/8. Available online at <https://db.eurocrim.org/db/en/doc/247.pdf>

# Beyond UNGASS

The Commission on Narcotic Drugs (CND) is the governing body of the United Nations Office on Drugs and Crime (UNODC). Essentially, it is the central drug policy-making body of the United Nations. Membership is made up of representatives from 53 UN member states, allowing for a spread of geographical representation. Ireland is not currently a member. The CND led preparations for the United Nations General Assembly Special Session (UNGASS) on the world drug problem held in 2016 and led negotiations on the associated outcome document.<sup>1</sup> While that document was heavily criticised by some stakeholders, it was also seen as indicating a more progressive direction in terms of putting health, human rights, and development more at the core of drug policy.<sup>2</sup>

## Implementing the UNGASS document

The CND is responsible for leading on the implementation of the recommendations of the document. Since UNGASS, they have appointed a 'facilitator for post-UNGASS matters' and have held a variety of meetings to progress the recommendations. They held two intersessional meetings to discuss each of the seven thematic areas covered in the UNGASS document. Member states, UN entities and specialised agencies, international and regional organisations and civil society (including non-governmental organisations) were all in attendance. The first meeting provided participants with an opportunity to share experiences across the themes, discuss lessons learnt, and report on 'concrete activities'<sup>3</sup> (p. 1) that had been undertaken to implement the UNGASS operational recommendations. The second meeting took a more forward-looking approach, focusing on what the CND could do to operationalise the recommendations. A recurring theme throughout the meetings was the need for the CND and UNODC to collaborate closely with all relevant UN entities and other international organisations and civil society to deliver on this work.<sup>3</sup>

## 60th Session of CND

The CND's 60th Session was held in Vienna (13–17 March 2017) and provided a valuable opportunity to demonstrate improved collaboration. As well as the core plenary sessions, around 100 side events and numerous exhibitions were held. Approximately 1500 people attended the session, representing the same broad scope of stakeholders as the earlier thematic meetings. Among the main issues discussed was the implementation of the UNGASS outcome document. At a plenary session that dealt specifically with the follow-up to UNGASS, statements were made by member states, a number of other UN entities and civil society. The United Nations Development Programme (UNDP), Office of the United Nations High Commissioner for Human Rights (OHCHR), UNAIDS and the World Health Organization (WHO) all made statements welcoming the UNGASS document and its progress towards a more health and human rights approach to drug policy. The closer links it established with the UN's Sustainable Development Goals were also welcomed.<sup>4,5</sup>

The need for the outcome document to produce 'concrete, operational results if it is ultimately to be deemed a success' was noted.<sup>4</sup> Among the challenges identified by the other UN entities in attendance were how different the situation currently exists in some states, when compared to what the outcome document required. For example, some of the OHCHR's key points were:

- The right to life continues to be challenged in some states, in particular through extrajudicial executions of drug users and traffickers.
- Those suspected of drug-related offences are often detained unlawfully or confined to compulsory detention or treatment.
- There has been a long history of inaction on the right to health of people in terms of their access to essential medicines, such as opioids for the relief of pain and for substitution therapy.

The UNDP<sup>5</sup> highlighted how challenging many stakeholders found it to deliver a more human rights approach to drug control policy. They remarked that there is little clear, comprehensive assessment of how to effectively deliver it in practice. To fill this gap, they are working in collaboration with a number of partners to develop international guidelines on human rights and drug control.

## In conclusion

Overall, the session was seen by commentators as indicating important progress by continuing the move more towards a health and human rights led approach to drug use reflected in the UNGASS document. For example, a HIV/AIDS-related resolution was passed that calls for member states to increase their funding for harm reduction activities for people who inject drugs.<sup>6</sup> UNODC Chief Yury Fedotov closed the event with a focus on people's health and welfare:

Together we have made a commitment under the international drug control conventions to the health and welfare of people and communities everywhere – an enduring promise to millions of children, women and men that we must uphold.<sup>7</sup>

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- 1 United Nations Office on Drug and Crime (2016) *Outcome document of the 2016 United Nations General Assembly Special Session on the world drug problem*. Vienna: United Nations Office on Drug and Crime. Retrieved 11 April 2017 from: <http://www.unodc.org/documents/postungass2016//outcome/V1603301-E.pdf>
- 2 Dillon L (2017) Responses to UNGASS 2016. *Drugnet Ireland*, 60: 8–9. <http://www.drugsandalcohol.ie/26701/>
- 3 United Nations Economic and Social Council (2017) *Remarks by H.E. Ambassador Pedro Moitinho de Almeida, CND Facilitator for post-UNGASS Matters: Second round of thematic discussions on UNGASS follow-up (January 2017)*. New York: United Nations Economic and Social Council. Retrieved 11 April 2017 from: [https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_60/CRPs/ECN72017\\_CRP1\\_V1701297.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_60/CRPs/ECN72017_CRP1_V1701297.pdf)

## Beyond UNGASS continued

- 4 CND Blog (2017) Plenary – Agenda Item 6: Follow-up to the special session of the General Assembly on the world drug problem held in 2016, including the seven thematic areas of the outcome document of the special session (Thursday, March 16, 2017 – Afternoon): Office of the High Commissioner for Human Rights statement. Retrieved 11 April 2017 from: <https://cndblog.org/2017/03/plenary-agenda-item-6-follow-up-to-the-special-session-of-the-general-assembly-on-the-world-drug-problem-held-in-2016-including-the-seven-thematic-areas-of-the-outcome-document-of-the-special-sess/>
- 5 United Nations Development Programme (2017) Commission on Narcotic Drugs 60th Session, 13 to 17 March 2016, Vienna [UNDP statement made at Plenary Agenda Item 6]. Retrieved 11 April 2017 from: <http://cndblog.org/wp-content/uploads/2017/03/UNDP.pdf>
- 6 Fordham A (2017) Drugs at the UN: the needle inches forward. London: International Drug Policy Consortium. Retrieved 11 April 2017 from: <http://idpc.net/blog/2017/04/drugs-at-the-un-the-needle-inches-forward>
- 7 UNODC (2017) Press release: 'Extraordinary' 60th session of the Commission on Narcotic Drugs closes with commitment to keep protecting people. Vienna: United Nations Office on Drugs and Crime. Retrieved 11 April 2017 from: <https://www.unodc.org/unodc/en/press/releases/2017/March/extraordinary-60th-session-of-the-commission-on-narcotic-drugs-closes-with-commitment-to-keep-protecting-people.html>

## Headshop legislation and changes in national addiction treatment data

A new paper by Smyth *et al.* explores the relationship between changes in legislation related to new psychoactive substances (NPS) and their problematic use.<sup>1</sup> In 2010, new psychoactive substances were the subject of two new pieces of legislation in Ireland. The first (enacted in May 2010), expanded the list of substances controlled under the Misuse of Drugs Act 1977–1984 to include over 100 NPS.<sup>2</sup> The second, the Criminal Justice (Psychoactive Substances) Act 2010 (enacted in August 2010), differed from the established approach to drug control under Ireland's Misuse of Drugs Act, in that it covered the sale of substances by virtue of their psychoactive properties, rather than the identity of the drug or its chemical structure. It was aimed at vendors of NPS and effectively made it an offence to sell a psychoactive substance.<sup>3</sup> This 'two-pronged legislative approach' was largely in response to an increase in the number of so-called 'headshops' selling NPS from late 2009 to a peak of 102 premises in May 2010. By October 2010, only 10 headshops were still open and by late 2010 the Gardaí indicated that none of the remaining shops were selling NPS.

Legislative bans such as these have attracted debate internationally as to their effectiveness in impacting on the overall availability and use of NPS, in particular problematic use.<sup>4</sup> Smyth *et al.* explored whether 'the arrival and subsequent departure of the headshops coincided with changes in presentation of problem NPS use among adults attending addiction treatment services in Ireland'.

### Methods

The paper is based on analysis of data from the National Drug Treatment Reporting System (NDTRS), an epidemiological database on treated drug and alcohol misuse in Ireland.<sup>5</sup> It collects self-reported information on service users' main problem drug and up to three additional problem drugs.

Problem drug use is 'generally understood [in the NDTRS] to equate to dependence or harmful use as described in ICD-10'. The system does not use a unique patient identifier and therefore the units of analysis reported on in the paper were treatment episodes, except where analysis focused on the cases of those never previously treated for drug use. A treatment episode was considered to be NPS-related, where a NPS was identified as a 'main' or 'additional' problem drug. A range of statistical analyses were carried out on the data, including odds ratios and jointpoint regression (further detail is available in the paper). To reflect the timeline of changes in problem NPS use in Ireland and the introduction of the relevant legislation, the paper examined episodes of treatment recorded in the NDTRS between 2009 and 2012 at four-month intervals.

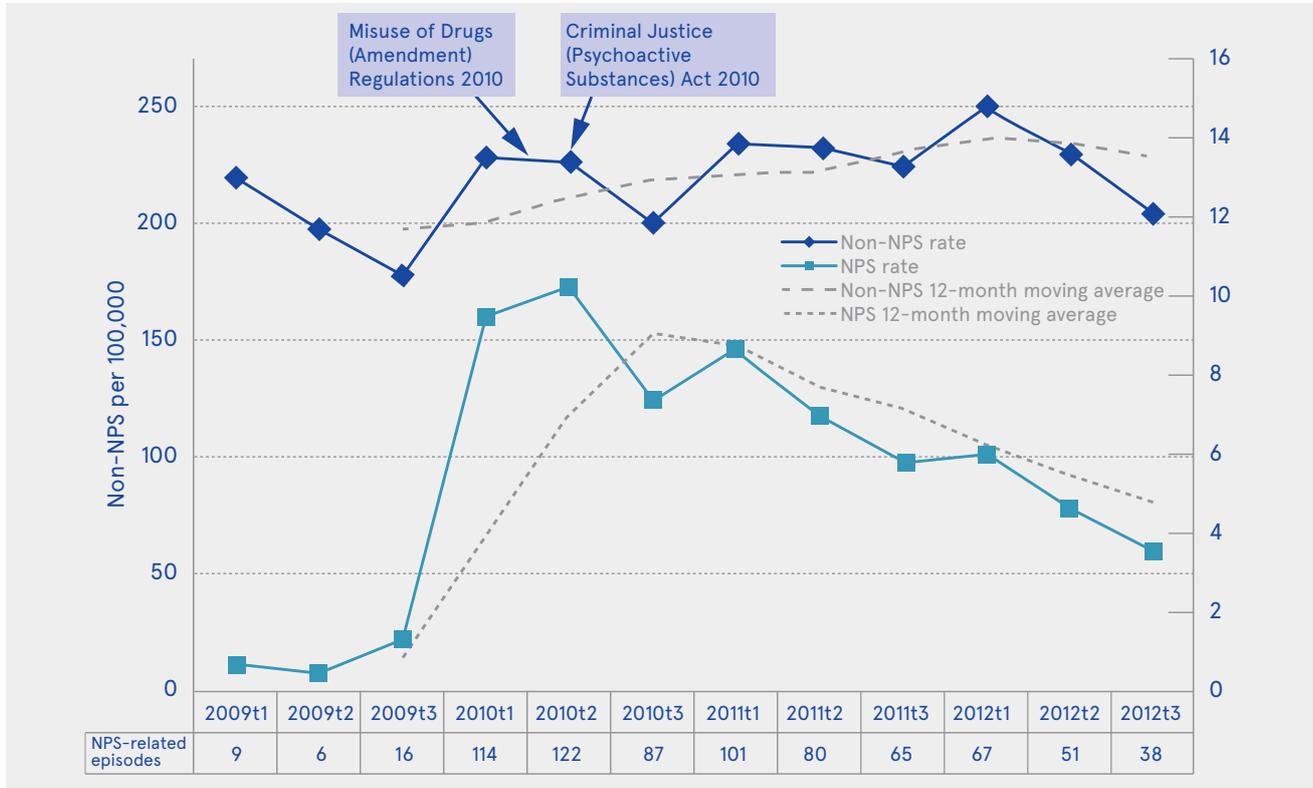
### Key findings

Key findings included that:

- NPS use can cause substance use disorders and create treatment demand. In what Smyth *et al.* called 'the headshop era' (i.e. January–August 2010), 4.2% of treatment episodes among 18–34-year-olds were NPS-related. This was compared to 2.4% of treatment episodes for the same age group over the three-year period 2009–2012.
- Between 2009 and 2012, the NPS group had a higher proportion of males when compared to the non-NPS group and had a younger age profile. The median age of the NPS group was 25 years compared to 35.6 years for the non-NPS group.
- A decline in treatment episodes for NPS followed the enactment of the second piece of legislation that effectively ended 'the headshop era' in August 2010. The rate of NPS-related treatment episodes increased rapidly from the period September to December 2009, through early 2010, and peaked between May and August 2010. It decreased progressively after that point (see Figure 1). Smyth *et al.* highlighted that the rate of NPS-related treatment episodes did not just 'plateau' following the enactment of the legislation causing the headshops to close, rather it 'declined progressively by almost 50%' over the subsequent two years.
- Similar changes were not found for non-NPS related treatment episodes over the same time period (2009–2012).

## Headshop legislation and treatment data continued

Figure 1: Rate of addiction treatment episodes among 18–34-year-olds, from 2009–2012, comparing episodes related to new psychoactive substances to those related to other substances.



- While there was an overall decrease in NPS treatment episodes after August 2010, where they did occur, NPS stimulant powders accounted for an increased proportion of them, while the proportion of NPS cannabis-like substances declined.
- The rate of NPS-related treatment episodes declined more acutely among young people who had never before sought addiction treatment, when compared to overall treatment episodes.
- An NPS was the main problem drug in 39% of NPS-related treatment episodes in 2010, but this fell to 16% in 2012. Therefore, even though NPS continued to feature in treatment episodes after the headshops had closed, they were more likely to be a 'peripheral problem'.

While acknowledging other possible explanations, the authors note that their findings 'are consistent with a hypothesis that the legislation and consequent closure of the headshops contributed to a reduction in NPS-related substance use disorders in Ireland'. They concluded that:

*While policy responses based on prohibition type principals appear to have fallen out of favour globally in the past decade, the experience of Ireland's response to NPS suggests that such policies remain a legitimate component of society's response to this complex and ever-changing challenge.*

However, more recent data from the NDTRS show that NPS use is still problematic in Ireland and is showing a slight increase. While reported use of an NPS as a main drug of problem use among all age groups peaked in 2010, at 2.5% of all cases treated, and dropped to 0.4% of all cases treated in 2012, since then it has increased slightly to represent 0.9% of all cases treated in 2015.<sup>6</sup>

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- 1 Smyth BP, Lyons S and Cullen W (2017) Decline in new psychoactive substance use disorders following legislation targeting headshops: evidence from national addiction treatment data. *Drug and Alcohol Review*, early online. <http://www.drugsandalcohol.ie/27172/>
- 2 Misuse of Drugs (Amendment) Regulations 2010. Available online at <http://www.irishstatutebook.ie/eli/2010/si/200/made/en/pdf>
- 3 Criminal Justice (Psychoactive Substances) Act 2010 (commencement) Order 2010. Available online at <http://www.irishstatutebook.ie/eli/2010/si/401/made/en/pdf>
- 4 Dillon L (2016) New psychoactive substances: legislative changes in the UK. *Drugnet Ireland*, 59: 9–10. <http://www.drugsandalcohol.ie/26231/>
- 5 For further information on the NDTRS, visit: <http://www.hrb.ie/health-information-in-house-research/alcohol-drugs/ndtrs/>
- 6 Health Research Board (2017) *Drug treatment in Ireland NDTRS 2009–2015*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/27023> and <http://www.hrb.ie/publications>

# Irish GP attitudes towards decriminalisation and medical use of cannabis

The debate on the decriminalisation of cannabis and legalising cannabis for medicinal use has been ongoing in Ireland and abroad. Despite this, the topic has received scant attention in the research literature. A 'unique' and recent study carried out in Ireland aimed to build on existing interest in this area by examining the attitudes of Irish general practitioners (GPs) towards decriminalisation and the medicinal use of cannabis (n=565).<sup>1,2</sup>

## Methodology

All GPs whose details were recorded on the Irish College of General Practitioner's database were invited to participate in an online survey. The response rate was 15% (n=565). The survey contained three sections:

- 1 Closed questions were related to age, practice location, specialist level 1 or 2 registration,<sup>3</sup> and experience in treating opioid users.
- 2 To assess GP attitudes, participants were asked to agree to a series of statements using a five-point Likert scale; for example, 'cannabis should be decriminalised', 'cannabis should be legalised for medical use', 'decriminalisation of cannabis use would lead to its increased use' (p. 4).
- 3 A series of open-ended questions that enabled participants to expand on the responses given in section 2.<sup>2</sup>

## Results

The quantitative analysis, which examined responses by gender, age and training level, indicated that:<sup>1</sup>

- 56.8% of Irish GPs (n=320) in this study did not agree with decriminalisation of cannabis.
- Male GPs were more likely than female GPs to agree with the decriminalisation and legalisation of cannabis for medical use (p<0.0001 and p=0.002, respectively).
- GPs who were younger (<50 years) were more likely to agree with the legalisation of cannabis for medical use (p=0.044).
- GPs agreed that cannabis use has a negative impact on individuals with mental and physical health problems, 82.7% and 60%, respectively.
- GPs agreed that cannabis use can leave young people at risk of developing schizophrenia (77.3%).

- However, more than two-thirds agreed that cannabis had a role to play in pain management (63.5%), treatment of multiple sclerosis (62.3%), and palliative care (68.5%).
- GPs with level 1 training for managing opioid users (n=86) agreed or strongly agreed that cannabis should be legalised for medical use (65%) and had a role to play in pain management (80%) and in multiple sclerosis (86%).
- GPs with level 2 training for managing opioid users (n=13) strongly agreed or agreed that cannabis should be decriminalised.

The qualitative analysis, which utilised a content analysis to examine the open-ended responses to the statements in section 2, resulted in five themes:<sup>2</sup> decriminalisation and legislation debates; cannabis for therapeutic purposes; young people and family impacts; adverse health consequences; and legal status and comparisons to legal substances.

## Decriminalisation and legalisation debates

These terms were often used interchangeably by GPs. The legalisation of drugs was seen as necessary by some, given that prohibition was perceived as not working. Decriminalising/legalising cannabis was viewed as a way to regulate and standardise the sale and production of cannabis, which would safeguard those that took cannabis. Decriminalisation was viewed as a way to reduce contact with dealers and reduce illegal income being generated from the sale of cannabis. Many GPs acknowledged the impact of using cannabis on mental health and the need to draw an evidence-based approach when trying to regulate the product.

## Cannabis for therapeutic purposes (CTP)

GP comments on prescribing cannabis for medical use were mixed. Concerns were raised over prescribing and patient misuse. Many commented on the lack of research evidence to support CTP and queried how comparable it was to other therapies. Although GPs acknowledged its potential for palliative and chronic illnesses and pain management, some argued that the risks of using it far outweighed the benefits.

## Young people and family impacts

The majority of GPs noted that using cannabis at a young age not only influenced the health and wellbeing of the young person but also influenced how well they did at school and their future career aspirations. Their families and the communities in which they lived also suffered. Concerns were raised over the level of mental illnesses, suicide attempts, and lack of engagement evident in this population. Drug education programmes were identified as a necessity to inform young people of the harms associated with cannabis use with the aim of preventing onset and progression to more risky drug-related behaviour. The potency of cannabis sold on the street troubled GPs, as it was a stepping stone towards using more potent illicit drugs, such as cocaine or heroin.

## Irish GP attitudes continued

### Adverse health consequences

Many GPs emphasised that long-term cannabis use can lead to negative outcomes, such as dependence and mental health problems. GPs were conscious that some individuals were more susceptible to drug-induced psychosis or developing schizophrenia. Comments also centred on the challenges of treating cannabis use in mentally ill patients, particularly those that presented with suicidal ideation and self-harm. GPs stressed that better psychiatric services to support treatment were required.

### Legal status and comparisons to legal substances

GPs compared the after-effects of using cannabis with nicotine, alcohol and opioid pain relief, and purported that cannabis was less harmful but only if taken in moderation.

### Limitations

As acknowledged by the authors, the response rate for this study was low (15%). This would suggest that the final sample may not be representative of the total GP population that were invited to participate in the survey.

### Conclusion

The majority of GPs in this study are not in favour of the decriminalisation of cannabis drug policy, yet are in favour of legalising the use of cannabis for medicinal purposes.

Due to the poor response rate, it could be argued that the results of this study should be interpreted with caution. However, despite this limitation, the study makes a unique contribution and builds on existing knowledge, while also providing insight into the attitudes of GPs from an Irish context. One of the study authors, Dr Des Crowley, hopes that this study 'will be considered within the ongoing debate on substance misuse in Ireland'.<sup>4</sup>

### Ciara H Guiney

- 1 Crowley D, Collins C, Delargy I, Laird E and Van Hout MC (2017) Irish general practitioner attitudes toward decriminalisation and medical use of cannabis: results from a national survey. *Harm Reduction Journal*, 14(4): 4. <http://www.drugsandalcohol.ie/26675/>
- 2 Van Hout MC, Collins C, Delargy I and Crowley D (2016) Irish general practitioner (GP) perspectives toward decriminalisation, legalisation and cannabis for therapeutic purposes. *International Journal of Mental Health and Addiction*: 1-14. doi:10.1007/s11469-016-9710-2. <http://www.drugsandalcohol.ie/27072/>
- 3 Level 1 registration refers to GPs trained in addiction treatment but not to an advanced level. Level 2 registration refers to GPs with advanced addiction specialist training.
- 4 Irish College of General Practitioners (2017) Irish family doctors support legalisation of cannabis for therapeutic use. Available online at [http://www.icgp.ie/go/about/policies\\_statements/2017/51D12BC8-E89A-0F29-4D05611C1C784A5F.html](http://www.icgp.ie/go/about/policies_statements/2017/51D12BC8-E89A-0F29-4D05611C1C784A5F.html)



## PREVALENCE AND CURRENT SITUATION

## Drug treatment figures from the NDTRS, 2009–2015

The National Drug Treatment Reporting System (NDTRS) has published its latest figures on treated problem drug use (excluding alcohol).<sup>1</sup> In the seven-year period 2009–2015, 61,439 cases were treated for problem drug use (excluding alcohol). The number of cases rose from 7479 in 2009 to 9892 in 2015. For the first time data from treatment in prison is included in annual figures. Of note, the data now include those cases with no fixed abode, no known address, or an address outside Ireland, in all tables, which were excluded from previous publications. Therefore, the data in this bulletin supersede all previously published data from NDTRS trend papers and web updates.

### Service provider

The majority of cases were treated in outpatient facilities (64.4%) over the period, similar to previous years (Table 1). The proportion of cases treated in prison decreased slightly from 10.8% to 8.4% over the reporting period. The NDTRS has been collecting information on treatment in prison since 2008, mainly from in-reach services (voluntary organisations providing counselling). However, since 2014, the Irish Prison Service's addiction services in Mountjoy Prison have participated in the NDTRS, followed by the women's prison, Dóchas, in 2015. In 2015, the proportion of cases treated in residential facilities increased for the first time in the period, from 14% in 2009 to 18% in 2015.

### Overview

The proportion of new cases decreased over the period from 45.9% in 2009 to 37.8% in 2015, with a corresponding increase in the number of previously treated cases (Table 2).

The increase in the number of previously treated cases is an indicator of the chronic, relapsing nature of addiction.

In 2015, half of those treated were aged 30 years. Over the reporting period, the median age of all cases treated increased from 28 years in 2009 to 30 years in 2015. There were differences depending on whether the case was new (25 years) or previously treated (32 years). In 2015, most of those treated were male (72.2%) similar to previous years. The proportion of cases who were homeless increased from 5.6% in 2009 to 9.2% in 2015.

For the first time, aggregated data on the numbers of cases from the Traveller community are presented in these routine statistics. The proportion of cases who identified as Travellers increased from 1.9% in 2009 to 2.9% in 2015. The proportion of Travellers in the general population is 0.7% (2016 Census).<sup>2</sup> In 2015, nearly two-thirds of all cases (64.4%) were unemployed. Unemployment rates in this group did not drop below 60% for all of the years reported. Unemployment rates were higher among previously treated cases.

Opiates (mainly heroin) continued to be the most commonly reported drug over the reporting period. While the number of cases treated for problem opiate use remained stable over the period, the proportion of cases treated decreased from 60.6% in 2009 to 47.8% in 2015. Cannabis was the second most common drug reported among those treated. The number of cases reporting problem cannabis use increased by 72%, from 1616 in 2009 to 2786 in 2015. Cocaine remained the third most common drug reported and in 2015, 10.4% of cases reported problem cocaine use, the highest proportion reported since 2010.

Another significant finding was the increasing proportion of cases reporting benzodiazepines as a main problem drug, which rose by 185% from 306 cases (4.1%) in 2009 to 873 cases (8.8%) in 2015. In addition, the number of cases treated for Z-drugs has increased significantly from 9 in 2009 to 154 in 2015.

Table 1: Number of cases treated for problem drug use, by type of service provider, NDTRS 2009–2015

	2009	2010	2011	2012	2013	2014	2015
<b>Total</b>	<b>7479</b>	<b>8806</b>	<b>8361</b>	<b>8005</b>	<b>9006</b>	<b>9890</b>	<b>9892</b>
Outpatient	5006	5563	5623	5299	5998	6251	5818
Inpatient*	1064	1232	1107	1124	1233	1348	1779
Low threshold	341	793	642	711	812	1190	1197
Prison	811	930	761	642	747	844	827
General practitioner	257	288	228	229	216	257	271

\* Includes any service where the client stays overnight, e.g. inpatient detoxification, therapeutic communities, respite and step-down

Table 2: Number of cases treated for problem drug use, by treatment status, NDTRS 2009–2015

	2009	2010	2011	2012	2013	2014	2015
<b>Revised total</b>	<b>7479</b>	<b>8806</b>	<b>8361</b>	<b>8005</b>	<b>9006</b>	<b>9890</b>	<b>9892</b>
New cases	3431	3741	3316	3272	3475	3776	3742
Previously treated cases	3891	4842	4862	4518	5239	5643	5855
Treatment status unknown	157	223	183	215	292	471	295

## Drug Treatment figures 2009–2015 continued

For the first time, the bulletin reports on treated problem use of novel psychoactive substances (NPS). The number of cases treated for NPS use peaked in 2010, at 2.5% of all cases treated, and dropped to 0.4% of all cases treated in 2012. Since then, it has increased slightly to represent 0.9% of all cases treated in 2015.

The majority of cases reported problem polydrug use (63.5%) over the period; however, the proportion has decreased from 68.4% in 2009 to 60.9% in 2015. Up to 2013, alcohol was the most common additional drug reported. Since 2014, benzodiazepines have become the most common additional drug reported.

The proportion of all cases treated who reported ever injecting remained relatively stable over the reporting period at around one-third of all cases. The proportion of new cases reporting ever injecting has decreased from 19.7% in 2009 to 14.5% in 2015.

### Suzi Lyons

- 1 Health Research Board (2017) *Drug treatment in Ireland NDTRS 2009–2015*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/27023>
- 2 Data on ethnicity is taken from the 2016 Census from the CSO. For more information, see <http://cso.ie/en/media/csoie/newsevents/documents/pressreleases/2017/prCensussummarypart1.pdf>

## Alcohol-related morbidity in Ireland

In 2016, the Health Research Board (HRB) published an overview of the situation in Ireland regarding alcohol consumption and harm and trends over time.<sup>1</sup> This overview provided an analysis of alcohol-related discharges from 1995 to 2013 that were wholly attributable (i.e. alcohol is a necessary cause for these conditions to manifest). The data were obtained from the Hospital In-Patient Enquiry (HIPE) scheme, which collects clinical and administrative data on discharges (including deaths) from acute Irish hospitals and is managed by the Healthcare Pricing Office (HPO) in the Health Service Executive (HSE). The purpose of this article is to update this analysis for the years 2014 and 2015. A detailed description of the methods undertaken in this analysis may be found in the 2016 overview.

### Number of alcohol-related discharges

The number of alcohol-related discharges increased in 2014 and 2015, with 17,917 recorded in 2015 (Table 1). The proportion of alcohol-related bed days has increased from 3.2% in 2006 to 3.8% in 2015. In 2015, alcohol-related discharges accounted for 175,750 bed days, which means that each day 482 beds were occupied by people with a wholly attributable alcohol-related condition. There has also been an increase in the mean length of stay, from 8.1 days in 2006 to 10.8 days in 2015, which suggests that patients with alcohol-related diagnoses are becoming more complex in terms of their illness.

### Discharges by gender and age

In 2015, males accounted for 73.3% of discharges and females for 26.7% of discharges. In general, female discharges were younger than male discharges. While males accounted for almost three-quarters of all discharges in 2015, they only accounted for 49.2% of discharges aged less than 18 years, while females accounted for 50.8%. The age profile of discharges is presented in Figure 1. Discharges for both males and females peaked in the 50–59-years age group and 62% of all discharges were aged under 60 years.

Table 1: Number and length of stay of alcohol-related discharges, 2006–2015

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
All persons	17,053	18,024	18,400	18,109	17,755	17,078	17,225	17,120	17,139	17,917
Males	12,629	13,344	13,579	13,254	13,015	12,457	12,552	12,398	12,435	13,128
Females	4424	4680	4821	4855	4740	4621	4673	4722	4704	4789
Average length of stay	8.1	8.0	8.8	8.6	9.1	9.4	9.2	10.1	9.9	10.8
% of bed days	3.2	3.3	3.6	3.5	3.6	3.7	3.6	3.6	3.6	3.8

# Alcohol-related morbidity in Ireland continued

## Discharges by diagnosis

In 2015, acute conditions accounted for 10.9% of alcohol-related discharges; chronic diseases accounted for 20.7% of such discharges, while other chronic conditions accounted for 58.3%. Acute conditions were more prevalent among younger people, while chronic diseases and other chronic conditions were more common among older age groups. Alcoholic liver disease (ALD) was the most common chronic alcohol disease, accounting for four-fifths or 3293 of all alcohol-related chronic diseases in 2015. The rate of discharges with ALD increased from 76.1 per 100,000 adults aged 15 years and over in 2006 to 91.3 in 2015, an increase of 20.0% (Figure 2). Of all discharges with an ALD diagnosis in 2015, 8.1% died while still in hospital. The proportion of ALD discharges that died shows a similar pattern since 2006, which suggests that there has been little improvement in the prognosis of patients with ALD.

## Conclusion

The number of alcohol-related discharges has increased slightly since 2013; however, the rate of discharges with a diagnosis of alcohol-related liver disease has increased by 4.1% since 2013, which is a cause for concern. Alcohol-related morbidity continues to be a public health problem, with 482 beds being occupied each day by people with a wholly attributable alcohol-related condition. Given that this does not include alcohol partially attributable discharges (alcohol must be a component cause), such as some cancers, cardiovascular disease, and intentional and unintentional injuries, the true burden is likely to be much higher. These hospital data indicate that the measures outlined in the Public Health (Alcohol) Bill 2015 need to be implemented as soon as possible.

## Deirdre Mongan

1 Mongan D and Long J (2016) *Overview of alcohol consumption, alcohol-related harm and alcohol policy in Ireland*. HRB Overview Series 10. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/25697/>

Figure 1: Percentage of alcohol-related discharges by gender and age, 2015

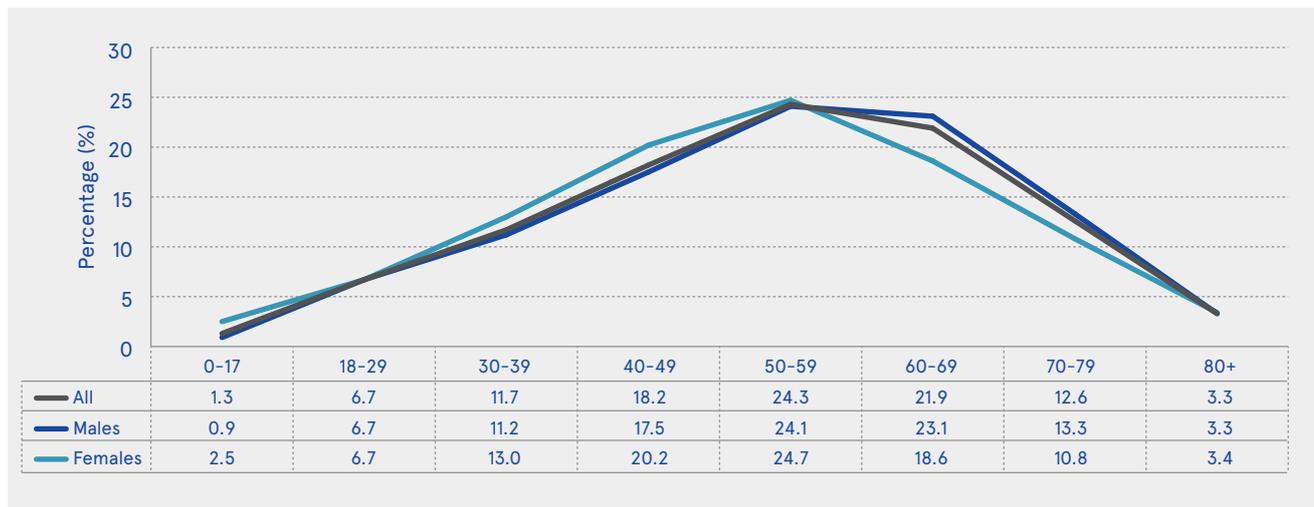
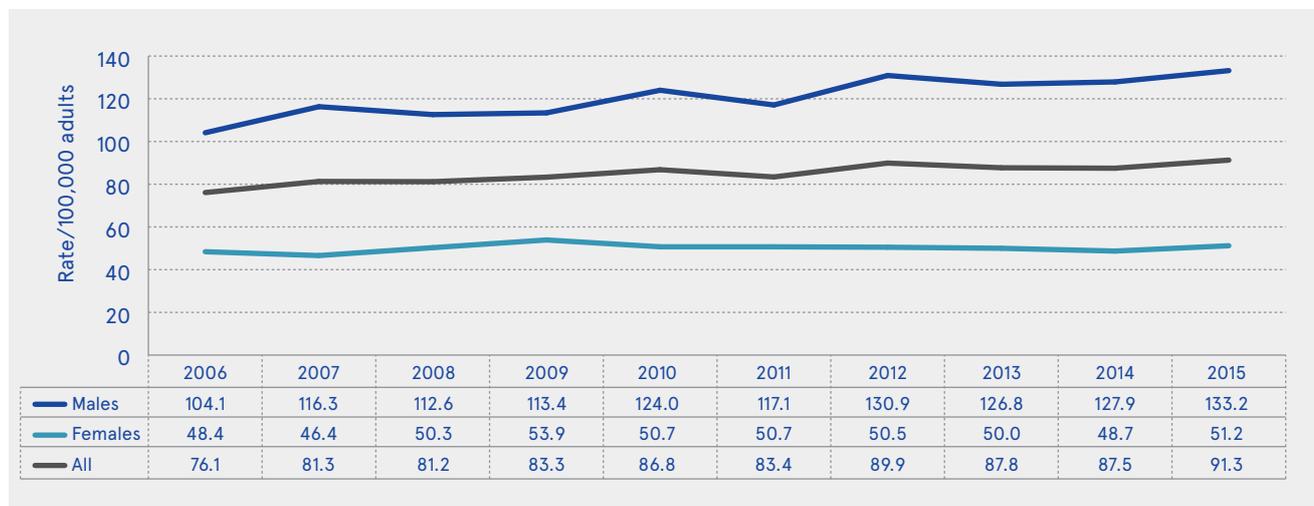


Figure 2: Rate of alcoholic liver disease discharges per 100,000 adults, by gender, 2006–2015



# Self-harm, alcohol consumption and public holidays

Research presented at the National Health Services Research Institute Research Day<sup>1</sup> by Dr Christina Dillon of the National Suicide Research Foundation (NSRF), which has recently been published in the *Journal of Affective Disorders*,<sup>2</sup> highlights the effect of alcohol consumption on self-harm presentations to Irish hospital emergency departments during public holidays.

The National Self-Harm Registry Ireland has consistently shown peaks in self-harm presentations out of hours at weekends and during public holidays. Presentations involving self-harm peak around midnight, and approximately one-third of presentations are recorded on Sundays and Mondays. Over recent years, peak attendances have been observed on public holidays. During the period 2007 to 2015, the mean number of self-harm presentations was 27 daily and 32 on public holidays. Across all years, St Patrick's Day and New Year's Day showed higher numbers of presentations compared to other public holidays, with a yearly average of 44 and 41, respectively.

It was found that alcohol was involved in 43% of self-harm presentations on public holidays compared to 38% on all other days. Self-harm presentations had a 24% increased likelihood of involving alcohol on public holidays compared to all other days (relative risk: 1.24, 95% CI: 1.17–1.32). In addition, self-harm presentations to hospital on Christmas Eve, Christmas Day and New Year's Eve had a 80%, 77% and 62% increased probability of involving alcohol, respectively (Figure 1).

The NSRF concludes that the findings support the hypothesis that self-harm presentations are elevated on public holidays and that alcohol consumption is more strongly associated with self-harm presentations on public holidays.

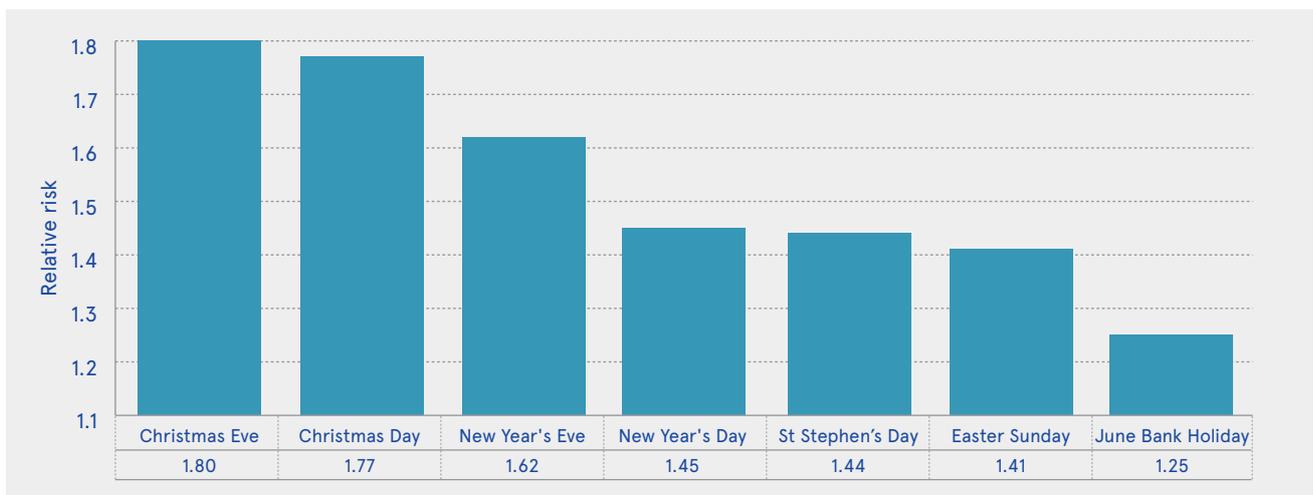
These findings highlight the need for continuing efforts to:

- Enhance health service capacity at specific times.
- Increase awareness of the negative effects of alcohol misuse and abuse.
- Educate self-harm patients and their families about the importance of reduced use of, and access to, alcohol.
- Arrange active consultation and collaboration between the mental health services and addiction treatment services in the best interests of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).
- Ensure the assessment of alcohol misuse and abuse is a structural part of the assessment to determine the risk of repeated self-harm and suicide.

## Seán Millar

- 1 National Suicide Research Foundation (2016) Self-harm, alcohol consumption and public holidays. *National Suicide Research Foundation newsletter*, 15: 2. Cork: National Suicide Research Foundation. <http://www.drugsandalcohol.ie/26645>
- 2 Griffin E, Dillon CB, O'Regan G, Corcoran P, Perry IJ and Arensman E (2017) *The paradox of public holidays: hospital-treated self-harm and associated factors*. *Journal of Affective Disorders*, 218: 30–34. <http://www.drugsandalcohol.ie/27285/>

Figure 1: Association between alcohol consumption and self-harm presentations during public holidays



Source: NSRF, 2016

# Communities That Care: a review

The National Substance Misuse Strategy<sup>1</sup> found that community mobilisation can be successful in bringing stakeholders together to develop alcohol and drug policies. *Communities That Care (CTC): a comprehensive prevention approach for communities* is a review of one such approach and was published as part of the EMCDDA Papers series.<sup>2</sup>

## Community mobilisation/coalitions

'Community mobilisation' and 'community coalitions' are strategic approaches used to reduce substance use and other harmful behaviours. Broadly speaking, they refer to a process through which communities work together to take action and bring about change, working with a range of stakeholders from the public, statutory and private sectors to identify the changes they want to bring about in their area. Based on the best evidence available, the different stakeholders plan together how to bring about the desired changes. They then implement the plan and monitor its progress in reducing the target behaviours.<sup>3</sup>

## Communities That Care (CTC)

CTC is a US-developed system for mobilising communities to address young people's health and behaviour problems, including substance use. According to the EMCDDA paper, it is essentially 'a prevention operating system' (p. 2) that provides a method for communities to assess the particular needs of their young people, coordinate the stakeholders, and select and implement suitable evidence-based programmes. The approach is based on the belief that by understanding the risk and protective factors experienced by the young people within the community, appropriate tested and effective prevention and early intervention programmes can be implemented to build on the protective factors and thus reduce problematic behaviours.

## The review

The EMCDDA paper reviews the evidence on the effectiveness of CTC programmes in preventing substance misuse in young people. The review was facilitated by the availability of 'some good-quality studies with diverse results', although most of the research comes from North America. Of the 18 studies included in the review, 12 related to the same randomised controlled trial (RCT) of a CTC project in the US. The paper provides an overview of the findings from two RCTs, a before-and-after study, two quasi-experimental longitudinal studies with a comparison group, and an EMCDDA report on international organisations. The primary outcomes considered were a reduction in incidence and prevalence of alcohol and other drug use among young people; and the enhanced ability of communities in adopting, implementing with fidelity, and sustaining tested and effective prevention and early intervention programmes. Secondary outcomes sought were reductions in delinquency and other problem behaviours among young people.

## Outcomes

The review's analysis is described by the author as 'limited' by the lack of a meta-analysis (p. 4). Such a pooled analysis was not possible given the variation between studies in the outcomes measured, the statistical analysis methods used, and the quality of reporting. Instead, an overview of the findings from each study can be found in the paper. Overall, the findings were mixed. The authors concluded that the two RCTs, which were conducted in very different contexts (US and Australia), 'do not provide conclusive evidence regarding the effectiveness of CTC, although they do strongly suggest a positive effect' (p. 9). The strongest evidence of effectiveness by reducing the incidence and prevalence of delinquency and substance use for some cohorts came from the US-based RCT.

## Transferability

The other studies reviewed were of Europe-based CTC projects. They were used to assess the transferability of CTC to Europe. A number of issues were identified, such as:

- The very concept of 'community' differs between countries. While the community members of the coalition tended to be volunteers in the US, they were more likely to be paid professionals in some European projects.
- The CTC sites in Europe were less rural and more heterogeneous than those in the US, and disadvantaged neighbourhoods were not as poor and their residents not as socially excluded.
- There is only a limited number of evidenced-based prevention programmes to draw upon in Europe compared to the US.
- More lead-in time was required for projects, as participants were not always familiar with the concept of prevention programmes and their implementation.

## Conclusion

In conclusion, the review described CTC as a 'useful preventative intervention in North America, but its effectiveness still needs to be clearly assessed in Europe' (p. 9). To do so would require a sufficiently robust randomised study to be supported, as well as the appropriate adaptation of the programme to fit the European context.

## Lucy Dillon

- 1 Department of Health (2012) *Steering group report on a national substance misuse strategy*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/16908/>
- 2 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2017) *Communities That Care (CTC): a comprehensive prevention approach for communities*. EMCDDA Papers. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/26931/>
- 3 The findings of the evaluation of an Irish community mobilisation programme were reported in issue 58 of *Drugnet Ireland*. <http://www.drugsandalcohol.ie/25954/>. See also Galligan C (2016) *National community action on alcohol pilot project 2015: external evaluation project*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/25098/>

# Drug misuse prevention: NICE guideline

The National Institute for Health and Care Excellence (NICE) in the UK published updated guidance on *Drug misuse prevention: targeted interventions*.<sup>1</sup> The focus was on preventing or delaying 'harmful use of drugs in children, young people and adults who are most likely to start using drugs or who are already experimenting or using drugs occasionally' (p. 5). It was concerned with the use of illegal drugs, 'legal highs' and prescription-only medicines. The guideline was aimed at a range of stakeholders: health and social care professionals; commissioners and providers; practitioners working in drug misuse prevention and specialist drug treatment services; owners and staff at venues where people using or at risk of using drugs attend; educational governance workers; drug users; their carers and families; and the public. The recommendations were based on the findings of an expert committee's review of the evidence and submissions from experts working in the area. They considered both the effectiveness of the interventions in reducing drug use and their cost-effectiveness. If an intervention delivered on the former but was not cost-effective, it was not recommended. Overall, the committee found limited evidence for the cost-effectiveness and effectiveness more broadly of drug misuse prevention interventions across the groups at risk.<sup>2</sup>

## Assessment

Carrying out an assessment of the individual's drug use was consistently found to be a part of effective interventions – this helped ensure that an appropriate intervention was offered. The committee recommended that people in these groups should be routinely and opportunistically assessed for vulnerability to drug use. This should be done as part of any appointments they might have with services such as health and social care services, and the criminal justice system.

## Children/young people assessed as vulnerable to drug misuse

Where children and young people were assessed as vulnerable to drug use, the committee recommended skills training for them and their carers or families. They did not recommend skills-based training for the young people alone or just their carers/families. This was found to be a more cost-effective way to reduce the risk of drug misuse than other interventions explored: family-based interventions, manualised/licensed programmes, or motivational interventions. They noted that skills training was likely to improve a range of drug-related and non-drug-related outcomes.

Components of effective skills training for children and young people included developing skills in listening, conflict resolution, refusal, managing stress, making decisions, coping with criticism, dealing with feelings of exclusion, and making healthy behaviour choices. For carers or families the skills to develop were: communication, developing and maintaining healthy relationships, conflict resolution, and problem

solving. They recommended that age, developmental stage, vulnerabilities, cultural context, religion, and ethnicity should all be considered when deciding on the details of the skills training sessions.

## Adults assessed as vulnerable to drug misuse

There was not enough evidence of effectiveness and cost-effectiveness to be able to recommend skills training or motivational interventions for adults who had been assessed as vulnerable to drug misuse. Instead, the committee recommended that practitioners continued to deliver 'current practice'. This was found to include brief information and education on drugs and their effects (including the health and social effects), with the opportunity for feedback. The committee also recommended that adults be given information on sources of advice and support if their risk of drug misuse increased. The information and other resources should be delivered at the time of assessment in both a written and verbal format. A plan for follow-up should also be made at the time of assessment.

## People at risk of using drugs

The report also makes recommendations for working with people who are not in touch with services. In the absence of an evidence base of effective interventions, they recommend providing information about drugs and an online assessment and feedback tool. This could be web-based and use social media. However, written information should be provided to those who do not access online services.

## Research recommendations

Given the weak evidence base for targeted prevention interventions, the committee recommended support for research on a number of topics, including: the long-term consequences of drug use, interventions for image and performance-enhancing drugs and new psychoactive substances; effectiveness of digital technologies in delivering prevention interventions; and acceptability of drug misuse prevention interventions among vulnerable groups.

## Lucy Dillon

1 National Institute for Health and Care Excellence (2017) *Drug misuse prevention: targeted interventions*. NICE guideline [NG64]. London: National Institute for Health and Care Excellence. <http://www.drugsandalcohol.ie/26887/>

2 For the purpose of the guideline, 'groups at risk' were defined as including: people who have mental health problems; people who are being sexually exploited or sexually assaulted; people involved in commercial sex work; people who are lesbian, gay, bisexual or transgender; people not in employment, education or training (including children and young people who are excluded from school or who truant regularly); children and young people whose carers or families use drugs; children and young people who are looked after or care leavers; children and young people who are in contact with young offender teams but not in secure environments (prisons and young offender institutions); people who are considered homeless; people who attend nightclubs and festivals; and, people who are known to use drugs occasionally or recreationally.

# Drug supply reduction: an overview of EU policies and measures

In January 2017, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published *Drug supply reduction: an overview of EU policies and measures*.<sup>1</sup> This is an introductory guide to the European Union's (EU) approach to drug supply reduction. A number of different strategies were presented.

## Policy areas

The main policy document that addresses drug supply reduction is the *EU drugs strategy 2013–2020* and its action plan 2013–2016.<sup>2,3</sup> The main objective of the strategy is to reduce the availability of illicit drugs by disrupting illicit drugs trafficking and dismantling organised crime groups (OCGs) involved. An efficient criminal justice system is viewed as essential along with intelligence-led law enforcement and sharing of intelligence among agencies. From an EU perspective, the main focus is placed on organised, large-scale and cross-border drug-related crime (p. 4). Drug supply reduction is also addressed in policies in other areas, for example, security, policy cycle (organised and serious international crime), maritime security, and regional programmes.

Figure 1: Main EU structures addressing drug supply reduction issues

	Policy-making processes	Legislative processes	Policy support, coordination and implementation
<b>EU institutions and bodies</b>			
European Council	★		
European Parliament	★	★	
Council of the EU	★	★	
European Commission	★	★	★
EEAS	★		★
<b>Council committees and working groups</b>			
COSI			★
HDG			★
<b>Coordination platform</b>			
EMPACT			★
<b>EU agencies</b>			
EMCDDA			★
Europol			★
Eurojust			★
Frontex			★
CEPOL			★
<b>Member states</b>	★	★	★

Source: EMCDDA and Europol, 2016<sup>4</sup>

Note: EEAS: European External Action Service; COSI: Standing Committee on Operational Cooperation on Internal Security; HDG: Horizontal Working Party on Drugs; Eurojust: EU Judicial Cooperation Unit; Frontex: European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union; CEPOL: European Police College.

## EU institutional system

EU structures involved in the design and implementation of strategies that aim to address drug supply include institutions, bodies and EU agencies (see Figure 1). Primarily, policy-making and legislative processes are carried out by the EU institutions, who along with council committees, working groups, EMPACT (European Multidisciplinary Platform against Criminal Threats) and EU agencies support, coordinate and implement the policies designed.

## Disrupting European drug markets

How drug trafficking routes are operated can raise security problems in the EU. The main responses identified in the paper to overcome the challenges that arise included:

- Intelligence-led policing along with cooperation between the EU and its member states is considered essential to address organised crime in the EU. Although the main organisation that aims to reduce drug supply and target OCGs is Europol, collaborative work is carried out with Interpol and law enforcement agencies worldwide. To determine the level of threat, assessments are carried out using Europol's Serious and Organised Crime Threat Assessment (SOCTA), which forms part of the EMPACT policy cycle.
- Legislation that aims to deter drug trafficking and apprehend OCGs has been put in place at an EU level and enables collaboration between member states to target cross-border criminal activities (see EMCDDA paper for a list of legislation implemented, Table 2, p. 8).<sup>1</sup>
- Chemicals (e.g. acetic anhydride) that are used in the manufacture of other products, such as perfumes and cosmetics, can also be used in heroin production. To ensure that chemicals are not used as drug precursors, regulations have been put in place at United Nation and EU levels to control and monitor their use.
- A key priority identified in the *European Agenda on Security (2015–2020)*<sup>5</sup> and the *EU action plan on drugs (2013–2016)*<sup>5</sup> is to prevent OCGs from gaining access to drug-related profits. Current legislation exists to enhance judicial cooperation in cross-border money-laundering cases and for asset confiscation and recovery and money laundering. The European Commission works with various organisations (e.g. International Financial Action Task Force (FATF) and Expert Group on Money Laundering and Terrorist Financing) to build and instigate responses to money laundering.
- As part of the ongoing EU commitment to drug supply reduction, four types of programmes are funded: framework programmes; programmes for EU candidate and potential candidate countries; geographic or regional programmes; and programmes that complement geographic ones.
- More often than not the main way to ship illicit drugs is by sea. This poses a serious challenge because the majority (70%) of the EU's external borders are maritime. Maritime interdiction in the EU is centred on information-sharing networks, for example, Common Information Sharing Environment for Maritime Surveillance in Europe (Maritime CISE). Other systems that aim to address challenges include Consistently Optimised REsilient (CORE) ecosystem, European Borders Surveillance System (EUROSUR) and Maritime Analysis Operations Centre – Narcotics (MAOC-N).

## Drug supply reduction: an overview continued

### Targeting international drug trafficking

OCGs take advantage of existing international trade routes and national infrastructures to move illicit drugs via land, sea or air. With the aim of overcoming these challenges, the EU works with member states and other stakeholders on numerous programmes that target international drug trafficking, for example, the Container Control Programme, Cocaine Route and Heroin Route Programmes, Border Management, Paris Pact Initiative, Cooperation Programme on Drug Policies (COPOLAD) and the Global SMART (Synthetics Monitoring: Analyses, Reporting and Trends) Programme, by providing financial assistance via the European Commission for the United Nations Office on Drugs and Crime (UNODC).

### Conclusion

The EU response to drug production and trafficking is ongoing and avails of a multifaceted interagency approach within and beyond Europe. The response is continuously evolving, as criminals alter methods used in drug production and trafficking in order to capitalise financially and prevent apprehension by law enforcement agencies.

This EMCDDA paper provides a clear and concise overview from a global context of how the EU is responding to the unending challenges presented by the illicit drugs market and it would be a particularly useful resource for those already working in this area and for individuals new to it.

### Ciara H Guiney

- 1 European Monitoring Centre for Drugs and Drug Addiction (2017) *Drug supply reduction: an overview of EU policies and measures*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/26686/>
- 2 Council of the European Union (2012) *The EU drugs strategy 2013–2020*. Brussels: Council of the European Union. <http://www.drugsandalcohol.ie/19034/>
- 3 Council of the European Union (2013) *EU action plan on drugs (2013–2016)*. Brussels: Council of the European Union. <http://www.drugsandalcohol.ie/20004/>
- 4 EMCDDA and Europol (2016) *EU drug markets report: in-depth analysis*. Luxembourg: Publications Office of the European Union. Available online at <http://www.emcdda.europa.eu/start/2016/drug-markets#panel1>
- 5 European Commission (2015) *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions – the European Agenda on Security*, COM (2015) 185 final. Strasbourg: European Commission. Available online at [https://ec.europa.eu/home-affairs/sites/homeaffairs/files/e-library/documents/basic-documents/docs/eu\\_agenda\\_on\\_security\\_en.pdf](https://ec.europa.eu/home-affairs/sites/homeaffairs/files/e-library/documents/basic-documents/docs/eu_agenda_on_security_en.pdf)

## A typology of alcohol consumption among university students in Ireland

Elevated levels of alcohol consumption among university students are well documented, with research indicating a rise in alcohol use among students in Ireland and increasing levels of high-risk drinking.<sup>1</sup> Policy-makers have attempted to combat this problem, as tailoring effective public health policy is crucial to tackling this burgeoning issue. Recently, typologies have been hypothesised as a pertinent public health tool. While traditional analysis methods tend to categorise individuals based on consumption profile alone, a typology approach may enhance an understanding of a societal phenomenon while making it possible to note patterns.

Recent research conducted by University College Cork aimed to develop a typology of alcohol consumption among the Irish university student population.<sup>2</sup> In this study, published in the journal *BMJ Open*, hundreds of possible statements on types of alcohol consumption were generated from a systematic review and a set of one-on-one interviews. These were then reduced to 36 statements. Forty-three students were advised to scan through the 36 statements and fill them into a 'forced choice, standardised distribution'. Following this, a 45–90-minute interview was conducted with students to illuminate subjectivity surrounding alcohol consumption.

A typology describing four distinct groupings of alcohol consumer was uncovered. These were:

- **'Guarded drinker, careful spender, controlled enjoyment'**: Characterised by students who enjoy socialising but only within the remit of social, family or cultural rules, which are self-regulated, and who described their alcohol consumption as cautious and light.
- **'Calculated hedonists'**: Students who indicated a hedonistic style of drinking. These students drank alcohol to feel pleasure, to enjoy themselves, to have fun and become drunk.
- **'Peer influenced with an ulterior motive'**: Students who focused on consuming alcohol as part of a group or at a party. These individuals were motivated by the sense of belonging they gain from alcohol consumption, indicating that drinking helps them to feel a part of the group and adds a sense of social confidence.
- **'Inevitable bingers'**: Students who described how they drink until all the alcohol they have is gone. These individuals noted self-inflicted dangerous situations arising from their own behaviours and drinking habits.

As this was the first study to propose types of alcohol consumption based on a student's own subjectivity, the authors acknowledge that future research will be required to investigate the degree to which each of these types is subscribed. Nevertheless, these profiles may provide a framework for public policy-makers and health promotion practitioners when tackling alcohol consumption at both a micro and macro level.

### Seán Millar

- 1 Davoren MP, Shiely F, Byrne M, Perry IJ (2015) Hazardous alcohol consumption among university students in Ireland: a cross-sectional study. *BMJ Open*, 5(1): e006045. <http://www.drugsandalcohol.ie/23350/>
- 2 Davoren MP, Cronin M, Perry IJ, O'Connor K (2016) Alcohol consumption among university students: a typology of consumption to aid the tailoring of effective public health policy. *BMJ Open*, 6(11): e011815. <http://www.drugsandalcohol.ie/26485/>

RESPONSES

# Drug-related intimidation

Drug-related intimidation (DRI) negatively impacts the health and wellbeing of individuals, families, communities and the functioning of local agencies who serve them. Intimidation can be explicit or implicit, involving actual, threatened or perceived threats of violence or property damage. It can leave targeted individuals feeling helpless, isolated, demoralised and fearful. The Health Research Board (HRB) recently published an evidence review, conducted on behalf of the Department of Health’s Drugs Policy Unit, to identify international best practice, community-based responses to DRI.<sup>1</sup> The review focused on intimidation carried out by those involved in the distribution of drugs, including *disciplinary intimidation*, used to enforce social norms within the drug distribution hierarchy, to discourage or punish informants, or as a means to reclaim drug debt, and *successional intimidation*, used to recruit new members or gain control over networks or territory.

The international literature evaluating direct responses to DRI was scant. Therefore, the review drew on three Irish studies describing the underlying structure and operation of Irish criminal and drug distribution networks to develop a conceptual framework for understanding potential pathways into DRI and potential intervention targets to disrupt this

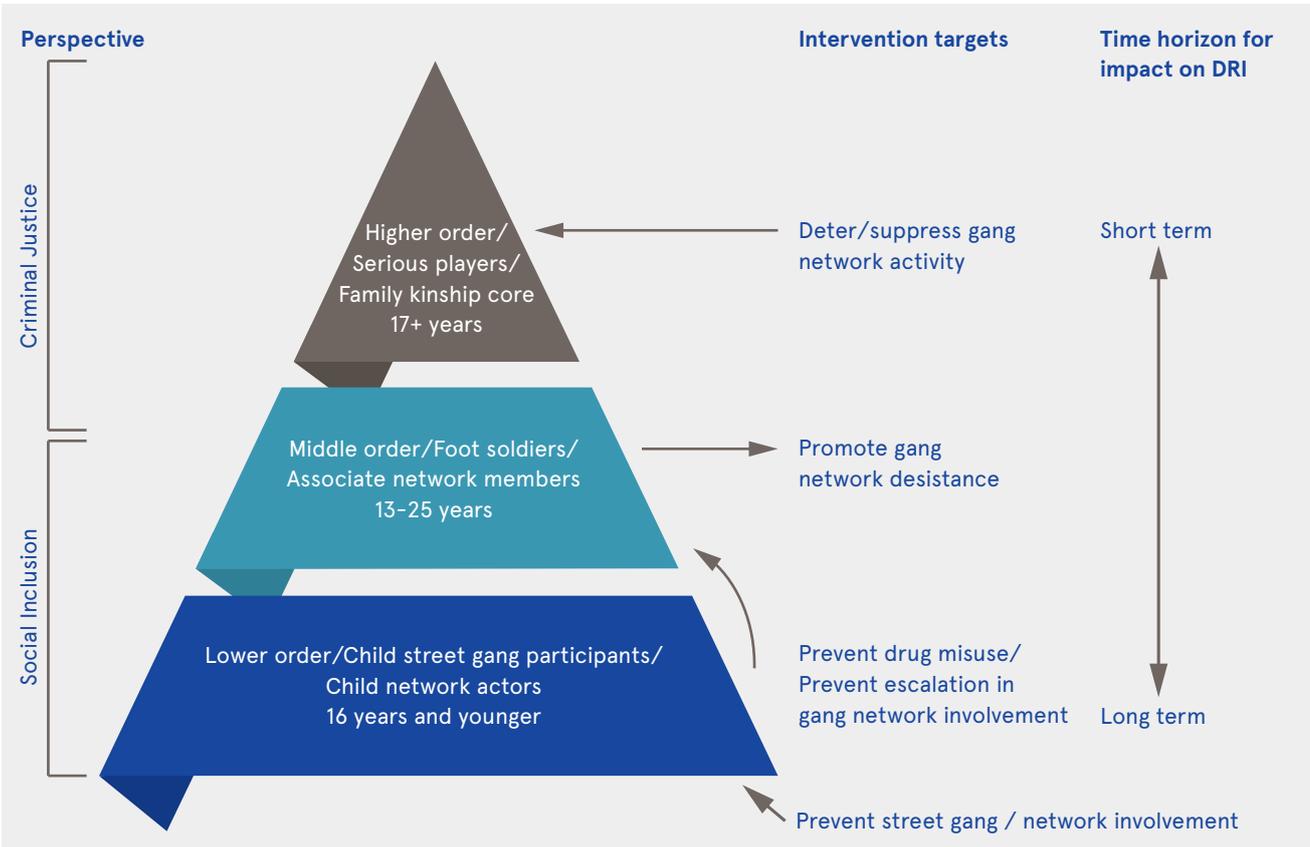
pathway (Figure 1). Despite using different methodologies in different Irish communities, these studies consistently described a three-tiered, hierarchical network structure involving: (1) a lower tier of highly disadvantaged young people generally involved in bullying, assaulting, stealing, vandalising, and spreading fear on behalf of the network; (2) a middle tier of young people typically engaged in high-risk, low-reward activities, such as transporting, holding or dealing drugs, carrying guns, and conducting shootings, beatings and serious intimidation; and (3) a higher tier of serious players, often formed around a kinship core. This framework suggests a number of potential intervention targets that differ in (a) their approach, whether based on a criminal justice or social inclusion perspective; (b) their target, whether they aim to prevent gang joining, prevent escalation in gang involvement, intervene to promote gang exit, or deter or suppress gang activity; and (c) the time horizon of their impact, whether short or long term.

Guided by this framework, the review sought to answer the following questions:

What community-based interventions are effective in:

- 1 Preventing entry into gang networks among at-risk children?
- 2 Promoting gang exit among gang-involved young people?
- 3 Deterring or suppressing drug gang-related crime, intimidation and/or violence?

Figure 1: Potential pathways into DRI and potential intervention targets to disrupt pathway



## Drug-related intimidation continued

The review drew on gang control literature, which evaluates approaches to target the group processes and structures involved in perpetuating a cycle of community intimidation and violence. The premise of the review was that reducing gang activity by targeting the underlying structure and functioning of drug/gang networks directly would indirectly reduce the fear, intimidation and violence that they create in communities.

### Methods

The review team (a) systematically searched 10 bibliographic databases, the publication sections of key international organisation websites, and the reference lists of included studies; (b) screened 1251 records on title and abstract and 136 on full text; and (c) included 45 reviews or studies in the final synthesis. The included literature was drawn from 12 countries, predominately the United States.

### Findings

#### Gang prevention

**Universal:** Most universal prevention programmes identified were school based, with or without parental involvement. Collectively, effective programmes had positive effects on short-term outcomes, such as problem solving, empathy, conduct problems, antisocial behaviour, delinquency, aggression, and long-term outcomes such as substance initiation and use, violence and crime. Key features of effective programmes were those with positive goals, parental involvement, group-based and interactive techniques, trained professional facilitators, manualised content, and frequent content delivery. One gang-specific prevention programme (Gang Resistance Education and Training – GREAT II) showed promise in preventing gang membership; however, the evidence was drawn from only one large-scale study.

**Selective:** Selective prevention programmes target those at higher than average risk and aim to prevent antisocial behaviour, substance use, delinquency and gang membership. A number of selective prevention programme models were identified. Good evidence suggests that skills-based programmes targeting parents of at-risk children aged 0–3 years produce immediate short-term impacts on child behaviour and parenting practices and improvements in long-term delinquency outcomes. Youth mentoring had small beneficial effects on conduct and recidivism. There was no evidence available on the effect of education and employment opportunities provision for preventing gang involvement. Community sports programmes had weak evidence that they may reduce youth crime. There was strong evidence that deterrence or discipline-based programmes, such as Scared Straight or boot camps, are ineffective and potentially harmful. Selective prevention programmes shared the same key features as effective universal prevention programmes.

**Indicated:** Indicated prevention programmes target individuals already engaged in high-risk behaviours, such as opposition behaviour, conduct disorder, antisocial behaviour, substance use and/or delinquency to prevent gang membership, gang embeddedness, and criminal activity. These include (a) therapeutic approaches: functional family therapy, multisystemic therapy, or multidimensional family therapy; and (b) gang-specific wraparound approaches,

which are individualised programmes of care identifying the precise supports needed by an individual and their family and providing them for as long as needed. There is good evidence that indicated prevention programmes, incorporating therapeutic principles that aim to create positive changes in the lives of young people and their families, prevent negative outcomes. Risk assessment, using tools such as the Gang Risk of Entry Factors tool, ensures appropriate targeting of these programmes.

### Intervention (gang exit)

**Gang alternatives interventions:** Gang alternatives interventions seek to motivate gang-involved youth to leave their gang, support them in doing so, and create opportunities for meaningful occupation outside of the gang. Five identified gang alternatives interventions, involving street outreach or opportunities provision programmes, had limited evidence of no or negligible impact on gang membership status, gang-related crime or violence.

**In-depth analysis of desistance process:** To address this gap in the available evidence, an in-depth analysis of primary peer-reviewed studies providing descriptive data – either qualitative or quantitative – on the nature or process of gang desistance was conducted. Analysis of this data suggested that gang members performed desistance work – they made an effort to reform their identity, pursue prosocial values, and seek belonging among prosocial groups. Gang exit requires this desistance work, which enables former gang members to become the primary agents in their exit from the gang.

### Suppression

**Gang activity prevention:** Gang activity prevention focuses on preventing the actions of gangs responsible for the most harm in the community by targeting specific activities, places or behaviours. Evidence for these approaches was limited in quantity and quality. Promising interventions in this category were carefully crafted civil gang injunctions, environmental design interventions, and urban renewal efforts. The latter had positive impacts on crime, while improving police legitimacy and communities' sense of control and cohesion.

**Gang activity suppression:** Gang activity suppression interventions seek to suppress or deter the harmful activities of gangs. 'Pulling levers'-focused deterrence strategies had the largest direct impact on crime and violence of all suppression strategies reviewed. Key features of successful focused deterrence approaches include: targeting specific crimes rather than specific gangs; strong, swift and consistent enforcement actions, alongside meaningful offers of support by community agencies; establishing a multiagency task force to lead and coordinate the initiative; and engaging community members.

**Comprehensive approaches:** Comprehensive gang control programmes, combining prevention, intervention and suppression, have shown promise but achieved mixed effects. Mixed effects have been attributed to poor model specification, poor implementation fidelity and an overly complex model given local capacity to coordinate and implement it. It is generally accepted that comprehensive approaches, designed within local capacity and resources, are likely to be the most appropriate approach to tackling gang-related crime, intimidation and violence in communities with acute gang problems.

## Key messages

- Comprehensive approaches should be developed using the best available information on what works within each of the three domains – prevention, intervention and suppression. The reviewed literature suggests:
  - Early intervention programmes involving schools and families, supporting positive goals, involving skills training, delivered by trained professionals and incorporating therapeutic approaches for those at higher risk according to risk assessment.
  - An assets-based approach to supporting the desistance work (efforts to reform identity and find belonging in prosocial groups) of gang members exiting their gang.
  - A ‘pulling levers’-focused deterrence strategy designed with community involvement.
- Comprehensive approaches should be designed to be feasibly delivered at a consistent high quality and sustained over time within local financial resources and organisational capacity.
- Any comprehensive approach requires stakeholder partnership among social services, schools, law enforcement, probation and parole, the courts system, and community representatives. Good coordination and communication is required to maintain this partnership.
- Engaging the local community and community leaders is important to the legitimacy of the effort. Community has a role to play in defining key issues, identifying young people who require support, designing responses, intervention delivery and increasing the legitimacy of the effort.
- Given the current state of the evidence, any approach that is implemented should:

- Have a theoretical underpinning
  - Be informed by local data
  - Be clearly articulated in advance
  - Be implemented according to a protocol with deviations documented
  - Include a process and outcome evaluation
- Lastly, researcher–practitioner partnerships may enable data-driven approaches, robust evaluation, and good implementation fidelity.

## Laura Murphy

- 1 Murphy L, Farragher L, Keane M, Galvin B and Long J (2017). *Drug-related intimidation. The Irish situation and international responses: an evidence review*. Dublin: Health Research Board, 2017. <http://www.drugsandalcohol.ie/27333>

Laura Murphy, lead author of *Drug-related intimidation. The Irish situation and international responses: an evidence review*, left the HRB in June to take up a new post with the HSE. Laura is a superb researcher and brought a wide range of knowledge, analytical ability and original thinking to the task of leading this study on gang-related interventions. Laura’s contribution to the field is not just a valuable resource for Irish practitioners and policy-makers but also a significant addition to the international literature on this topic. We are sorry to lose such an able, sociable and supportive colleague, but we wish her the very best in her new position and in all her endeavours.

# New clinical guidelines for opioid substitution treatment

New clinical guidelines for opioid substitution treatment (OST) in Ireland have been published.<sup>1</sup> They were developed by a working group comprising the Health Service Executive (HSE), the College of Psychiatrists of Ireland, the Irish College of General Practitioners, the Pharmaceutical Society of Ireland and HSE addiction services. The group reviewed all relevant national and international guidelines and consulted stakeholders in the addiction services. Professor Michael Farrell, director of the National Drug and Alcohol Research Centre at the University of New South Wales, provided expert opinion throughout the process.

This comprehensive document is divided into seven sections, each covering all different aspects of OST treatment: the guiding principles; rehabilitation and psychosocial components of OST; principles and key operational stages

of pharmacological interventions of OST; assessment of dependence and management of OST; drug testing; OST and associated health considerations; and specific treatment situations and populations.

The guidelines emphasise the importance of clinical governance and standards in OST treatment. Governance looks to put the service user first, working towards delivering a quality service and maintaining patient safety (see Appendix 1, p. 70). The need for properly qualified and accredited staff to deliver the right interventions is also spelt out.

There is an acknowledgment of the importance of family/carers in the treatment process. The guidelines recommend that services should proactively engage with family/carers to enable them to be active partners in the treatment, with the service user’s consent. This is particularly important for teenagers. The guidelines also note that this group can have their own issues, distinct from the service user, which may need to be addressed.

The document includes in-depth information for prescribing buprenorphine/buprenorphine–naloxone. The guidelines state that due to the safer profile of these formulations, induction and stabilisation can be quicker. They can be commenced by level 2 general practitioners (GPs) and HSE addiction clinic prescribers.

## New clinical guidelines for OST

continued

Other recommendations include:

- The first dose must not start until the service user experiences withdrawal symptoms (usually eight hours after last taking heroin or 24 hours after the last dose of methadone), as there is a risk of precipitated withdrawal.
- Precipitated withdrawal occurs when buprenorphine displaces other opiates from the opioid receptors and, being a partial opiate agonist, this results in a rapid reduction of the effects of opiates, which in turn results in severe withdrawal symptoms.
- The recommended starting dose is between 4 mg and 8 mg daily, which can be increased by between 2 mg to 8 mg daily (usually 4 mg).
- The dose can be increased up to a maximum of 24 mg for buprenorphine/naloxone or 32 mg for buprenorphine alone.
- The stabilisation phase for these drugs is usually between four to 6 weeks, shorter than methadone, usually between 16 mg and 24 mg.
- Maintenance on buprenorphine/buprenorphine-naloxone can be overseen by level 1 GPs.
- While it may vary with individual service user, a suitable maintenance dose will reduce or eliminate withdrawal symptoms and cravings over a 24-hour period.
- Once the service user is stable, the frequency of supervision and/or dispensing can be reduced, for example, buprenorphine-naloxone can be taken on alternate days (e.g. 8 mg daily dose can be taken as 16 mg on alternate days). However, the dose given on any one day cannot exceed 24 mg.
- All service users on long-term prescriptions should have regular care plan reviews (three monthly) within a wider treatment plan of social and psychological support.
- For detoxification, buprenorphine/buprenorphine-naloxone can be reduced by 2 mg every 2 weeks. Detoxification from this formulation is often quicker than with methadone.

The guide states that evidence shows that contingency management (CM), for example using incentives such as take-home OST, is proven to improve outcomes in this patient group. However, it does have some disadvantages and it is therefore recommended that it be provided as part of a structured care plan in combination with other evidence-based interventions. The guidelines directly address the issue of diversion. They state that take-home OST as an incentive for CM should be balanced against the known positive benefits to the service user and any potential risks, such as unsafe storage in homes or diversion. The criteria for deciding whether or not a client is suitable for take-home OST is based on known risk factors and an assessment of the individual service user and community safety, but also clinical stability. In the guidelines, clinical stability is defined as:

- Adherence with treatment directives
- No recent problematic drug or alcohol use
- Stable housing

- Stable dose of methadone (with allowances for occasional dose increases)
- Emotional stability and good insight into safety issues

Contraindications to receiving take-home OST are:

- Repeated intoxication on presentation at the clinic/ pharmacy
- Children living in the patient's household, with concerns that they may be at risk of harm
- Current chaotic and unpredictable behaviour
- Assessed as at risk of self-harm
- Current hazardous use of drugs (including benzodiazepines or alcohol), as this can increase risks of fatal overdose

A brief summary of the entire guide contents and all key points are reproduced below.

### 1. Guiding principles

**Contents:** good governance; therapeutic alliance; and information sharing (p. 11). The key points are:

- OST plays an intrinsic role in supporting patients to recover from opioid dependence.
- OST should be provided at the lowest level of complexity, matching the patient's needs, and as close to home as possible.
- Service users should be fully involved in the development of their care plans, setting goals and reviewing progress.
- It is good practice to involve service users in the design, planning, development, and evaluation of services.
- One of the strengths of drug treatment and rehabilitation in Ireland is the valuable partnership between statutory drug treatment services and the community/voluntary sectors.
- Services should be proactive in their engagement with family members, with the recognition that they have distinct needs from service users.
- A good therapeutic alliance is crucial to the delivery of any treatment intervention.

### 2. Rehabilitation and psychosocial components of OST

**Contents:** OST as a component of rehabilitation; integrated care plans; psychosocial interventions; key steps involved in the integrated care pathway (p. 13). The key points are:

- All drug users entering treatment:
  - Should have a care plan based on assessed need, which is regularly reviewed.
  - Should have full risk assessments to evaluate immediate health concerns, mental health issues, and risks to children.
  - Should have their needs assessed across the domains of drug and alcohol use, health, offending, and social functioning.
- Key working is a basic delivery mechanism for interventions in addiction services.
- Psychosocial interventions:

- Are a fundamental part of drug and alcohol treatment.
- Are the mainstay of treatment for the use of cocaine and other stimulants.
- Can also address common associated or co-occurring mental disorders, such as depression or anxiety.
- Self-help and mutual aid approaches have been found to be highly effective for some individuals.
- Contingency management (CM), Community Reinforcement Approach (CRA), Community Reinforcement Approach and Family Training (CRAFT) and Adolescent Community Reinforcement Approach (ACRA), and family and couples interventions should be offered, where appropriate.

### 3. Principles and key operational stages of pharmacological interventions for OST

**Contents:** aims and objectives of OST; legislative requirements for prescriptions and initiation of OST (including buprenorphine/naloxone); provision of information to the patient; communication between prescriber, dispensing pharmacist and multidisciplinary team; contingency management; diversion of opioid substitution medication; supervised consumption; ongoing assessment of OST; and referral procedure for change of OST location (p. 17). The key points are:

- Good communication between the patient, the prescriber, the pharmacist, and other members of the interdisciplinary team is crucial in providing optimal treatment.
- Carers should be active partners in drug treatment, where consent is given.
- Patients should be made fully aware of the risks of their medication and of the importance of protecting children from accidental ingestion.
- Prescribing, supervision, and dispensing arrangements should also aim to minimise risks to children.
- Supervision of methadone has been proven to reduce deaths related to overdose of methadone.
- Supervised consumption needs to be available for all patients for a length of time appropriate to their needs and risks.
- Ongoing assessment and care planning is central to the treatment process.

### 4. Assessment of dependence and management of OST

**Contents:** Phase 1 assessing dependence; Phase 2 induction phase; Phase 3 stabilisation; Phase 4 maintenance; and Phase 5 detoxification (p. 26). The key points are:

- Methadone or buprenorphine, used at the optimal dose range, are both effective medicines for OST.
- Dose induction with methadone should aim to achieve an effective dose, while also exercising caution about the inherent risks of too rapid an increase.
- Dose induction with buprenorphine may be carried out more rapidly, with less risk of overdose.
- Clinicians should aim to optimise treatment interventions for patients who are not benefiting from treatment, usually by providing additional and more intensive

interventions (pharmacological and psychosocial) that may increase retention and improve outcomes.

- Once stable on OST, at least one dose per week should be supervised.
- Methadone and buprenorphine are both effective in detoxification regimens.
- OST is a medical treatment and should not be used punitively, i.e. there should be no dose reduction as a sanction for ongoing illicit drug use.
- Opioid detoxification should be offered as part of a care plan to patients ready for and committed to abstinence.
- Health professionals working in isolation must ensure they maintain up-to-date good practice.

### 5. Drug testing

**Contents:** objectives of drug testing; rationale; procedures for testing; usefulness of drug testing; urine sample adulteration; supervision of urine samples; testing for alcohol and Z-drugs (p. 38). The key points are:

- Drug testing may be used as an ongoing tool for monitoring illicit drug use and adherence with prescribed medications.
- Most drug testing processes consist of two separate types of analysis: a screening test and a confirmation test.
- The clinical situation will dictate the type of testing (screening or confirmatory) and frequency of testing.
- Once a patient reaches a stable point with OST, a reduction in frequency of drug testing is recommended.
- Drug testing should be randomised where possible.
- Direct observation of urine specimen collection is not required in routine clinical practice.
- The use of oral fluid drug testing is an acceptable alternative to urine drug testing.
- Drug testing results should be shared between treatment locations and agencies, with appropriate consent, to prevent the duplication of testing.
- Addiction services, including level 1 and level 2 GPs, nationally should have access to an appropriately accredited laboratory for drug testing / confirmatory analysis.
- Biological fluids should be handled with appropriate standard and transmission-based precautions.
- The recommendations for frequency of testing are to be viewed as a minimum standard for all patients receiving OST. In certain clinical situations, some patients may find that more regular testing may help them reach and maintain stability.
- Stability and safer prescribing of OST is assessed on a range of criteria, drug screening being one of those. There are limitations to the value of drug testing, and clinicians need to assess stability across a range of parameters.

### 6. OST and associated health considerations

**Contents:** responses to continued drug and alcohol misuse for patients; mental health; viral infections; vaccinations; health implications for continued drug and alcohol use; pain management for drug misusers; ECG monitoring; and drug-related deaths (overdose, reducing drug-related deaths, dealing with overdose emergency) (p. 43). The key points are:

## New clinical guidelines for OST

continued

- OST should be provided with a range of other medical interventions.
- Psychosocial interventions can also address common associated or co-occurring mental disorders.
- Common mental health problems are frequent in people accessing addiction services. Interventions may need to be provided in addiction services, in conjunction with Community Mental Health Teams (CMHTs). Those with severe mental health problems should have care integrated with acute community-based secondary mental health services.
- Reducing potential harm due to overdose, blood-borne viruses, and other infections should be part of patient care.
- All drug users should be offered testing and vaccination against hepatitis A and B, where indicated. This discussion should be documented in the patient's record.
- All drug users should be offered testing and appropriate treatment for hepatitis C and HIV infections.
- Retaining patients in high-quality treatment is protective against overdose. This protection may be enhanced by other interventions, including training drug users and their families and carers in the risks of overdose, its prevention, and how to respond in an emergency.
- Drug users who are also using alcohol in a problematic way should be offered alcohol treatments.
- Drug users who smoke tobacco should be offered smoking cessation interventions.
- Effective, safe and responsive services for service users involve working together and with others in teams in primary care and/or secondary care.
- Interventions must be carried out by trained and competent people with a clear understanding of the impact of problematic drug use.
- Appropriate communication and transfer of information between professionals is vital to ensure seamless care in line with the HSE consent policy.
- Assessment and evidence-based care provided by a liaison or multidisciplinary team is appropriate in many cases.
- Quality of treatment should be consistent across the criminal justice system, including prisons.
- Drug users in hospitals will require interventions that facilitate their medical treatment and, if possible, improve their engagement with drug misuse treatment.
- Clinicians working with pregnant women should aim to support the woman in achieving drug stability in order to reduce the risk of neonatal abstinence syndrome (NAS).
- Young people are likely to require different interventions compared to adults, and healthcare professionals will require specific competencies to deliver these interventions.
- Information sharing, governance, policies and practice should include guidance for clinicians working with the parents of under 18-year-old service users.
- Older drug users are likely to have increased drug-related and non-drug-related health needs. Drug users in pain will have needs for pharmacological and other interventions similar to non-drug users.

### 7. Specific treatment situations and populations

**Contents:** hidden harm; criminal justice system (Garda custody, Drug Treatment Court, probation, prison); opiate-dependent patients in hospital; pregnancy and neonatal care; young people; older current and ex-drug users; and palliative care and life-limiting conditions (p. 57). The key points are:

## AskAboutAlcohol.ie

On 7 March 2017, the then Minister of State for Health Promotion Marcella Corcoran Kennedy TD launched the Health Service Executive's (HSE) new website on alcohol – AskAboutAlcohol.ie. The website was created to provide clear and authoritative information on alcohol to the public, and is the first dedicated website dealing with alcohol to be created by a State body. It provides advice on low-risk drinking limits and detailed evidence on the mental and physical impacts of alcohol. It also contains a drinks calculator so the public can understand exactly how much they are drinking and whether it is within low-risk limits. There is also information on available supports and guidance for anyone who wants to cut back on their drinking and for those with a family member who drinks excessively.

At the launch, Minister Corcoran Kennedy spoke about the evidence in relation to high-alcohol consumption and

harm in Ireland and described AskAboutAlcohol.ie and the information campaign as 'an important first step in enabling people to manage their own drinking ... simple yet effective tools like the drinks calculator will empower people to assess their drinking habits and make informed choices to improve their health and wellbeing'. This was reiterated by Dr Stephanie O'Keeffe, HSE National Director for Health and Wellbeing, who said that many Irish people remained unaware their drinking may have fallen into harmful patterns, and that underestimation of amounts consumed remains a prominent trend among young people in particular.

AskAboutAlcohol.ie is also designed to work in tandem with public health legislation and planned regulatory changes on alcohol labelling, availability and pricing. The launch of the website has been complemented by a public information campaign through the media and online. Leaflets exploring how alcohol impacts different individuals and societal groups will be released shortly.

### Suzi Lyons

- 1 Health Service Executive (2016) *Clinical guidelines for opioid substitution treatment*. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/26573/>

### Deirdre Mongan

# Updated community detoxification protocols for methadone and benzodiazepines

The Ana Liffey Drug Project has produced updated community detoxification protocols for both methadone and benzodiazepines.<sup>1,2,3</sup>

One of the main changes is the removal of the need for the mandatory broker role in the community detoxification structure. Key to the detoxification process is a named key worker or healthcare professional to provide psychosocial support and a GP to provide the necessary initial assessment and medical support throughout the process. There is an emphasis on psychosocial support and the key work process in the updated documents. The issues of dual diagnosis and mental health in community detoxification are discussed. Other updates relate to suggested detoxification schedules for methadone.

## Methadone detoxification schedule 1

- After stabilisation, dosage should be reduced every 1–2 weeks, which will bring the person down to zero in approximately 12 weeks, typically a reduction of 5 mg. While some people may prefer to detox more quickly at the beginning, there is currently no evidence to support whether this is more effective than that of a slowly tapered dose.

## Methadone detoxification schedule 2

- Reduction of dosage by 10 mg per week down to 40 mg per day, after which the dosage should be reduced by 5 mg per week. The reduction in dosage should be decided upon with the person, and there should be no more than one dosage change per week.

## Timeframe for detoxification from methadone

The rate and pace of dosage reduction for detoxification should be decided on a case-by-case basis, depending on the needs and wishes of the person. For people with dual addiction with a hypnotic (e.g. benzodiazepines or Z-drugs) and methadone, the protocols recommend that they should be detoxified off the hypnotic first, then methadone. There are no updates to the suggested detoxification schedules for benzodiazepines.

The aim of the protocols is to improve service delivery and ensure best possible practice for each person seeking a detoxification. This in no way precludes healthcare professionals providing additional supports to meet the needs of the person based on their particular circumstances: 'The Steering Committee fully recognises, and wishes to emphasise, the importance of local knowledge and expertise in ensuring successful delivery of services. There is nothing to prevent services mandating an individual or agency locally to promote and/or coordinate the new guidelines' (p. 11).

## Suzi Lyons

- 1 Ana Liffey Drug Project (2016) National community detoxification: methadone guidelines. Dublin: Ana Liffey Drug Project. <http://www.drugsandalcohol.ie/26888/>
- 2 Ana Liffey Drug Project (2016) National community detoxification: benzodiazepine guidelines. Dublin: Ana Liffey Drug Project. <http://www.drugsandalcohol.ie/26889/>
- 3 For further information on community detoxification, visit: [http://www.drugs.ie/resources/community\\_detox/information\\_for\\_drug\\_users](http://www.drugs.ie/resources/community_detox/information_for_drug_users)

# Evaluation of pilot stage of Pharmacy Needle Exchange Programme in Ireland

## Pharmacy needle exchange in the Republic of Ireland

The current National Drugs Strategy aims to reduce harms arising from substance misuse and to reduce the prevalence of blood-borne viruses among people who inject drugs (PWID) through the expansion of needle exchange provision to include community pharmacy-based programmes. In October 2011, the Health Service Executive (HSE) rolled out the national Pharmacy Needle Exchange Programme, which is a partnership initiative between the Elton John AIDS Foundation, the Irish Pharmacy Union, and the HSE.

Once pharmacies have signed a service level agreement with the HSE, their contact details are passed on to the relevant HSE services so that they can promote access to sterile injecting equipment at the participating pharmacies and accept referrals for investigation and treatment. There are pharmacies providing needle exchange in each regional drugs task force area, apart from those covering counties Dublin, Kildare and Wicklow, which are served by a mix of static and outreach needle exchange programmes. At the end of 2014, there were 115 pharmacies providing needle exchange.

In line with best practice, the Steering Group of the HSE Pharmacy Needle Exchange Programme commissioned Liverpool John Moores University – in partnership with Waterford Institute of Technology – to carry out an external evaluation.<sup>1</sup> This study was undertaken to evaluate the three-year pilot stage of the programme and the progress in delivering needle exchange services to PWID.

## Pharmacy Needle Exchange Programme continued

It aimed specifically to:

- Understand client and stakeholder satisfaction with needle exchange and attitudes towards, and experiences of, these services.
- Provide information relating to safer injecting, safer sexual behaviour, and the prevalence of blood-borne viruses that can be compared to international literature and to data collected during future evaluations.
- Provide recommendations regarding the development and delivery of services and policy.

This article presents the methodology and main findings from this study.

### Methodology

All pharmacies participating in the programme in April 2014 were eligible to take part in the study, and staff were asked to complete an online survey. Pharmacy staff were also requested to opt in to additional parts of the research, including participating in an interview with a member of the research team.

Pharmacies were provided with questionnaires that staff were requested to ask any client using the needle exchange programme to complete. Visits were made to five of the 10 pharmacies participating in the programme that had the greatest number of monthly transactions, where needle exchange clients were approached and asked if they would like to participate in the study through an interview. A brief online consultation with stakeholders was also undertaken, examining their perceptions of the programme effectiveness, and identifying strengths, weaknesses, and areas for further development.

### Main findings

#### Pharmacy staff results

##### *Experience of service provision*

Pharmacy staff reported a variety of successes. The service was described in interviews as quick and efficient, with minimal impact on the running of other pharmacy activities. However, uptake was viewed as sporadic in some sites, with comments around levels of heroin availability impacting on injecting rates. Increasing uptake was reported in some sites, but with no change in gender profiles. Although a majority of staff reported positively about the needle exchange and clients, negative impacts of the service identified by small numbers of staff included the risk of crime and undesirable behaviour in the pharmacy and surrounding area. In addition, where pharmacies were located within shopping areas, it was apparent that some local businesses and security objected to the needle exchange.

##### *Engagement and trust in needle exchange*

The majority of staff surveyed believed they had engaged well with clients, although difficulties identified included a lack of interest in engagement from some clients. The exchange itself was described by the majority of interviewed staff as a quick process, with service users appearing anxious to leave the site. Lack of interaction was generally due to service user reluctance to engage and pharmacist

lack of time. While it was noted that clients may like the speedy transaction, it was also recognised that this limits the opportunity to offer further intervention. First contact characterised by friendliness on the part of the pharmacist and frontline staff was viewed by many as being vital when initially developing positive and trusting relationships with service users.

##### *Needle and equipment provision*

Pack size options were described by the majority of interviewees as optimising efficiency and discretion for the user. However, some staff observed that service users report that the needles and syringes provided are not the right size or right volume, and identified that needles for groin injecting would be a useful addition. Further potential additions to packs that were suggested by pharmacy staff included tourniquets and condoms. The needle exchange transaction itself was viewed as efficient, but in some instances hampered by poor dialogue between pharmacist and service users, as well as low return rates.

##### *Training and information needs*

The most frequent response when staff were asked to identify methods to improve the service was the provision of more information through training about local services and helplines, as well as refresher courses in response to emergent drug issues and service needs. In particular, training regarding performance and image-enhancing drugs, such as steroids and melanotans, was commonly requested. The majority of pharmacies engaged with local community drug services and methadone clinics, but observed the need for greater visibility of services and referral routes.

#### Client-reported outcomes

##### *Client satisfaction with services*

The survey sample (n=74) included 23 females and 46 males, with five clients not reporting their gender, with a mean age of 32 years. The majority (88%) reported using heroin, with less than 15% reporting use of any other drug. Generally, PWID reported high satisfaction with service provision, including the injecting kits provided, pharmacy location, opening hours, staff knowledge and information provision. A minority of clients reported dissatisfaction with the attitudes of staff (24%) and privacy within the needle exchange (30%), with lower satisfaction on both criteria among females. Experiences of accessing the pharmacies were generally positive, with few comments around stigma associated with injecting drug use, or uncomfortable feelings on accessing the pharmacy. Participants were additionally satisfied with the confidential nature of the exchange. Pharmacy staff were viewed as friendly and polite, with the primary reasons stated for using specific pharmacies being related to location of the pharmacy and staff attitude.

##### *Client behavioural outcomes*

Self-reported rates of hepatitis B, C and HIV diagnosis were 7%, 22% and 5%, respectively. Approximately one-third of clients reported never having been tested for each of these blood-borne viruses. Almost half (49%) of the survey sample reporting having used a needle with which someone else had already injected, with 28% having done so in the past month. Females were more likely to have shared a needle ever, or in the past month, than males. Approximately half (47%) of clients reported having multiple sexual partners in the past month, including a small proportion with five or more partners (7%). A minority (39%) of clients reported always using a condom during sexual intercourse.

## Pharmacy Needle Exchange Programme continued

### Stakeholder survey

Six stakeholders completed the survey, including representatives from drug services, the Irish Pharmacy Union, and outreach services. Overall, the programme was rated as being 'very effective' (n=3) or 'somewhat effective' (n=3). Key strengths identified included the increase in availability and accessibility of needle exchange services, and the impact of this on access to equipment and health professionals. Perceived weaknesses included difficulties encouraging returns, the need for a 'pick and mix' service as opposed to pre-prepared packs (which are not suitable for all clients), a lack of signposting to other services, and the identification of some stigma affecting needle exchange relations with local businesses and customers.

### Conclusions

Overall, the evidence from the study suggests that the Pharmacy Needle Exchange Programme is acceptable and accessible to PWID in Ireland, and largely supported by pharmacy staff. Nevertheless, despite these successes, a number of recommendations were suggested that might help improve service provision and further meet client needs.

These were to:

- Provide a wider range of equipment or packs suitable for all clients. Additionally, the possibility of providing 'pick and mix' services, in addition to pre-prepared packs, may better meet client needs.
- Develop integrated care pathways to link the exchange programme with other services for PWID, such as drug agencies and sexual health services. As more health interventions become embedded within the pharmacy, this is likely to become increasingly important to prevent pharmacies from becoming isolated from other related organisations providing services for injecting drug users.

- Consider offering within-pharmacy testing for blood-borne viruses. Where this is not possible, ensure that pharmacy staff have sufficient information on local services to enable efficient referral processes and signposting.
- Increase frequency of training provision for pharmacy staff and include information about anabolic steroids, melanotans and associated performance and image-enhancing drugs to help staff provide services to clients who inject these drugs. Training should be constantly reviewed to ensure that it is meeting the needs of pharmacy staff. The profile of PWID is likely to change, and therefore the knowledge and skill requirements of staff will change too, leading to the need for top-up training.
- Ensure that staff have sufficient training and knowledge about drug use and health-related issues to confidently provide harm reduction advice and support.
- Encourage (through training and information for staff) a consistent approach to increase returns and improve engagement with clients. Additionally, build on current work being undertaken regarding appropriate community responses to drug-related litter.
- Oversee the transition from a paper-based monitoring system to an electronic data monitoring system to be used by all participating pharmacies.

As well as these recommendations, the authors suggest that future evaluations should use the same survey procedures to allow comparison on outcomes as an indication of programme development. In addition, the possibility of collecting biological samples from clients was also mentioned.

### Seán Millar

1 Bates G, van Hout MC, Hearne E, Mackridge A and McVeigh J (2015) *Evaluation of the pilot stage of the Pharmacy Needle Exchange Programme in Ireland*. Liverpool: Liverpool John Moores University. <http://www.drugsandalcohol.ie/26905>

## Outcomes for drug misuse treatment: an evidence review

In January 2017, Public Health England (PHE)<sup>1</sup> published *An evidence review of the outcomes that can be expected of drug misuse treatment in England*.<sup>2</sup> PHE was commissioned by the Department of Health in England to 'review the evidence on: what can be expected of the drug treatment and recovery system and provide advice to inform future policy' (p. 12).

To meet this aim, they covered a number of topics related to drug treatment in England:

- The nature and prevalence of drug misuse and how drug treatment evolved to address it
- The outcomes achieved to date by the treatment system
- The international literature on treatment effectiveness and how England compared to other countries
- How housing, unemployment and social deprivation impact on treatment outcomes
- The changing profile of the drug treatment population
- How to improve treatment outcome measures

A recurring theme throughout the report was that 'indicators that are used to manage and commission drug treatment can have a powerful impact on how services are developed and on how resources are allocated locally' (p. 115). The authors therefore called for 'caution' (p. 132) when selecting indicators to ensure the risk of generating unintended consequences was minimised. Indeed, they noted that indicators can be used to positively affect outcomes.

## Outcomes for drug misuse treatment continued

### Approach to the review

The work was overseen by an expert reference group made up of a variety of stakeholders: academics, service commissioners and providers, and experts by experience (service users). PHE took a mixed methods approach to the review: they used focus groups with service users; statistical analysis of the National Drug Treatment Monitoring System data; and a series of evidence reviews using a rapid evidence assessment method.

### Treatment outcomes in the literature

In their review of the international literature, the authors found that a broad range of outcomes were used to measure treatment effectiveness. These included drug use; abstinence; drug injecting; overdose; mental and physical health; mortality; crime; and social functioning indicators such as employment, housing, family relations, and service users' perceptions of their recovery. The breadth of these measures was taken to reflect the broad range of harms caused by drug misuse and, in turn, the benefits that could be expected by users entering treatment and addressing their drug use. In terms of the cost-effectiveness of treatment, estimates in the literature suggested a net benefit-cost ratio of approximately 2.5 to 1. For every £1 spent on treatment, there was a £2.50 benefit to society.

### Social factors

The link between social deprivation and drug use is well established. The review found that social factors also influenced treatment outcomes. Unemployment and housing problems had a 'marked negative impact' on treatment outcomes and increased the risk that someone would relapse after treatment.

### Changes in treatment population

The review used modelling to estimate the likely size, characteristics, and needs of the treatment population over the next 4 years. Two changes in particular were expected to have implications for services and the measurement of their outcomes. First were changes in the profile of drugs for which treatment was being sought. Increases in the use of new psychoactive substances and prescription drugs were expected to continue. Second was the ageing profile of opiate users in treatment. Older heroin users (aged 40 and over) accounted for an increasing proportion of those in treatment, and the authors estimated that this proportion would continue to grow over the coming years. This cohort have entrenched dependence over a long period of time and their needs are complex. They experience cumulative physical and mental health conditions as well as being more susceptible to overdose. The reviewers argued that stakeholders should maintain a 'realistic recovery ambition' for this cohort, accepting that they were less likely to complete treatment than 'newer' users.

### Indicators

The authors make a number of recommendations for the improvement of local and national drug treatment outcomes and their indicators. At the time of the review, the primary treatment outcome in England was the sustained successful completion of treatment. 'Successful completion' was defined as where a user had left treatment free of their dependence, was not in receipt of an opiate substitute, and did not re-present for treatment for 6 months. Based on the findings of the review, it was recommended that this period be extended to 12 months to ensure that post-treatment recovery support be maintained.

It was recommended that drug treatment indicators for opiate users be segmented into those for 'new users' and those for the older more chronic cohort of users. This would allow for the fact that it is much harder to effect change among long-term users who have very entrenched patterns of use and complex health and social needs, when compared to opiate users who engage with treatment after a shorter period of opiate use. It would allow for an increased focus on providing the older cohort with access to the primary and specialist healthcare services they might need.

More generally, the report concluded that drug treatment outcomes should be expanded to better reflect the breadth of the benefits of drug misuse interventions. In summary, they suggested developing a set of indicators around the following: waiting times for treatment; the proportion of opiate and crack users in treatment; illicit opiate use in treatment; drug-related deaths and drug-related hospital admissions; incidence of blood-borne viruses; offending behaviour; treatment entry rates following prison release; employment status; and housing status.

### Lucy Dillon

- 1 Public Health England is an executive agency of the Department of Health in England. It offers advice and support to their government, local authorities and the National Health Service, based on 'world-class science, knowledge and intelligence, advocacy, partnerships and providing specialist public health services'. For more information on PHE, visit <https://www.gov.uk/government/organisations/public-health-england/about>
- 2 Burkinshaw P, Knight J, Anders P, Eastwood B, Musto V, White MJ and Marsden J (2017) *An evidence review of the outcomes that can be expected of drug misuse treatment in England*. London: Public Health England. <http://www.drugsandalcohol.ie/26696/>

# Alcohol treatment services in Ireland: how the public view them

The Health Service Executive (HSE) has recently published findings from a study which examined the level of public support in Ireland for alcohol screening in healthcare settings, and to assess if alcohol treatment services are deemed available and adequate.<sup>1</sup> The study was based on two cross-sectional national drinking surveys conducted in 2006 and 2010. For the purpose of this research, the two survey data sets were combined (n=2011) to allow for detailed analysis.

A similar methodology was used across the two surveys, that of a national quota sample of adults aged 18 years and over, using face-to-face interviews. The response rate was 62%. Several main findings from the study are discussed below.

## Alcohol screening in healthcare settings

A majority of survey respondents agreed that intervention by health professionals regarding patients' drinking habits in different healthcare settings should take place. The highest level of support for asking patients about their drinking behaviours as standard practice was in maternity services (91%), followed by general hospitals (84%), and in primary care (80%).

## Demographics

A higher percentage of married people (82%) in comparison to single people (77%) agreed that general practitioners (GPs) should ask all patients about their drinking habits as standard practice. Across regions of Ireland, those living in Dublin were less supportive of GP intervention in comparison to the rest of Leinster (79% vs 87%). More women than men (86% vs 82%) were supportive of alcohol screening; respondents who were younger were less supportive. Support was higher among those from lower socioeconomic classes (87%) in comparison with other classes.

## Drinking pattern and alcohol harms

Participants who abstained from alcohol were more supportive of health professionals asking patients about their drinking behaviours as standard practice. Respondents who were heavy drinkers were less supportive of alcohol screening in primary care, general hospitals, and maternity services. Those who reported one or more of seven negative consequences due to their own drinking were also less supportive of alcohol screening by health professionals in general hospitals and in maternity services. Nevertheless, even among heavy drinkers, the majority (70%–86%) were in favour of health practitioners asking about drinking habits.

## Availability and adequacy of alcohol treatment services

Just 4 in 10 respondents agreed that alcohol treatment services were available in their local health service area, while a similar number (43%) were unaware (don't know) if alcohol treatment services were available (Figure 1). In addition, only 1 in 5 agreed that alcohol treatment services were adequate, 1 in 4 believed treatment services were not adequate, and over one-half were unsure. Subjects who lived in Dublin were significantly ( $p<0.01$ ) less aware of the availability of alcohol treatment services in their local health service area when compared to subjects in other regions, with two-thirds saying they did not know if treatment services were available.

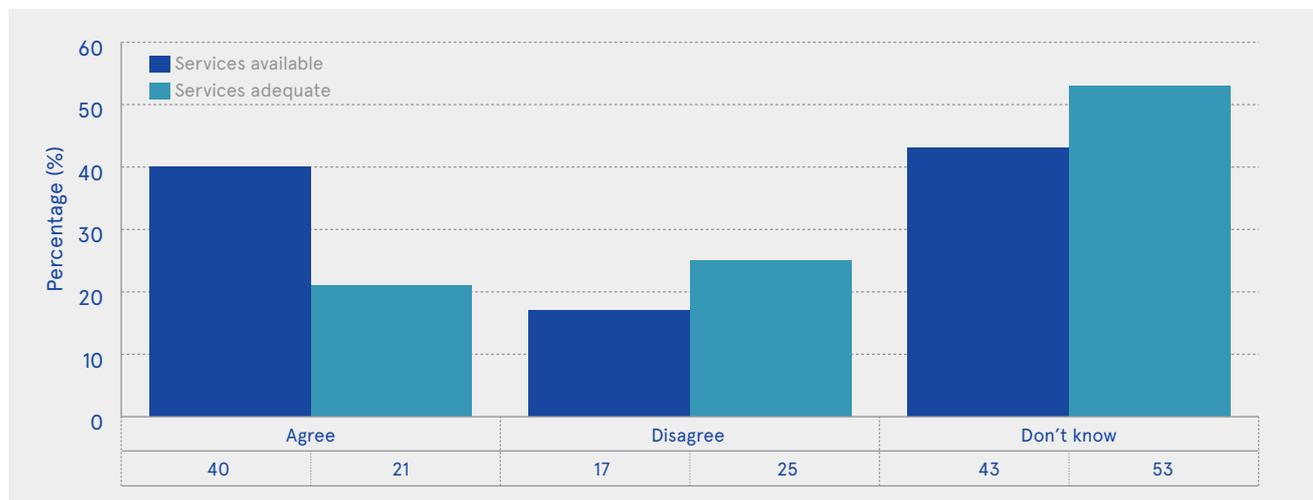
## Conclusions

The results from these surveys suggest that most Irish adults are supportive of alcohol screening in a healthcare setting. However, the findings also indicate that a high percentage of survey respondents were unaware of availability of alcohol treatment services in local health areas. The authors suggest that these findings will be relevant in the planning of future services in relation to alcohol. Effective delivery of alcohol screening, and early intervention, may help reduce the burden and associated cost of alcohol-related problems in Ireland.

## Seán Millar

1 Hope A and Barry J (2016) *Alcohol treatment services in Ireland: how the public view them*. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/26577>

Figure 1: Alcohol treatment – perceived availability and adequacy of services



Source: HSE, 2016

# Healthcare in Irish prisons

A report entitled *Healthcare in Irish prisons*, prepared by the Inspector of Prisons, the late Mr Justice Michael Reilly, was presented to the Tánaiste and Minister for Justice and Equality on 25 November 2016.<sup>1</sup> There were three specific aims of the report:

- To point out the absolute entitlement of prisoners to healthcare and the case for such healthcare to be provided by the Department of Health.
- To point to the necessity of carrying out a health needs assessment of prisoners and a staffing needs analysis in each Irish prison.
- To give guidance to the Irish Prison Service (IPS), to the management of prisons, and the providers of healthcare in the prisons on what will be expected of them in the area of healthcare when inspections are carried out in the future.

## Obligation to provide healthcare in prisons equivalent to that in non-prison community

The report stressed that the right to health is a fundamental right and that Article 12(1)<sup>2</sup> of the International Covenant on Economic, Social and Cultural Rights urges state parties 'to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. In addition, it is generally accepted as international best practice that the provision of healthcare in prisons should be equivalent to that available in the non-prison community.

Entitlement to health services in the Republic of Ireland is primarily based on residency and means. In particular, eligibility to access health services depends on whether a person is a medical card holder or not. It is well established that a majority of prisoners come from lower socioeconomic sectors of communities, and that many present with mental health and other preexisting health problems often resulting from a chaotic lifestyle. Therefore, the report urged that healthcare should be provided to prisoners on the basis that they are entitled to the same treatment and choices as people in the free community who are in receipt of medical cards.

Healthcare services in Irish prisons are, in the main, provided by the IPS. An exception is the provision of in-reach mental health psychiatric services by the Central Mental Hospital, which come at no cost to the IPS, as this service is funded by the Health Service Executive (HSE). Doctors are engaged either on a full- or part-time basis. The report noted that the recruitment of full-time doctors is proving difficult. As a result, the IPS are over-reliant on locum doctors, who by their nature are transitory, to provide medical services to prisons. Nurses are employees of the IPS and as such are answerable to the governors of the prisons to which they are attached.

The report suggested that Ireland could comply with best international practice by ensuring that the present prison-administered healthcare services form close links with the HSE. However, Judge Reilly also stated that the Department of Justice and Equality have acknowledged that the international trend is now towards a service that is within the responsibility of the Department of Health, and that the Committee of Ministers of the Council of Europe, in its official commentary to the revised and updated European Prison Rules 2006,<sup>3</sup> states:

*The most effective way of implementing Rule 40 [organisation of healthcare] is that the national health authority should also be responsible for providing health care in prison, as is the case in a number of European countries.*

Judge Reilly noted that there may well be resource issues in transferring responsibility for prisoner healthcare from the IPS to the HSE and the Department of Health. However, he also stated that this cannot be used as an excuse for delaying such a transfer of responsibility. The report stressed that it must be borne in mind that the State accepts a heavy responsibility when it detains a person to ensure the wellbeing of that person, and that it is internationally acknowledged that a lack of financial means cannot reduce this responsibility.

## Necessity of carrying out health needs assessment of prisoners and staffing needs analysis in each Irish prison

The report stated that irrespective of which body is responsible for healthcare in Irish prisons, be it the IPS or the HSE, a comprehensive assessment of the healthcare needs of prisoners in the 13 prisons in the Republic of Ireland must be undertaken. This must be followed by a staffing needs analysis of healthcare personnel within each prison. Judge Reilly noted that no such assessment has ever been undertaken within Ireland, and that it was impossible to express a view on the adequacy of the healthcare currently provided in Irish prisons, as it seemed to operate on an ad hoc basis.

Judge Reilly recommended that a Director of Healthcare, who is a registered healthcare professional, should be appointed immediately. The duty of the director would be to manage the healthcare in prisons and to oversee the transition of healthcare from the IPS to the HSE. The report also stated that the provision of healthcare in Irish prisons should not be confined to that which is provided by doctors and nurses, but should embrace all aspects of care, including addiction, psychiatric and psychology services.

## Guidance to IPS on what will be expected of them in area of healthcare when future inspections are carried out

The report indicated that at any time upon request, prison governors and/or healthcare staff should be in a position to make the following available to inspecting officials:

## Healthcare in Irish prisons continued

- The health needs assessment for the prison.
- The staffing needs analysis for the prison.
- The number of nurses, doctors, psychiatrists, dentists, other specialists, psychologists, auxiliaries, etc. (engaged full-time or part-time) and their hours of duty.
- The number of medical referrals to hospital emergency departments for a given period.
- The average time for transfer of prisoners to emergency departments, with the longest and shortest time, for a given period.
- The number of medical referrals to external consultants for a given period.

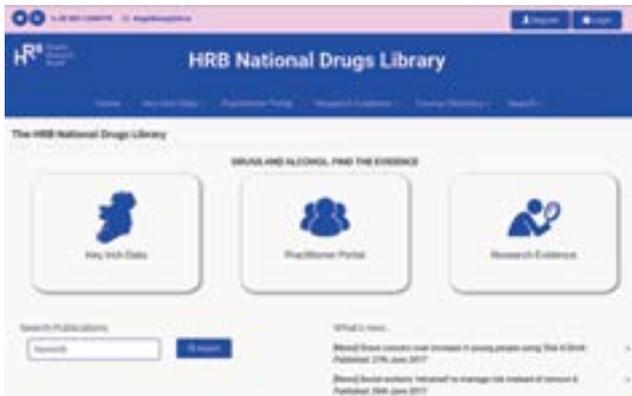
- The number of cancellations of appointments with external consultants, with reasons for such cancellations, for a given period.

### Seán Millar

- 1 Reilly M (2016) *Healthcare in Irish prisons*. Dublin: Department of Justice and Equality. <http://www.drugsandalcohol.ie/26885/>
- 2 United Nations Human Rights Office of the High Commissioner (1966) *International Covenant on Economic, Social and Cultural Rights*. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>
- 3 Council of Europe (2006) Commentary to Recommendation REC(2006) 2 of the Committee of Ministers to member states on the European Prison Rules. In *European Prison Rules*. Strasbourg: Council of Europe Publishing. <https://rm.coe.int/16806f3d4f>

## HRB National Drugs Library launches new website

The HRB National Drugs Library is a free, open-access resource providing a unique collection of Irish and international research evidence relating to drug and alcohol misuse. You can access our resources and services through our newly redesigned website at [www.drugsandalcohol.ie](http://www.drugsandalcohol.ie).



As well as our online course directory and search facility, we have three main sections.

The **key Irish data** section draws together the latest information on the Irish situation, with treatment, prevalence and deaths data, factsheets, key reports and newsletters.

The **practitioner portal** makes it easier for those working in the drugs and alcohol area to find publications of particular interest to them. You may access pages by profession or subject of interest.

The third section of our new website, **research evidence**, reflects the need for practitioners, policy-makers and researchers to access key international reports, guidelines and resources. We have also added a glossary and resources for undertaking and critically appraising research.

Our aim is to enable those involved in health and social care, education, and research to make evidence-informed decisions. We hope that our resources will provide quick and easy access to the latest best evidence.





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](http://www.drugsandalcohol.ie)

## POLICY AND LEGISLATION

### Correlation between tobacco control policies, consumption of rolled tobacco and e-cigarettes, and intention to quit conventional tobacco, in Europe

Lidón-Moyano C, Martín-Sánchez JC, Saliba P, Graffelman J and Martín-Sánchez JM (2017) *Tobacco Control*, 26: 149-152. <http://www.drugsandalcohol.ie/25209/>

**Aims:** To analyse the correlation between the implementation of tobacco control policies and tobacco consumption, particularly rolling tobacco, electronic cigarettes (e-cigarettes) users and the intent to quit smoking in 27 countries of the European Union.

**Conclusion:** The level of smoke-free legislation among European countries is correlated with a decrease in the prevalence of smoking of conventional cigarettes and an increase in the intent to quit smoking within the past 12 months. However, the consumption of other tobacco products, particularly hand-rolled tobacco, is positively correlated with TCS among former cigarette smokers. Therefore, tobacco control policies should also consider other tobacco products, such as rolling tobacco, cigars and pipes.

## PREVALENCE AND CURRENT SITUATION

### Decline in new psychoactive substance use disorders following legislation targeting headshops: evidence from national addiction treatment data

Smyth BP, Lyons S, Cullen W (2017) *Drug and Alcohol Review*, Early online <http://www.drugsandalcohol.ie/27172/>

The aim of this study was to ascertain if legislation that caused the closure of headshops had an impact on the rate of NPS use disorders.

**Conclusion:** Over the 2 years after the enactment of prohibition-styled legislation targeting NPS and headshops, the rate of NPS related addiction treatment episodes among young adults declined progressively and substantially. We found no coinciding trend change in the rate of episodes linked to other drug groups.

### Factors associated with different smoking status in European adolescents: results of the SEYLE study

Banzer R, Haring C, Buchheim A, Oehler S, Carli V, Wasserman C, Kaess M, Apter A, Balazs J, Bobes J, Brunner R, Corcoran P, Cosman D, Hoven CW, Kahn JP, Keeley HS, Postuvan V, Podlogar T, Sisask M, Varnik A, Sarchiapone M and Wasserman D (2017) *European Child & Adolescent Psychiatry*, Early online <http://www.drugsandalcohol.ie/27139/>

The aim of the presented analysis was to investigate risk and influencing factors for different smoking status in a big sample of European adolescents.

**Conclusion:** Our data show that smoking among adolescents is still a major public health problem and adolescents who smoke are at higher risk for mental problems. Further,

adolescent smoking is associated with broken home families and parental behaviors. Therefore, early preventive measures are necessary not only for adolescents, but also for their parents.

### Alcohol consumption among university students: a latent class analysis

Davoren MP, Dahly DL, Shiely F and Perry IJ (2017) *Drugs: Education Prevention and Policy*, Early online <http://www.drugsandalcohol.ie/27020/>

The aim of the current research was to use latent class analysis to employ a person centred approach to describe alcohol consumption among university students with particular reference to gender.

**Conclusion:** Both men and women reported a class of 'Guarded Drinkers', 'Responsible Conformers' and 'Realistic Hedonists'.

The remaining class of women was described as 'Peer-influenced drinkers'. Identifying consumption typologies provides those working on tackling excessive alcohol consumption with profiles to implement tailored health promotion strategies.

### The country-level effects of drinking, heavy drinking and drink prices on pre-drinking: an international comparison of 25 countries

Labhart F, Ferris J and Winstock A (2017) *Drug and Alcohol Review*, Early online <http://www.drugsandalcohol.ie/27039/>

The aim of this study was to model the impact of the on-premise/off-premise drinks price ratio, the prevalence of current drinkers and of heavy drinkers on the percentage of pre-drinkers.

Conclusion: Pre-drinking appears to be a worldwide phenomenon. The significant effects of all three indicators demonstrate the role of country-level determinants underpinning the prevalence of pre-drinking across countries. Policy makers could use the reported findings for initiating campaigns to reduce pre-drinking behaviour.

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### Cross-cultural comparisons of drinking motives in 10 countries: data from the DRINC project

Mackinnon SP, Couture ME, Cooper ML, Kuntsche E, O'Connor RM and Stewart SH (2017) *Drug and Alcohol Review*, Early online <http://www.drugsandalcohol.ie/27108/>

This study tested the measurement invariance of the Drinking Motives Questionnaire-Revised Short Form (DMQ-R-SF) in undergraduates across 10 countries.

Conclusion: There was broad cross-cultural consistency in the factor structure and mean patterns of drinking motives. Undergraduate students appear to drink mainly for positive reinforcement (i.e. for social and enhancement reasons), although this tendency is particularly pronounced among those from more individualistic countries.

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### 'APAAN in the neck' – a reflection on some novel impurities found in seized materials containing amphetamine in Ireland during routine forensic analysis

Power JD, Kavanagh P, McLaughlin G, Barry M, Dowling G and Brandt SD (2017) *Drug Testing and Analysis*, Early online <http://www.drugsandalcohol.ie/27080/>

The Republic of Ireland has a population of approximately 4.7 million citizens. Illicit drug misuse is tackled by legislative control mechanisms and the sole national forensic laboratory (Forensic Science Ireland) is tasked with detailing any controlled drugs present in seized materials by issuing a 'certificate of analysis' which is utilized for court purposes.

This paper reports on the newly identified impurities detected in Irish amphetamine importation seizures, some of which have been published previously, others presented for the

first time. Reagent purity and synthesis conditions have been shown to affect the components observed during analysis of seizures. Post synthesis additions (adulteration) and storage conditions may also have a profound effect on the analytical profiles obtained from seized items. The finding of new impurities, their abundances, the use of reagents that contain or form known existing impurities and post synthesis additions all have the potential to adversely affect existing profiling methodologies, which aim to link different seizures to a source.

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### Lifetime risk of mortality due to different levels of alcohol consumption in seven European countries: implications for low-risk drinking guidelines

Shield KD, Gmel G, Gmel Gd, Makela P, Probst C, Room R and Rehm J (2017) *Addiction*, Early online <http://www.drugsandalcohol.ie/27053/>

The aim of this study was to estimate alcohol mortality risks for seven European countries based on different average daily alcohol consumption amounts.

Conclusion: If low-risk alcohol guidelines were based on an acceptable risk of 1 in 1,000 premature deaths, then maximums for Europe should be 8-10 g/day for women and 15-20 g/day for men, and some of the current European guidelines would require downward revision.

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### Experiences of codeine use, misuse and dependence: application of Liese and Franz's cognitive developmental model of substance abuse

Van Hout MC, Norman I, Rich E and Bergin M (2017) *Behavioural and Cognitive Psychotherapy*, Early online <http://www.drugsandalcohol.ie/26839/>

Aims: We present the application of Liese and Franz's (1996) cognitive developmental model of substance abuse to the trajectory from legitimate codeine use for pain, towards that of therapeutic and other forms of misuse, and physical and psychological dependence. It illustrates a cognitive behavioural analysis of the experiences of codeine misusers – which 'surfaces' the specific beliefs, thoughts, emotions and behaviours of this group of hidden codeine dependent individuals, who

are distinct and unique from other opioid-dependent cohorts.

Conclusion: The concept mapping of codeine misuse and dependence presented here could provide psychological therapists working with individuals experiencing problems with codeine, misusing codeine and those with iatrogenic dependence, with an enhanced understanding of the key concepts involved in misuse and recovery pathways.

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### Use of prescription medication by individuals who died by suicide in Northern Ireland

Benson T, Corry C, O'Neill S, Murphy S and Bunting B (2017) *Archives of Suicide Research*, Early online <http://www.drugsandalcohol.ie/26779/>

Aim: To understand medication use prior to suicide in relation to patterns, polypharmacy and adherence.

Conclusion: Both medication use but also non-adherence rates were high in this sample of individuals who died by suicide. Potential implications and areas for future research are discussed.

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### New psychoactive substances: current health-related practices and challenges in responding to use and harms in Europe

Pirone A, Bo A, Hedrich D, Ferri M, van Gelder N, Giraudon I, Montanari L, Simon R and Moutaney J (2017) *International Journal on Drug Policy*, 40: 84-92. <http://www.drugsandalcohol.ie/27032/>

The aim of this study was to explore current health responses to NPS, and highlight key issues in order to inform planning and implementation of adequate responses.

Conclusion: Immediate investments are required in expanding substance identification capabilities, competence building among professionals and dissemination of risk information among relevant stakeholders. The risks of neglecting under-served risk populations and failure to address the information needs of health professionals and users on NPS harms in a context of rapid changing drug markets in Europe may have unforeseeable consequences at societal level.

## Recent publications continued

### RESPONSES

#### Hospital readmissions – independent predictors of 30-day readmissions derived from a 10 year database

Kidney R, Sexton E, van Galen L, Silke B, Nanayakkara P and Kellett J (2017) *Acute Medicine*, 16(1): 4-9. <http://www.drugsandalcohol.ie/27176/>

The aim of this study was to investigate what factors were most strongly associated with early readmission.

Conclusion: Disease and patient-related factors beyond control of the hospital are the factors most strongly associated with 30 day readmission to hospital, suggesting that this may not be an appropriate quality indicator.

#### Promoting college students to seek help for mental health difficulties: a social normative approach

Murphy D and Hennessy E (2017) *International Journal of Mental Health Promotion*, Early online <http://www.drugsandalcohol.ie/26845/>

The aim of this study was to test whether an online social normative intervention would promote college students' help seeking attitudes and intentions.

Conclusion: The findings of this study are discussed with respect to methodological considerations, and recommendations for practice and future research are provided for student counselling clinics.

#### Development and implementation of a 'Mental Health Finder' software tool within an electronic medical record system

Swan D, Hannigan A, Higgins S, McDonnell R, Meagher D and Cullen W (2017) *Irish Journal of Medical Science*, 186(1): 191-200. <http://www.drugsandalcohol.ie/27144/>

We describe the development and initial implementation of a software tool ('mental health finder') within a widely used primary care electronic medical record system (EMR) in Ireland to enable large-scale data collection on the epidemiology and management of mental health and substance use problems among patients attending general practice.

Conclusion: The finder is a feasible and promising methodology for large-scale data collection on mental health problems in primary care.

