The newsletter of Ireland's focal point to the EMCDDA

drugnet IRELAND

Issue 67 | Autumn 2018

In this issue

New report on bloodborne viruses
See page **16**

07 Latest drug treatment data

08 Adult smoking data

09 Youth smoking data

17 Responses to crack cocaine use

24 Third-level alcohol prevention programme

Drugnet Ireland is produced in collaboration with the HRB National Drugs Library. To have *Drugnet Ireland* delivered to your desktop, sign up at **www.drugsandalcohol.ie**

National Drugs Forum 2018

On 12 November 2018, the Department of Health's Drugs Policy Unit and the Health Research Board (HRB) will host the first annual National Drugs Forum in the Aviva Stadium.

The objectives of the forum are:

- To support evidence-informed practice and service delivery
- To promote participation of communities, service users, and their families in national structures
- To strengthen the implementation and performance of the national drugs strategy.

The theme for the forum is *Working better together by developing communities of practice*. This event aims to strengthen the capacity of existing communities of practice and to provide examples for collaborative working across the statutory, community, and voluntary sectors.

L-R: Cllr Mark Ward (mayor of South Dublin County Council and task force board member), Jennifer Clancy (coordinator of Clondalkin Local Drug and Alcohol Task Force) and Ms Frances Fitzgerald TD at the launch of the SAFE Campaign (see p. 18)

HRB Health Research Board

Research. Evidence. Action.

Contents

COVER STORY

National Drugs Forum 2018 1

POLICY AND LEGISLATION

LGBTI+ Youth Strategy 3
Quality and Capacity Building Initiative (QCBI) 4
Drug and alcohol abuse targeted in UN's 2030 Agenda and 17 Sustainable Development Goals 5

PREVALENCE AND CURRENT SITUATION

Drug treatment figures from the NDTRS, 2010–2016 7
Adult smoking in Ireland: findings from the Healthy Ireland Survey and the Irish Longitudinal Study on Ageing 8
Decline in adolescent smoking in Ireland and associated factors 9
Youth smoking in Ireland: findings from the Health Behaviour in School-aged Children survey 9
Forensic Science Ireland annual report 2017 10
Irish Prison Service and Probation Service strategic plan 2018–2010 12
Prevalence of major mental illness, substance misuse and homelessness among Irish prisoners 13
Hospital presentations and preceding factors of drug overdose among adolescents 15

RESPONSES

New report on drug-related bloodborne viruses in Ireland 16
Integrated hepatitis C care for people who inject drugs 16
High uptake of sterile crack pipes in response to surge in cocaine use in Dublin 17
SAFE campaign launched in Clondalkin 18
The help-seeking behaviours of family members affected by substance-use disorders 19
An Garda Síochána Policing Plan 2017 20
Let's Get Specific – a prevention forum 22
Prevention interventions targeting at-risk youth: Targeted Youth Funding Scheme 23
Responding to excessive alcohol consumption in third-level (REACT): a study protocol 24
Optimising treatment in opioid dependency in primary care 26
Reducing the harms of cocaine use in Ireland 27
Opioid substitution treatment for heroin-dependent adolescents 28
Tabor Group annual report, 2017 28

UPDATES

Recent publications 30

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

In brief

The objectives and actions of the national drugs strategy, *Reducing harm, supporting recovery,* are underpinned by the values of equity and partnership and a commitment to an evidence-informed approach. The involvement of communities in the response to problem drug use is key to realising the strategy's aims. The strategy also underlines the place of evidence in service development and delivery. It recognises how important it is to engage stakeholders both in the implementation of research findings and in sharing learned experience.

In November 2018, the Department of Health and the Health Research Board will host a national forum that will provide an opportunity for community-based services to inform colleagues about their work, to exchange knowledge around what works, and to identify information gaps. It will recognise the dynamism and commitment of these services, enable shared learning and encourage discussion among practitioners, activists, and administrators who face similar challenges. This event aims to strengthen the capacity of existing communities of practice and provide examples for new networks and collaborative working across the statutory, community, and voluntary sectors.

The idea of communities of practice in drugs and alcohol services builds on the origin of the concept in other spheres that sought more effective ways of learning while working. Communities of practice are usually defined in terms of groups of people prepared to work together to find solutions to a problem they have in common. The opportunity offered means that information and advice can be shared and existing tools and methods can be adapted and applied to new situations. If maintained, the community of practice can share a body of knowledge and develop new practices and approaches.

Identifying interventions which have been shown to work is an essential part of developing effective responses but, just as importantly, is identifying what evidence is relevant to the national situation, where the gaps in evidence are, and how will we know if the response is effective. These are all questions that can be answered more convincingly if those who face the same type of problem and learning occurs through practice and interaction with colleagues. Participants in the forum will hear from services with similar concerns to them. They can share knowledge from their own experience and learn about ways of continuing this interaction so that a common approach can be developed, based on evidence but also on the practical knowledge built up throughout successive drugs strategies.

National Drugs Forum continued

The forum will feature two keynote presentations from international experts, followed by four parallel workshops. Dr Karen Minyard from Georgia Health Policy Center in Georgia State University will speak on the centre's recent evidence review on dual diagnosis and will describe how communities of practices can be effective vehicles for transferring evidence into practical work. Professor Harry Sumnall of Liverpool John Moores University will examine the evidence base for interventions in the prevention and social reintegration field. Both are internationally renowned scholars with vast experience in policy development and knowledge transfer.

Workshops

The following four workshops will take place:

1. Supporting prevention work in the community.
2. Dual diagnosis: using partnership and peer support as resources in treatment.
3. The role of social reintegration in recovery.
4. Harm reduction services: engaging with people who use drugs.

A report on the forum will identify the key message from each of these workshops and suggest ways of developing communities of practices and learning from ongoing work in each of these areas throughout the country.
You can register for the conference by visiting the HRB National Drugs Library website at **www.drugsandalcohol.ie** and following the link to the Eventbrite registration page.

Brian Galvin

POLICY AND LEGISLATION

LGBTI+ Youth Strategy

The Department of Children and Youth Affairs (DCYA) has published the world's first national LGBTI+ Youth Strategy.[1] This follows on from a commitment in the 2016 Programme for Government to `develop an LGBT Youth Strategy that will encompass education, youth services, mental health and other issues' (p. 106).[2] A key part of the process of developing the strategy was a DCYA-led consultation with young people from across Ireland, the findings of which have also been published.[3]

LGBTI+ Youth Strategy

The LGBTI+ Youth Strategy document is structured around three goals:

1. Create a safe, supportive and inclusive environment for LGBTI+ young people.
2. Improve the mental, physical and sexual health and wellbeing of the entire LGBTI+ community.
3. Develop the research and data environment to better understand the lives of LGBTI+ young people.

Each of these goals is supported by a set of objectives and actions. Responsibility for delivering on them is spread across government departments, with actions that cover a wide variety of areas. These include schools, higher education institutions, health and social services, workplaces, youth services, and the wider community.

The findings of the consultation (as outlined below) were used to heavily inform the strategy. As with the consultation, the strategy identifies high levels of smoking, drug use, and alcohol consumption as one of the challenges faced by LGBTI+ young people in Ireland. It has a specific action to address young people's call for more alcohol-free spaces in which to meet. Under the first goal, it commits to `map existing LGBTI+ youth services and groups and increase the awareness of these services and consider increasing the provision of non-alcoholic safe spaces which are inclusive of LGBTI+ young people' (p. 21). Drug and alcohol use is not dealt elsewhere in the strategy but reference is made to the national drug and alcohol strategy.[4]

The consultation

There were two key strands to the consultation: an online survey and a series of consultation events. The consultations reached a total of 3,882 young people from across Ireland (n=3710 young people completed the survey; n=172 young people attended one of seven consultation events). While most of the participants identified themselves as a member of the LGBTI+ community (69% of survey respondents and 93% of event participants), the consultation was not limited to this group.

LGBTI+ Youth Strategy

continued

The consultations focused on three broad questions:

1 What is positive about being a young LGBTI+ person in Ireland today? (Positives)
2 What issues are faced by young LGBTI+ people in Ireland today? (Issues)
3 What changes would improve the lives of young LGBTI+ people? (Changes)

The findings

The extensive body of data collected was analysed thematically. A broad range of themes was identified, a detailed account of which is beyond the scope of this article. However, illustrations of the key findings in relation to each of the consultation's three questions are:

- **Positives:** There is less discrimination and an increased sense of acceptance and social support than there has been in the past. Examples of this included positive legal reform around marriage equality and equal status, and gender recognition legislation.
- **Issues:** Despite improvements, there is an ongoing sense of discrimination and stigma attached to the LGBT community. Participants reported experiences of bullying and harassment, isolation and exclusion, among others.
- **Changes:** Changes to education within schools and improved training for professionals on LGBTI inclusion and related issues were the most commonly cited areas of need.

The LGBTI+ community is identified in the national drug and alcohol strategy as one of a number of groups who experience a higher risk of problematic substance use than the general population.[4]

This was echoed in the findings from the consultation. Participants identified a culture of drug and alcohol misuse within their community, which had a negative impact on people's mental health and wellbeing. Explanations provided for this higher level of use included that substances were used as 'bad coping mechanisms to deal with exclusion' (p. 80).[3]

Linked to a call by participants for improved access and delivery of mental health services was a call for improved access to early intervention and other drug-related services.

Concerns were also expressed about the lack of alcohol-free spaces and places for young LGBTI+ people to meet up. People's experiences were that many of the 'safe' social spaces for meeting up were nightclubs that were also 'hyper sexualised' with a focus on 'hooking up' (p. 23). The shortage of safe alcohol-free spaces presented particular challenges and risks for those who were under 18 years of age.

Lucy Dillon

1 Department of Children and Youth Affairs (2018) *LGBTI+ national youth strategy 2018–2020.* Dublin: Department of Children and Youth Affairs. https://www.drugsandalcohol.ie/29267/

2 Government of Ireland (2016) *A programme for a partnership government.* Dublin: Department of the Taoiseach. https://www.drugsandalcohol.ie/25508/

3 Fullerton D, McGrellis S, Power I, McKenna O and Velthuis S (2017) *LGBTI+ national youth strategy: report of the consultations with young people in Ireland.* Dublin: Department of Children and Youth Affairs. https://www.drugsandalcohol.ie/28323/

4 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025.* Dublin: Department of Health. https://www.drugsandalcohol.ie/27603/

Quality and Capacity Building Initiative (QCBI)

The Quality and Capacity Building Initiative (QCBI) of the Department of Children and Youth Affairs (DCYA) has been under development since 2016, with progress being made on implementing some key components over 2017/18. The QCBI aims to take a coordinated approach to enhancing capacity, knowledge and quality in prevention, and early intervention for children, young people and their families, with a focus on those at risk of developing poor outcomes. It aims to ensure that effective practice is harnessed and applied across the relevant services and supports. There are four key strands to the initiative that set out to embed and enhance prevention and early intervention in children and young people's policy, service provision, and practice.

The strands and their aims are:

1 **Data working strand:** To improve access and use of data and information relating to children, young people, and their families by aligning and developing what currently exists in this area.
2 **Evidence working strand:** To harness the learning from prevention and early intervention initiatives and research and actively support the use of this learning as a source and resource to inform planning, delivery, evaluation, and continuous improvements.
3 **Professional development and capacity-building working strand:** To enhance the capacity and skills development of policymakers, providers and practitioners in the appraisal and application of evidence-informed approaches in prevention and early intervention for children and young people through capacity building and development.
4 **Quality working strand:** To align, enhance and sustain quality in prevention and early intervention as it relates to the development and delivery of policy, provision, and practice for children and young people.

QCBI continued

Some key activities carried out under each strand are as follows:

1. Data working strand

Development work is underway on an actively resourced data hub that includes data relating to children and young people that can be used by all stakeholders.

2. Evidence working strand: Evidence Matrix

In April 2018, the DCYA sent out a call for tenders to develop an 'evidence matrix'.[1] The matrix will be an online tool that will be hosted on the QCBI area of the DCYA website.[2] It is described as an 'open access online guide/clearinghouse which will provide details and rated assessment of the costs and standards of evidence of impact of prevention and early intervention evidence based programmes globally and in Ireland' (p. 3).[1] The focus is on manualised programmes. The matrix will support stakeholders to identify, select, and implement the right evidence-based programmes to address one of a set of five broad national outcomes for children set out in the *Better outcomes, brighter futures*[3] policy document, which includes those related to the prevention of drug and alcohol use. While the scope of programmes to be included in the matrix is broader than just the prevention of drug use, it will be a useful resource for those working in the sector.

Among the requirements of the matrix are that it will:

- Provide details and an assessment of evidence and costs for prevention and early intervention-based programmes commonly implemented for children and young people services globally or in Ireland.
- Rate the standard of evidence of impact available on each programme included on the online matrix.
- Rate the costs of the programmes.
- Provide details of each programme, including how it works.
- Provide information on how the programme should be implemented and the resources required to implement it effectively.
- Provide details of the 'most reliable' evaluations that have been carried out in Ireland and globally on the programme.
- Provide contact details of licence holders and/or individuals/organisations that have implemented the programme in Ireland or Europe.
- Provide technical guidance on evaluations, analyses, and further suggested reading related to the programme.

Work on the matrix is expected to begin in 2018, with a contract running to the end of 2020.

3. Professional development and capacity-building working strand

The planned output under the professional development and capacity-building working strand is a standardised module of training in prevention and early intervention, with the associated supports. A mapping exercise of existing training in this field has been carried out.

4. Quality working strand

While there have been no specific deliverables completed under the quality strand, much of the work being carried out under the other three strands is expected to impact on the quality of service design and delivery.

Lucy Dillon

1 Department of Children and Youth Affairs (2018) *Request for tenders 27 April 2018 for the development of evidence matrix for the Quality and Capacity Building Initiative.* Dublin: Department of Children and Youth Affairs. https://www.drugsandalcohol.ie/29299/

2 Further information is available at: https://www.dcya.gov.ie/cat/EN/Quality-and-Capacity-Building-Initiative/1406.htm

3 Department of Children and Youth Affairs (2014) *Better outcomes, brighter futures: the national policy framework for children and young people 2014-2020.* Dublin: Department of Children and Youth Affairs. https://www.drugsandalcohol.ie/21773

Drug and alcohol abuse targeted in UN's 2030 Agenda and 17 Sustainable Development Goals

In September 2015, at an historic United Nations (UN) Summit, the 193 member countries of the UN adopted the 2030 Agenda for Sustainable Development.[1] Within that resolution, 17 Sustainable Development Goals (SDGs) and 169 related targets were announced. The objectives of this agenda are to leave no one behind and to end all forms of poverty, fight inequalities, and tackle climate change. The 17 goals are a call to action aimed at all countries, poor, rich and middle-income, to promote prosperity while protecting the planet. Goal 3 calls for countries to 'ensure healthy lives and promote well-being for all at all ages'. As one of the 13 related targets, it encourages action by countries to 'strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol'.

The SDGs are a compass for aligning countries' plans with their global commitments, and the implementation and success of the goals will rely on each country's own sustainable development policies, plans and programmes. At a national level, governments will develop individual indicators to monitor progress made towards each goal and target; while at a global level, a global indicator framework was agreed and adopted by the UN General Assembly on 6 July 2017.[2]

Sustainable Development Goals

continued

Under the drug and alcohol target, the indicators in use globally are:

- Coverage of treatment interventions (pharmacological, psychosocial, and rehabilitation and aftercare services) for substance use disorders.
- Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol.

In 2018 in Ireland, the Department of Communications, Climate Action and Environment (DCCAE) published *The sustainable development goals national implementation plan 2018–2020*[3] detailing Ireland's response. It identifies the national policies and their key objectives that align with each global indicator. On a drug policy level, in its strategy, *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025,*[4] the Department of Health aims to:

- Promote and protect health and wellbeing.
- Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery.
- Address the harms of drug markets and reduce access to drugs for harmful use.
- Support the participation of individuals, families and communities.
- Develop sound and comprehensive evidence-informed policies and actions.

On a legislative level, with the proposed Public Health (Alcohol) Bill 2015, the Government aims to reduce alcohol consumption in Ireland to the OECD average of 9.1 litres of pure alcohol per capita by 2020.

In addition, the Government has undertaken to produce national reports on its implementation of the goals every two years and voluntary national reviews every four years, beginning in 2018.

Michael O'Sullivan

1 Further information on the 2030 Agenda, goals and targets is available online at: https://www.un.org/sustainabledevelopment/

2 Further information on the global indicators is available online at: https://unstats.un.org/sdgs/

3 Department of Communications, Climate Action and Environment (2018) The sustainable development goals national implementation plan 2018–2020. Dublin: Government of Ireland. Available online at: https://www.dccae.gov.ie/documents/DCCAE-National-Implement-Plan.pdf

4 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. https://www.drugsandalcohol.ie/27603/

PREVALENCE AND CURRENT SITUATION

Drug treatment figures from the NDTRS, 2010–2016

The National Drug Treatment Reporting System (NDTRS) published its latest figures on treated problem drug use (excluding alcohol) in May 2018.[1] These figures exclude those who reported alcohol as their primary problem substance as this will be reported in a separate bulletin. In the seven-year period, 2010–2016, 63,187 cases were treated for problem drug use (excluding alcohol). The number of cases increased from 8,806 in 2010 to 9,227 in 2016.

In 2016, the NDTRS began the implementation of a new web-based data collection tool; this has significantly changed the way the NDTRS works and the transition may have contributed to the reduction in the number of cases reported for 2016. While fewer cases were reported for 2016 than 2015, the trends remained consistent with those reported for 2010 to 2015.

Service provider

The majority of cases were treated in outpatient facilities (63.4%) over the period, similar to previous years (see Table 1). The proportion of cases treated in prison decreased slightly from 10.6% to 8% over the reporting period. In 2016, the proportion of cases treated in residential facilities was 20.4%, an increase from 14% in 2010.

Overview

The proportion of new cases decreased over the period from 42.5% in 2010 to 38.2% in 2016 (see Table 2). The proportion of previously treated cases increased from 55% in 2010 to 57.8% in 2016. The increase in the number of previously treated cases is an indicator of the chronic, relapsing nature of addiction.

In 2016, the median age (age at which half the population is older and half is younger) of those treated was 30 years. The median age differed depending on whether the case was new (25 years) or previously treated (32 years). Over the reporting period, the median age of all cases treated increased from 28 years in 2010 to 30 years in 2016.

Similar to previous years, the majority of those treated in 2016 were male (72.4%). The proportion of cases that were homeless increased from 5.1% in 2010 to 9.6% in 2016.

The proportion of cases that identified as Travellers increased from 2.8% in 2010 to 3.2% in 2016. The proportion of Travellers in the general population is 0.7% (2016 Census).[2] In 2016, two-thirds of all cases (66.2%) 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. The proportion of cases treated decreased from 58.1% in 2010 to 47% in 2016. Cannabis was the second most common drug reported among those treated. The proportion of cases reporting problem cannabis use increased by 23% in 2010 to 26.4% in 2016. Cannabis is the most common drug reported by new cases. Cocaine remained the third most common drug reported and, in 2016, 12.3% of cases reported problem cocaine use, the highest proportion reported since 2010.

Table 1: Number of cases treated for problem drug use, by type of service provider, NDTRS 2010 to 2016

	2010		2011		2012		2013		2014		2015		2016	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases	**8806**		**8361**		**8005**		**9006**		**9890**		**9892**		**9227**	
Outpatient	5563	(63.2)	5623	(67.3)	5299	(66.2)	5998	(66.6)	6251	(63.2)	5818	(58.8)	5481	(59.4)
Inpatient*	1232	(14.0)	1107	(13.2)	1124	(14.0)	1233	(13.7)	1348	(13.6)	1779	(18.0)	1885	(20.4)
Low threshold	793	(9.0)	642	(7.7)	711	(8.9)	812	(9.0)	1190	(12.0)	1197	(12.1)	886	(9.6)
Prison	930	(10.6)	761	(9.1)	642	(8.0)	747	(8.3)	844	(8.5)	827	(8.4)	737	(8.0)
General practitioner	288	(3.3)	228	(2.7)	229	(2.9)	216	(2.4)	257	(2.6)	271	(2.7)	238	(2.6)

* 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 2010 to 2016

	2010		2011		2012		2013		2014		2015		2016	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Revised total	**8806**		**8361**		**8005**		**9006**		**9890**		**9892**		**9227**	
New cases	3741	(42.5)	3316	(39.7)	3272	(40.9)	3475	(38.6)	3776	(38.2)	3742	(37.8)	3526	(38.2)
Previously treated cases	4842	(55.0)	4862	(58.2)	4518	(56.4)	5239	(58.2)	5643	(57.1)	5855	(59.2)	5335	(57.8)
Treatment status unknown	223	(2.5)	183	(2.2)	215	(2.7)	292	(3.2)	471	(4.0)	295	(3.0)	366	(4.0)

Drug treatment figures continued

Another significant finding was the increasing proportion of cases reporting benzodiazepines as a main problem drug, which rose from 4.1% in 2010 to 9.7% in 2016. In addition, the proportion of cases treated for Z-drugs increased from 0.1% in 2010 to 1.1% in 2016.

The bulletin also reports on treated problem use of novel psychoactive substances (NPS). In this period, reported problem use of NPS as a main problem 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 0.8% of all cases treated in 2016. The majority of cases reported problem polydrug use (62.7%) over the period; however, the proportion has decreased from 66.7% in 2010 to 61.8% in 2016. Up to 2013, alcohol was the most common additional drug reported. Since 2014, benzodiazepines have become the most common additional drug reported by polydrug users.

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 15.2% in 2010 to 13.5% in 2016.

Ita Condron

1 Health Research Board (2018) *Drug Treatment in Ireland NDTRS 2010 to 2016.* Dublin: Health Research Board. https://www.drugsandalcohol.ie/28986/

2 Data on ethnicity is taken from the 2016 Census from the Central Statistics Office (CSO). Further information is available online at: http://www.cso.ie/en/csolatestnews/presspages/2017/census2016profile8-irishtravellersethnicityandreligion/

Adult smoking in Ireland: findings from the Healthy Ireland Survey and the Irish Longitudinal Study on Ageing

Smoking is the leading cause of preventable death in Ireland, with over 100 people dying from diseases caused by tobacco use each week; this represents almost one in five of all deaths.[1] The Health Service Executive (HSE) has recently published a report detailing findings from an Irish study that examined smoking behaviours in Ireland among adults aged 15+ using data from the Healthy Ireland Survey and The Irish Longitudinal Study on Ageing (TILDA).[2] Key findings from the report are discussed below.

Characteristics of adults who smoke in Ireland

It was found that one in five Irish adults smoke daily, which equates to approximately 714,000 current adult smokers in Ireland. The highest prevalence of current smoking was among 25–34-year-olds. Male subjects were more likely to smoke and to have begun smoking at an earlier age than females. Individuals who were current smokers were also more likely to be single, unemployed or in a routine manual occupation.

The impact of smoking on health and wellbeing

Results from both surveys showed that people who smoke are more likely to self-report poor health – both poorer physical health and mental health. The prevalence of smoking-related chronic diseases was found to be highest among ex-smokers. In addition, among all people who smoke, the prevalence of these diseases was related to the amount smoked. It was also found that survey participants who smoke experience limitations in activities of daily living as a result of their smoking, particularly in later life and that, again, the prevalence of limitations is related to the amount smoked. The study also found that people who smoke are more likely to utilise healthcare services, at all ages.

Intention to quit smoking and smoking cessation

Encouragingly, results from the surveys indicate that two in three people who smoke wish to quit smoking. Odds ratios showed that factors associated with wishing to give up smoking included being under the age of 35 (1.6, 95% CI: 1.3–2.0), being married (1.3, 95% CI: 1.0–1.5), having a tertiary-level education (1.6, 95% CI: 1.1–2.4), and having an occupation of a non-routine/non-manual nature (1.3, 95% CI: 1.0–1.6). Almost one-half of those attempting to quit smoking used willpower alone; e-cigarettes and nicotine products were the most common methods among those who used smoking cessation aids. Similar to subjects who demonstrated an intention to give up smoking, successful quitters were also more likely to be young, educated to levels higher than primary level, and to have occupations of a non-routine/non-manual nature.

Conclusions

The authors concluded that the study provides a better understanding of the demographic factors independently associated with current smoking and that this might enable policymakers to adopt more targeted approaches to combat smoking. In addition, the study provides keen insights into the factors associated with quitting and remaining smoke-free. The HSE will consider these results in the context of its *State of tobacco control*[3] report to better understand the challenges and priorities for its Programme Plan 2018–2021.

Seán Millar

1 Department of Health (2013) *Tobacco free Ireland: report of the Tobacco Policy Review Group.* Dublin: Department of Health. https://www.drugsandalcohol.ie/20655/

2 Sheridan A, O'Farrell A, Evans D and Kavanagh P (2018) *Adult smoking in Ireland: a special analysis of the Healthy Ireland Survey and The Irish Longitudinal Study on Ageing* (TILDA). Dublin: Health Service Executive. https://www.drugsandalcohol.ie/29203/

3 Health Service Executive (2018) *The state of tobacco control in Ireland: HSE Tobacco Free Ireland Programme, 2018.* Dublin: Health Service Executive. https://www.drugsandalcohol.ie/29348/

Decline in adolescent smoking in Ireland and associated factors

Policies designed to discourage adolescents from smoking have been at the forefront of tobacco prevention in recent years. In Ireland, the *Tobacco free Ireland* report of 2013 stated that the protection of children must be prioritised with regard to initiatives outlined in the policy.[1] A number of studies have been conducted regarding interventions for preventing adolescent smoking, including research evaluating policies to restrict access and raise awareness of risk. While some studies have examined perceptions of risk and its association with smoking, other studies have investigated correlates in the domestic and social sphere. These include associations with parental monitoring, relationships with parents, family structure, truancy from school, and peer smoking.

A recent Irish study examined trends in smoking among Irish adolescents aged 15–16 years between 1995 and 2015 and factors associated with smoking behaviours.[2] In this research, published in the journal *BMJ Open*, data were obtained from Irish waves of the European School Survey Project on Alcohol and Other Drugs (ESPAD). Multivariate logistic regression was performed to examine the factors associated with smoking behaviour. Smoking behaviour was defined as having smoked in the last 30 days. Independent variables examined included gender, survey years, perceived ease of access to cigarettes, perceived risk of smoking, perceived relative wealth, parental monitoring, maternal relationship, family structure, truancy, and peer smoking.

The study found that smoking prevalence among adolescents has dropped from 41% in 1995 to 13% in 2015. The prevalence was much higher among girls than boys in 1995 (44.9% vs 36.7, p<0.001). However, this gender gap was closed by 2015 (12.8% for females and 13.1% for males). Odds ratios from multivariate regression results demonstrated that peer smoking (18.9, 95% CI: 11.4–31.2), perceived access to cigarettes (1.4, 95% CI: 1.0–2.1), perceived risks of smoking (1.9, 95% CI: 1.6–2.3), parental monitoring (3.2, 95% CI: 2.3–4.6), truancy (2.8, 95% CI: 1.9–4.1), maternal relationship (1.8, 95% CI: 1.4–2.4), perceived relative wealth (1.3, 95% CI: 1.0–1.7), and family structure (1.6, 95% CI: 1.1–2.2) were all significantly associated with adolescent smoking, with some of the factors having different effects for female and male students.

The authors concluded that Ireland has successfully achieved a considerable decrease in adolescent smoking from 1995 to 2015. Further improvement might be attained through strengthening enforcement of adolescent access to cigarettes and maintaining a high-intensity tobacco control media campaign. Parents could also contribute by enhancing monitoring.

Seán Millar

1 Department of Health (2013) *Tobacco free Ireland: report of the Tobacco Policy Review Group*. Dublin: Department of Health. https://www.drugsandalcohol.ie/20655/

2 Li S, Keogan S, Taylor K and Clancy L (2018) Decline of adolescent smoking in Ireland 1995–2015: trend analysis and associated factors. *BMJ Open* 8(4): e020708. https://www.drugsandalcohol.ie/28946/

Youth smoking in Ireland: findings from the Health Behaviour in School-aged Children survey

Smoking is the leading cause of preventable death in Ireland.[1] As smoking typically initiates in youth, and given the highly addictive properties of nicotine, a high proportion will continue to smoke into adulthood with negative health consequences. The Health Service Executive (HSE) has recently published a report detailing findings from an Irish study that examined smoking behaviours in Ireland among children aged 9–18 years using data from the Health Behaviour in School-aged Children (HBSC) survey.[2] Key findings from the report are discussed below.

Characteristics of young people who smoke in Ireland

It was found that 16% of children aged 9+ had smoked cigarettes in their lifetime, while 6% were classified as current smokers. Of these, 54% smoked every day, with 19% smoking at least once a week, and 27% smoking less often than once a week. The likelihood of being a current smoker increased with increasing age and lower socioeconomic status. There were no significant differences between boys and girls with regard to current smoking status.

Impact of smoking on health and wellbeing

After accounting for age, gender and social class, the study observed that children who smoked were almost 12 times more likely to have consumed alcohol and approximately 39 times more likely to have consumed cannabis in the last month; they were seven times more likely to have reported ever having had sex. Smokers were also three times more likely to have reported fair or poor health, to not being happy with life, and to disliking school. They were also more likely to have been in a fight in the last 12 months compared to non-smokers.

Impact of tobacco control measures

It was found that after controlling for age, gender and social class variables, smokers were less likely to have an understanding of the harms of smoking. Smokers were more likely to think that cigarette packs 'looked cool', to report that they had no smoking restrictions in their households, and twice as likely to report that they had no smoking restrictions in their family cars when compared to non-smokers. Children who smoked were also more likely to report that they found it easy to purchase cigarettes or that they found it easy to find someone to purchase cigarettes for them.

Youth smoking in Ireland continued

Conclusions

The authors note that progress has been made in Ireland in preventing smoking initiation in children and young people and that the Government has made a welcome commitment to bring the tobacco epidemic to an end through its Tobacco Free Ireland programme.[1]

However, they stress that a continued focus on initiation prevention will be critical to success. By identifying demographic factors independently associated with smoking behaviours, the current report will enable policymakers take a more focused approach to the problem.

Seán Millar

1 Department of Health (2013) *Tobacco free Ireland: report of the Tobacco Policy Review Group.* Dublin: Department of Health. https://www.drugsandalcohol.ie/20655/

2 Evans D, O'Farrell A, Sheridan A and Kavanagh P (2018) *Youth smoking in Ireland: a special analysis of the Health Behaviour in School-aged Children (HBSC) study.* Dublin: Health Service Executive. https://www.drugsandalcohol.ie/29202/

Forensic Science Ireland annual report 2017

Forensic Science Ireland (FSI) delivers a scientific service that supports the Irish criminal justice system by analysing samples that are gathered at crime scenes (e.g. DNA, chemistry, and drugs). Substances are submitted for analysis mainly by An Garda Síochána but also by the Garda Síochána Ombudsman Commission (GSOC), Customs and Excise, and the Military Police. In order to monitor the chain of custody, FSI has set procedures in place: substances are first accepted by FSI reception or case intake staff, then items are stored safely and securely, after which they are passed to a relevant scientist for analysis. In May 2018, FSI published its second annual report.[1] What follows is an overview of the results and progress made by the FSI team in 2017.

Results and progress of FSI team

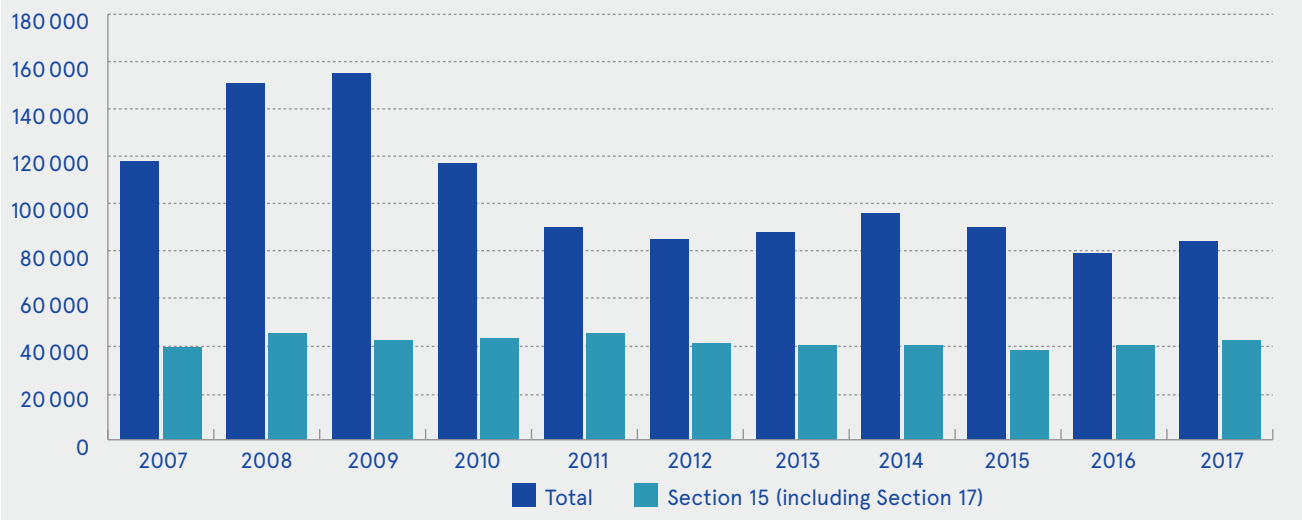
Overall, 15,200 cases were submitted for analysis in 2017, which was an increase of approximately 8% since 2016 (n=14008). The demand for analysis went beyond the available resource capacity of FSI. Moreover, cases submitted varied in complexity and involved the prioritisation of several high-profile cases that involved drug seizures and gangland murders. These challenges resulted in backlogs, particularly for drugs submissions.

Over 50% of cases (n=8456) received by FSI centred on substances that violated the Misuse of Drugs Acts 1977—2015. Figure 1 provides a summary of drug trends between 2007 and 2017 for drugs that were submitted to FSI for analysis. Following a peak in overall drug submissions in 2009, submissions declined until 2012. Between 2012 and 2014 a slight increase was evident. Although a decreasing trajectory was shown between 2014 and 2016, between 2016 and 2017 a slight increase was illustrated. Analyses of submissions for drugs that contravene Sections 15 and 17 of the Misuse of Drugs Acts increased between 2015 and 2016 and again between 2016 and 2017.

Figure 2 provides a summary of the number of cases analysed by drug type in 2017. The majority of cases submitted were for cannabis (39%), followed by powder (usually cocaine) and then heroin, 30% and 14%, respectively.

Figure 3 compares drug submissions between 2016 and 2017, showing that submissions for cannabis and heroin decreased by 5% and 6%, respectively.[1,2] In contrast, submissions for powder (usually cocaine) and tablets (usually MDMA) increased by 6% and 5%, respectively.

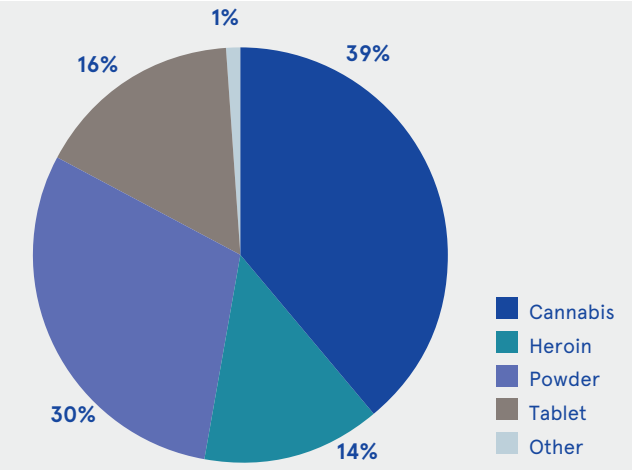
Figure 1: Trends in drug submissions to FSI from 2007 to 2017



Source: *Forensic Science Ireland annual report 2017,* Figure 2, p. 14

Forensic Science Ireland continued

Figure 2: Different types of drug analysis carried out by the FSI Drugs Section



Source: *Forensic Science Ireland annual report 2017,* Figure 3, p. 15

New substances

The emergence of new substances creates another challenge for FSI, as no reference standards are available to which they can be compared. In 2017, some 15 new substances were identified in Ireland.

Court appearances and defence visits

In 2017, FSI employees gave evidence in court in 104 cases, covering drugs, sexual assault, armed robbery, burglary, explosives, and firearms. In addition, defence scientists visited FSI on 49 occasions to re-examine evidence, for example, DNA and drugs seizures.

Presumptive testing

Presumptive drug testing (PDT), which was introduced in 2011, enables Gardaí trained by FSI to carry out tests using commercially available chemical test kits to determine if suspect materials are controlled drugs (e.g. cannabis herb or resin; cocaine). The rationale behind this approach was to reduce the frequency of Section 3 drug cases being submitted to FSI so that they could target their resources on Section 15 (dealing) and Section 17 (cultivation) cases. However, 1,700 of 4,282 Section 3 cases submitted to FSI were indeed cannabis cases, which could have been assessed by PDT. FSI continues to liaise with An Garda Síochána to promote the use of PDT.

DNA database

Another useful resource implemented by FSI in 2015 was the DNA database. This database allows Gardaí to make investigative links between people and unsolved crimes. Cases can be linked individually or in clusters. In 2017, some 601 hits occurred and which assisted 913 cases. There were two types of hits: linking crime scene samples and linking persons to crime stains.

Linking crime scene samples

Crime scene samples linked to other crime scene samples were reported 66 times in 2017 and resulted in 138 investigative links, two of which were related to drugs.

Linking persons to crime stains

Person-to-stain matches were reported 535 times, which assisted 775 cases, of which 28 were related to drugs.

Conclusion

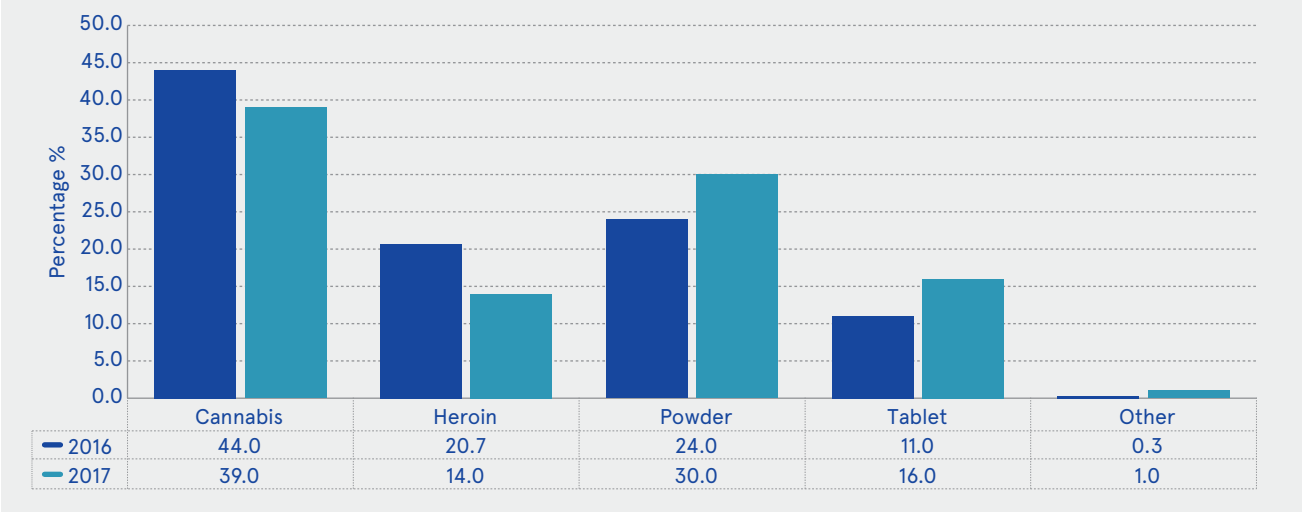
The annual report illustrated that the FSI service contributed substantially to assisting law enforcement agencies in the fight against crime. The demand for analyses far exceeded FSI resource capacity and this gap is expected to further increase in 2018. However, a new workforce plan aims to target this issue, enabling FSI to improve the services it provides, widen its capabilities and personnel.

Ciara H Guiney

1 Forensic Science Ireland (2018) *Forensic Science Ireland annual report 2017.* Dublin: Forensic Science Ireland. https://www.drugsandalcohol.ie/29055/

2 Forensic Science Ireland (2017) *Forensic Science Ireland annual report 2016.* Dublin: Forensic Science Ireland. https://www.drugsandalcohol.ie/27308/

Figure 3: Comparison of different types of drug analysis carried out by the FSI Drugs Section by year



	Cannabis	Heroin	Powder	Tablet	Other
2016	44.0	20.7	24.0	11.0	0.3
2017	39.0	14.0	30.0	16.0	1.0

Source: Data extracted from *Forensic Science Ireland annual report 2016,* Figure 5, p. 14; *Forensic Science Ireland annual report 2017,* Figure 3, p. 15

Irish Prison Service and Probation Service strategic plan 2018–2010

On 25 June 2018, the Minister for Justice and Equality, Charlie Flanagan TD, launched the joint Irish Prison Service (IPS) and Probation Service (PS) strategic plan for 2018–2020.[1] This is the third joint strategy of these agencies. It includes the following actions:

- Improve sentence management
- Maximise joint working between IPS and PS
- Develop responses for female offenders
- Enhance engagement with victims of crime
- Develop innovative responses for specific groups of offenders
- Enhance offender employability
- Engage with service users
- Promote research and evaluation
- Improve provision of drug and alcohol services

Improve sentence management

With the aim of decreasing recidivism, programmes will continue to be established and delivered in prison. It is hoped that this will increase offender engagement, resettlement and reintegration into society, and stability on release from prison leading to less re-offending and safer communities.

Maximise joint working between IPS and PS

To enhance collaborative working between agencies, improvements to systems will continue. This will involve the establishment of service level agreements identifying the role of the PS in sentence management and reintegration, and improvements on how data will be captured. Joint development of interventions will continue along with joint training to promote collaboration and shared learning. In addition, the IPS psychology service will assign a psychologist to PS headquarters to consult on cases, programme development, assessment, and to assist in training.

Develop responses for female offenders

The IPS and PS intend to build on current gender-informed approaches, broaden opportunities, and target through-care and resettlement into society. This work will be informed by joint research and best evidence-based practice on female offending and custodial trends. Interventions will aim to increase recovery and provide education and training. To help women and children affected by domestic violence and abuse, perpetrators of these crimes will continue to be targeted.

Enhance engagement with victims of crime

In line with current legislative requirements for victims of crime,[2,3] the IPS and PS will develop and apply procedures on engaging with victims of crime. Existing information and how it is accessed will be reviewed. The provision and response to restorative justice intervention requests will follow existing practices. Written submissions to the Parole Board by victims will also be facilitated. Further victim engagement will be informed by evaluations of existing practices and procedures.

Develop innovative responses for specific groups of offenders

Drawing on evidence-based best practice, the IPS and PS will collaborate to increase engagement with specific groups of offenders, such as sexual and violent offenders, young adults aged 18–24 years, older adults, and the Traveller community. Several actions will be taken, for example:

- The Sex Offender Risk Assessment and Management (SORAM) will be fully implemented in prisons.
- The Building Better Lives (BBL) programme for sexual violence will be established in the Midlands Prison and Arbour Hill Prison.
- Young adults sentence planning and community reintegration will continue to progress.
- Work will continue to increase engagement and interventions with offenders who are mentally unwell, members of the Traveller community, and perpetrators of domestic violence.

Enhance offender employability

The IPS and PS will collaborate to maintain and increase employment opportunities for ex-offenders. For example, the social enterprise strategy, *A new way forward,*[4] will be implemented. In addition, greater emphasis will be placed on employment outcomes for GATE (Gaining Access to Training, Education and Employment) and Linkage services provided by the Irish Association for the Social Integration of Offenders. The IPS and PS will also work with Intreo services of the Department of Employment Affairs and Social Protection to establish joint procedures to make certain the move from training to employment goes smoothly.

Engage with service users

The intention is to enhance service delivery by working with service users and organisations to make peer-led opportunities available. For example, a joint service level agreement will be established between the IPS/PS and the Irish Red Cross to increase community-based health and first aid (CBHFA) programmes in prisons and the community and widen the curriculum to help reduce recidivism. Rehabilitation programmes will also be facilitated by the IPS and PS for female ex-offenders that have participated in the BRIO programme.

Promote research and evaluation

To ensure that the work undertaken by the IPS and PS is informed by evidence-based practice, research and evaluation will be encouraged in several areas; for example, working with female offenders, life-sentenced prisoners, provision of rehabilitative interventions, desistence from offending, and the impact of the CBHFA programme. Research in these areas will increase knowledge and enhance opportunities to stop and prevent crime.

Improve provision of drug and alcohol services

The IPS and PS will jointly increase drug and alcohol service provision in prisons and the community. Their actions will be guided by the recommendations of the *Review of drug and alcohol treatment* and the current national drugs and alcohol strategy, *Reducing harm, supporting recovery.*[5,6]

Irish Prison Service and Probation Service continued

Conclusion

This strategy was welcomed by the Minister for Justice and Equality, who stated that:

> *This is an excellent example of agencies working together. The Strategic Objective of the Plan is to have a multi-agency approach to offender management and rehabilitation from pre to post imprisonment in order to reduce re-offending and improve prisoner outcomes.*[7]

An integrated approach is viewed by the minister as an essential component for the effective reintegration of offenders into the community and society.[7]

Ciara H Guiney

1 Irish Prison Service and Probation Service (2018) *Irish Prison Service & Probation Service: strategic plan 2018–2020.* Dublin: Irish Prison Service and Probation Service. https://www.drugsandalcohol.ie/29241/

2 Criminal Justice (Victims of Crime) Act 2017. Available online at: http://www.irishstatutebook.ie/eli/2017/act/28/enacted/en/html

3 European Commission (2012) Directive 2012/29/EU. Available online at: https://ec.europa.eu/anti-trafficking/legislation-and-case-law-eu-legislation-criminal-law/directive-201229eu_en

4 Irish Prison Service and Probation Service (2017) *'A new way forward': social enterprise strategy 2017–2019.* Dublin: Department of Justice and Equality. https://www.drugsandalcohol.ie/27287/

5 Clarke A and Eustace A (2016) *Review of drug and alcohol treatment services for adult offenders in prison and in the community.* Dublin: Probation Service and Irish Prison Service. https://www.drugsandalcohol.ie/26569/

6 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025.* Dublin: Department of Health. https://www.drugsandalcohol.ie/27603/

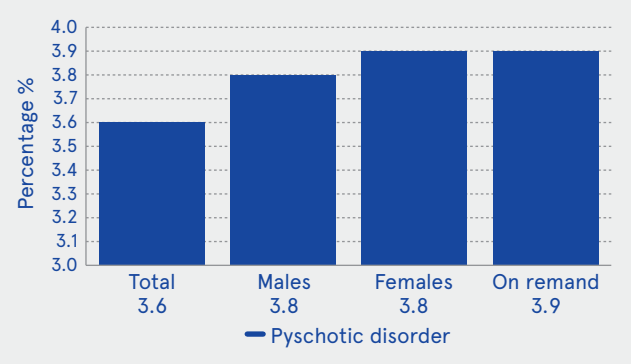
7 Department of Justice and Equality (2018) *Minister Flanagan publishes the Probation Service Strategy 2018–2020 'One Vision, One Team, One Standard', the third Probation Service and Irish Prisons Service joint strategic plan 2018–2020 and the Probation Service and Irish Prison Service annual reports 2017.* Dublin: Department of Justice and Equality. Available online at: https://www.justice.ie/en/JELR/Pages/PR18000207

Prevalence of major mental illness, substance misuse and homelessness among Irish prisoners

There are 12 institutions in the Irish prison system, comprising 10 traditional 'closed' institutions and two open centres, which operate with minimal internal and perimeter security. The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy Prison in Dublin, while the remainder are located in a separate part of Limerick Prison.[1] Between 1970 and 2011, the Irish prison population increased by 400%.[2] Mental disorders, substance misuse and homelessness have been highlighted as key areas of need among Irish prisoners. However, although the prevalence of these vulnerabilities have been studied by health services and governmental or non-governmental organisations, they have not been systematically reviewed.

Recent Irish research aimed to systematically review studies from Irish prisons that estimate the prevalence of major mental illness, alcohol/substance misuse and homelessness at the time of committal.[2] In this study, published in the *Irish Journal of Psychological Medicine*, healthcare databases were searched for studies quantifying the point prevalence for each outcome of interest. Searches were augmented by scanning bibliographies and searches of governmental and non-governmental websites. Proportional meta-analyses were completed for each outcome. The major findings with regard to these outcomes are discussed below.

Figure 1: Percentage of Irish prisoners with a psychotic disorder at time of committal



Source: Gulati *et al.* (2018)[2]

Psychotic and major affective disorders

Eight studies with a total sample size of 28,012 prisoners reported data on psychotic disorders. Using a random effects model, the pooled percentage of Irish prisoners suffering from a psychotic disorder was 3.6% (95% CI: 3.0–4.2%). The prevalence in male samples was estimated at 3.8%. Only two studies evaluated prevalence in purely female samples, and estimates for females were 3.9%. Estimates of prevalence in purely remand samples could be extracted from four studies and were 3.9% (see Figure 1).

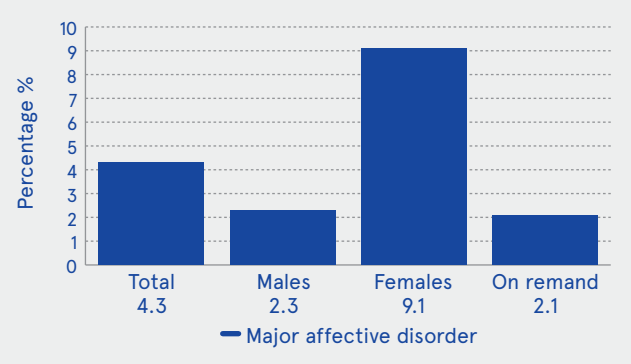
Seven studies with a total sample size of 7,928 prisoners reported on affective disorders. The pooled percentage of prisoners suffering from an affective disorder was 4.3% (95% CI: 2.1–7.1%). Prevalence estimates from male samples were 2.3% and from female samples were 9.1%. Estimates of the prevalence of affective disorders in purely remand samples could only be extracted from two studies and were 2.1% (see Figure 2).

Alcohol and substance use disorders

Six studies with a total sample size of 1,659 prisoners reported on alcohol or substance use disorders. The pooled percentage

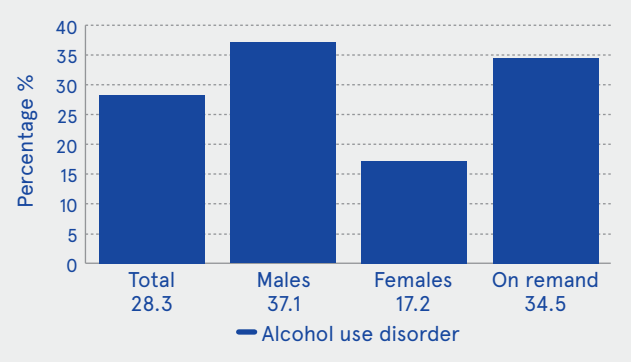
Irish prisoners continued

Figure 2: Percentage of Irish prisoners with a major affective disorder at time of committal



Source: Gulati *et al.* (2018)[2]

Figure 3: Percentage of Irish prisoners with an alcohol use disorder at time of committal

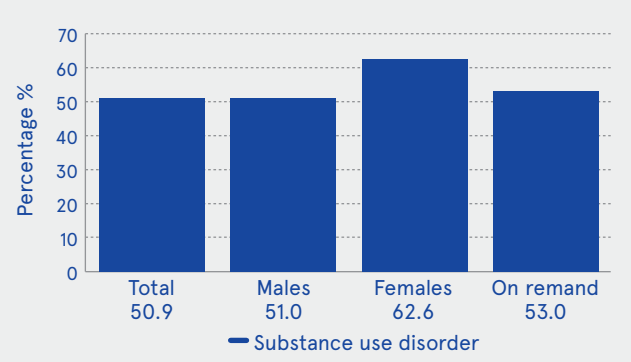


Source: Gulati *et al.* (2018)[2]

of prisoners suffering from an alcohol disorder across the six studies was 28.3% (95% CI: 19.9–37.4%) (see Figure 3). The pooled percentage of prisoners reporting a substance use disorder was 50.9% (95% CI: 37.6–64.2%) (see Figure 4).

The prevalence estimates for male only samples were 37.1% and 51% for alcohol and substance use disorders, respectively. Two studies evaluated prevalence in purely female samples and estimates for females were 17.2% for alcohol use disorder and 62.6% for substance use disorder. Prevalence estimates for purely remand samples could be extracted from only one study and were 34.5% and 53% for alcohol and substance use disorders, respectively.

Figure 4: Percentage of Irish prisoners with a substance use disorder at time of committal

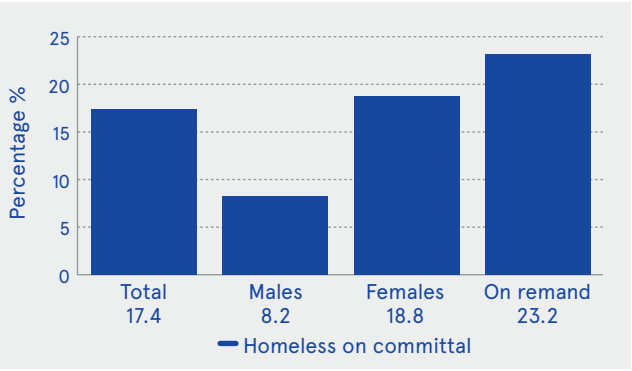


Source: Gulati *et al.* (2018)[2]

Homeless on committal

Five studies with a total sample size of 1,523 prisoners reported on prisoners who were homeless at time of committal. The pooled percentage of homelessness from a random effects model was 17.4% (95% CI: 8.7–28.4%). Prevalence estimates in purely male samples were 8.2%. Only one study evaluated prevalence in a purely female sample and the estimate for females was 18.8%. Prevalence estimates from remand samples could be extracted from two studies and were 23.2% (see Figure 5).

Figure 5: Percentage of Irish prisoners who were homeless at time of committal



Source: Gulati *et al.* (2018)[2]

Conclusions

The authors concluded that the study showed prevalence estimates of psychotic illness and substance abuse among Irish prisoners that are in keeping with international estimates of morbidity in prisons, while those for affective disorders are lower. The prevalence of homelessness on committal to Irish prisons is higher than some international estimates.

As rates of psychoses, alcohol/substance misuse and homelessness among Irish prisoners are significantly higher than in the general population, the study highlights the need for improved screening for affective disorders, the development of diversion services, and the consideration of integrated treatment plans for addressing psychiatric and psychosocial need. In particular, the authors suggest that homeless individuals with mental illness are unlikely to seek help or treatment.

In addition, subjects who have an active substance misuse disorder are often excluded from temporary accommodation, which may result in further social decline and increased risk of imprisonment.

Seán Millar

1 Irish Prison Service (2018) *Irish Prison Service annual report 2017.* Longford: Irish Prison Service. https://www.drugsandalcohol.ie/29244/

2 Gulati G, Keating N, O'Neill A, Delaunois I, Meagher D and Dunne CP (2018) The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners: systematic review and meta-analyses. *Ir J Psychol Med:* 1–11: doi:10.1017/ipm.2018.15. https://www.drugsandalcohol.ie/29009/

Hospital presentations and preceding factors of drug overdose among adolescents

Suicide is one of the major causes of death in many populations, particularly adolescents, and poisoning or drug overdose (OD) is the leading method of attempted suicide. Public health interventions aim to reduce the morbidity and mortality of self-poisoning by limiting the availability of potentially toxic medications to at-risk populations. An understanding of the preceding factors and potential triggers of self-poisoning and drug overdose may aid in the development of specific intervention strategies.

Recent Irish research aimed to highlight the pattern of presentations and preceding factors of OD in an adolescent population.[1] In this study, published in the *Irish Medical Journal*, the authors retrospectively evaluated the data of 85 adolescents (81.2% female) presenting to a large regional hospital in Ireland with OD over a three-year period. Data were retrieved from the Hospital Inpatient Enquiry (HIPE) system, and included information on patients' demographics, preceding factors, and drugs used in OD.

Results

The median age at presentation was 15.83 years. The median time from event to hospital presentation was 2.6 hours, with the mean length of hospital stay being 2.24 days. Thirty-eight (44.7%) adolescents had a history of deliberate non-drug-related self-harm, while 14.1% (n=12) were previously seen for deliberate self-poisoning/OD. Among factors associated with OD, the following were noted:

- Depression was the most common mental health problem associated with OD.
- Other preceding factors included unstable family dynamics, family history of mental illness, social problems, and romantic break-ups.
- Certain factors had gender predilection: substance abuse and conduct disorder were more common among males.

The drugs implicated in adolescent OD presentations are shown in Figure 1. The most common agents of overdose were analgesics (n=83), with acetaminophen being the most commonly used analgesic. Other drugs used in OD cases included antidepressants, antipsychotics, antibiotics, and antihistamines. Forty-six (54.1%) cases presented with polypharmacy overdose. Three patients (3.5%) inhaled a kitchen aerosol spray, while concomitant alcohol (vodka) and drug overdose was documented in 17.6% (15/85) of cases.

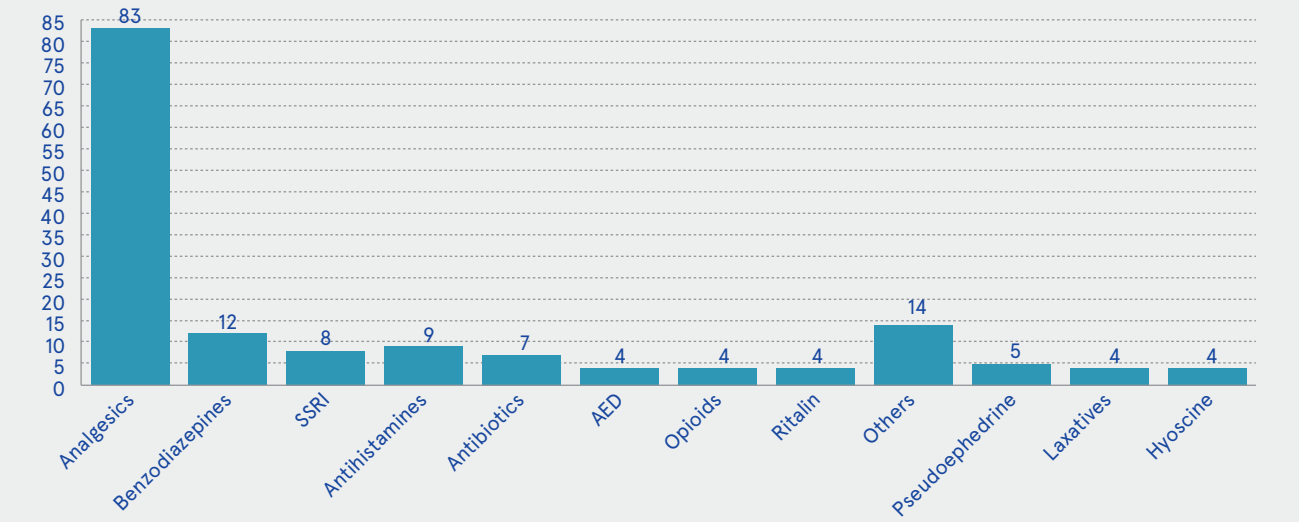
Conclusions

The authors suggest that the number of OD patients in this study probably represent only a small proportion of OD cases among adolescents and that it is likely that substantial numbers of self-poisoning occur in the community. Gender differences should be considered in the assessment, prevention, and management of future self-harm or suicides by community policymakers and clinicians.

Seán Millar

1 Maduemem K, Adedokun C and Umana E (2018) Presentations and preceding factors of drug overdose amongst adolescents admitted to a large regional hospital. *Ir Med J,* 111(4): 731. https://www.drugsandalcohol.ie/28870/

Figure 1: Number of drugs implicated in OD among adolescents



Source: Maduemem *et al.* (2018)[1]
SSRI: Selective serotin reuptake inhibitor
AED: Anti-epilepsy drug
Others: Multivitamins; iron; Lyrica; Eltroxin; oral contraceptive pills; valerian; pantoprazole; furosemide; statins; ecstasy; bleach; kitchen spray

RESPONSES

New report on drug-related bloodborne viruses in Ireland

People who inject drugs (PWID) are at high risk of contracting bloodborne viruses (BBV) and comprise three-quarters of diagnosed cases of hepatitis C in Ireland. Surveillance of drug use and drug-related BBV is essential for monitoring the impact of prevention and harm reduction programmes. The Health Protection Surveillance Centre (HPSC) recently published a comprehensive summary of drug-related BBV in Ireland.[1] The report was compiled by a collaborative group comprising representatives from several health agencies, doctors, and others active in harm reduction and drug treatment work in Ireland. The final report was authored by HPSC staff.

The aim of this report is to summarise what is currently known about drug-related BBV in Ireland. The report focuses on hepatitis C, HIV, and hepatitis B and begins by outlining problem drug use associated with an increased risk of these infections. Recent opioid prevalence data show that the numbers of those using opioids, mainly heroin, have not changed substantially between 2006 and 2014, but that a much higher proportion of those who are using these drugs are aged between 35 and 64 years.[2] Incidence of opioid use is declining and National Drug Treatment Reporting System (NDTRS) data indicate a steady decline in new entrants to treatment who reported opioids as their primary problem drug between 2009 and 2016, and a decrease in the proportion who inject.[3] Treatment coverage for people who use opioids is high by international standards and opioid substitution treatment (OST) is available in most parts of the country. Incidence of BBV among PWID has been declining in recent years.

With good uptake of BBV testing and the use of highly effective direct-acting antiviral drugs, it is possible to anticipate the elimination of hepatitis C in Ireland. Nevertheless, statutory notifications, studies on OST settings and in prison indicate a high prevelance of this disease in Ireland among PWID. Further, a small number of those entering treatment for cocaine use are injecting and 12% of those entering treatment in 2015 had injected at some time in the past. This cohort of PWID, along with those using new psychoactive substances, performance enhancing drugs, or chemsex drugs, are less likely to self-identify as problem drug users or avail of BBV testing, harm reduction and drug treatment services.

The report identifies gaps in knowledge and opportunities for improvements in the way information is collected and recorded. Routine monitoring would be much improved by extending electronic record-keeping of treatment information and laboratory results to facilitate easy extraction of the data for reporting. There are extensive and heavily used needle exchange services. If these services could be expanded to include BBV screening and onward referral, it would then be possible to collect data on the users of these services most at risk from BBV.

Brian Galvin

1 Health Protection Surveillance Centre (2018) *Drug-related bloodborne viruses in Ireland*. Dublin: Health Protection Surveillance Centre. http://www.drugsandalcohol.ie/29685/

2 Hay G, Jaddoa A, Oyston J, Webster J, Van Hout MC and Rael dos Santos A (2017) *Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods*. Dublin: National Advisory Committee on Drugs and Alcohol. http://www.drugsandalcohol.ie/27233/

3 Health Research Board (2018) *Drug treatment in Ireland (NDTRS) 2010–2016*. Dublin: Health Research Board. http://www.drugsandalcohol.ie/28986

Integrated hepatitis C care for people who inject drugs

Hepatitis C virus (HCV) infection is a major cause of chronic liver disease and death. Drug use remains the significant cause of new infections in the European Union (EU), with estimates of HCV antibody prevalence among people who inject drugs (PWID) ranging from 5% to 90% in 29 European countries.[1] In the Republic of Ireland and the EU, primary care is a key area to focus efforts to enhance HCV diagnosis and treatment among PWID. Recently developed HCV direct-acting antiviral drugs are well tolerated and delivered for shorter courses (8–12 weeks), with trials reporting more than 90% cure rates among PWID.[2] However, despite these highly effective treatments, many people at risk are unaware of their infection and obstacles may limit access to HCV care, resulting in many patients not being treated.

A recent paper, published in the journal *JMIR Research Protocols*, outlines the protocol for a study which will examine integrated HCV care for PWID.[3] The research will be a prospective, non-randomised, pre-post intervention feasibility study, and will be conducted in opioid substitution treatment (OST)-prescribing general practices from three sites across the HepCare Europe consortium (Dublin, London and Seville). A total of 24 OST-prescribing general practices have been recruited from the professional networks and databases of members of the research consortium. Patients were eligible for inclusion in the study if aged ≥18 years, on OST, and had attended the practice for any reason during the recruitment period. Baseline data on HCV care processes and outcomes were extracted from the clinical records of the participating patients.

Intervention and outcomes

The aim of the intervention is to enhance identification and linkage to HCV care and treatment among patients attending primary care for OST. It includes the following:

- Outreach of an HCV-trained liaison nurse into general practices

Hepatitis C care continued

- In-practice education for clinicians regarding developments in diagnosis and treatment of HCV
- Enhanced access of patients to community-based evaluation of HCV disease, including novel approaches to diagnosis
- A researcher-facilitated practice audit of HCV care processes and feedback to general practices.

Primary outcomes measures of the study will include the proportion of participants who have been screened for HCV and the proportion of HCV antibody-positive patients who commenced/completed antiviral therapy and who achieved a sustained virologic response. Secondary outcomes will include the following:

- The proportion of those screened who tested HCV antibody positive
- The proportion of HCV-positive patients who have been assessed using novel approaches
- The proportion of HCV-positive patients who have been referred to specialist hepatology or infectious disease services
- The proportion of HCV-positive patients who have attended specialist hepatology or infectious disease services
- The proportion of HCV-positive patients who received an alcohol screening brief intervention
- The proportion of participants tested for anti-HIV antibody, anti-HBc (hepatitis B core) antibody, or hepatitis B surface antigen (HBsAg)
- The proportion of participants immunised against hepatitis B/A virus
- The experience and evaluation of the intervention among key informants (clinicians and patients)
- The number of patients attending general practice for OST post-intervention for follow-up testing
- Evaluation of the feasibility and possible efficacy of the intervention by comparing pre-post intervention data
- Evaluation of the cost-effectiveness of the intervention
- Comparison of clinician knowledge, attitudes and practice pre-post intervention.

Conclusions

The authors of this research protocol state that the study is ongoing and has the potential to make an important impact on patient care and provide high-quality evidence to help clinicians make important decisions on HCV testing and onward referral. As a substantial proportion of HCV-positive patients on OST in general practice are not engaged with specialist hospital services, but qualify for direct-acting antiviral drugs treatment, the study has the potential to reduce HCV-related morbidity and mortality.

Seán Millar

1 Lazarus JV, Sperle I, Maticic M and Wiessing L (2014) A systematic review of hepatitis C virus treatment uptake among people who inject drugs in the European region. *BMC Infect Dis,* 14 (Suppl 6): S16. https://www.drugsandalcohol.ie/22756/

2 Dore GJ, Altice F, Litwin AH, Dalgard O, Gane EJ, Shibolet O, *et al.* (C-EDGE CO-STAR Study Group) (2016) Elbasvir-Grazoprevir to treat hepatitis C virus infection in persons receiving opioid agonist therapy: a randomized trial. *Ann Intern Med,* 165(9): 625-34.

3 McCombe G, Swan D, O'Connor E, Avramovic G, Vickerman P, Ward Z, *et al.* (2018) Integrated hepatitis C care for people who inject drugs (Heplink): protocol for a feasibility study in primary care. *JMIR Res Protoc,* 7(6): e149. https://www.drugsandalcohol.ie/29155/

High uptake of sterile crack pipes in response to surge in cocaine use in Dublin

An article published in July 2018 by *The Journal.ie* explained that needle exchange services in Dublin had noted a strong uptake of clean crack pipes by service users in response to a surge in the availability and consumption of crack cocaine in 2018.[1]

Merchants Quay Ireland (MQI), which offers a range of services for people who are homeless and experiencing addiction issues, began providing clean crack pipes from its centre on the south quays on 13 July; 69 pipes were dispensed in the scheme's first week of operation. The Ana Liffey Drug Project (ALDP), which runs an outreach needle and syringe programme based in Middle Abbey Street, began handing out reusable crack pipes in April 2017. Since then, 287 pipes have been distributed. Of these, almost one-half (128) were handed out between March and July 2018. ALDP noted that while most of their clients smoke crack, staff have recently been engaging with a cohort of people who are neck-injecting the drug, an activity which ALDP describes as a 'very risky activity'.

The use of cocaine has now returned to Celtic Tiger levels in Ireland and the Health Service Executive (HSE) has recently launched a new harm reduction campaign, in conjunction with ALDP, to provide information and advice to users about both cocaine powder and crack cocaine.[2] Tony Geoghegan, CEO of MQI, noted that individuals they deal with are primarily street drug users, rough sleepers, and people who are homeless, and that these would not necessarily be archetypal users, as cocaine use is more widespread across society. Nevertheless, he stated that it is important to address drug use in this cohort, as cocaine and crack have the propensity for harm very quickly.

Seán Millar

1 Hennessy M and Brophy D (2018) High uptake of sterile crack pipes in response to surge in use of drug in Dublin, *The Journal.ie,* 22 July. Available online at: http://www.thejournal.ie/crack-dublin-4138921-Jul2018/

2 Health Service Executive (2018) *Cocaine – reduce the harms.* Dublin: Health Service Executive. 2018. Available online at: https://www.hse.ie/eng/services/news/media/pressrel/cocaine-reduce-the-harms.html

SAFE campaign launched in Clondalkin

SAFE (Support, Advice, Free Exchange, Empathy) is a new harm reduction awareness campaign based in Clondalkin, Dublin. It is the result of a collaborative effort between Clondalkin Drug and Alcohol Task Force (CDATF), An Garda Síochána, Irish Rail and local drug services, Tus Nua and Clondalkin Addiction Support Programme (CASP). Ms Frances Fitzgerald TD launched the campaign on 1 October 2018 at an event attended by all the stakeholders involved in the campaign and local community groups. SAFE began as a response to the increasingly visible use of drugs, antisocial behaviour, and drug litter in the Clondalkin area. A steering group was established to coordinate a harm reduction initiative with a focus on providing support to very vulnerable people, many of whom had travelled to the area to obtain or use drugs.

The steering group was particularly concerned with activity around the local railway station and there was a need to coordinate the response with organisations outside of the Clondalkin area. The involvement of the South Western Regional Drugs and Alcohol Task Force (SWRDTF) and the Ana Liffey Drug Project (ALDP) in the campaign provided the continuum of support needed to deal with the mobile nature of the problem. SAFE provides harm reduction services to those who are using crack cocaine and heroin. Over the 10 months leading up to the launch, it has built an effective, coordinated response to the problems identified by the steering group and provided support to a very marginalised group of people.

Many of the people whom SAFE supports present with specific and complex needs and are often hard to reach. SAFE has developed a vital service that is safe, supportive and empathetic to the service user's individual needs.

The effectiveness of the campaign is due to the close partnership between Irish Rail, An Garda Síochána (AGS), CASP, Clondalkin Tus Nua, SWRDTF, South Dublin County Council, ALDP, and the HSE Addiction Services Outreach Team. The success of the initiative is underpinned by collobaration between all of these agencies and the local drugs task force. It is an excellent example of a coordinated, targeted, and effective harm reduction campaign.

Brian Galvin

Attending the launch of the SAFE Campaign on 1 October 2018 in Clondalkin (from L-R): Inspector Liam Casey (AGS), Brian Downes (assistant station manager with Irish Rail), Sharon Harty (team leader with CASP), Emma Fox (treatment and rehabilitation officer with CDATF), Paul Grace (outreach worker with Clondalkin Tus Nua), Cllr Mark Ward (mayor of South Dublin County Council and task force board member), Jennifer Clancy (coordinator with CDATF), Ms Frances Fitzgerald TD, Leeann McDonagh (AGS), Tara Deacy (prevention officer with CDATF), Paul Stanton (area manager with Irish Rail), and Jane Cregan (communications officer with Irish Rail)

The help-seeking behaviours of family members affected by substance-use disorders

Research published in April 2018 in *Child Care in Practice* explored in depth the help-seeking behaviours of those affected by substance-use disorder among family members, with a view to informing the design and delivery of support services for affected persons.[1] The study focused on affected family members' use and assessment of available supports, barriers encountered in accessing supports, and recommendations for overcoming these barriers.

Background

There is an increasing awareness that persons affected by the substance-use behaviours of their family members are in need of support in their own right. Support can enable affected family members to learn ways of coping with the emotional, psychological, and physical stress experienced as a result of problem substance use in their family. Formal support for affected family members is provided through community, voluntary, and statutory addiction services and through specialised family support and family-based programmes. Affected family members may also access support informally through family, friends, and community, and semi-formally through professionals in other sectors.

Research links the adequacy of the support received with positive outcomes for families.[2,3] However, research suggests that affected family members tend to put their family's wellbeing before their own and to seek help for their family member and not themselves.[4,5] Additionally, affected family members may avoid seeking help because of the stigma attached to persons who have issues with problem substance use and to their associates.[6]

Method

Interviews were conducted with 10 participants (nine females and one male) who were recruited through Drug and Alcohol Task Forces and statutory drug services across urban and rural locations. Participants were persons with at least one family member with a history of substance-use disorder for a minimum of five years and who had sought support from at least one formal drug/alcohol service/programme. Participants had varying relationships to their family members (parents, partner, sibling, and adult child) and the circumstances of their family members ranged from active substance use, to in recovery, to deceased.

Findings

Participants reported multiple negative consequences of the substance use of their family member, including overdose, attempted suicide, bereavement, imprisonment, and drug-related intimidation and violence. Participants experienced stress and strain and feelings such as guilt, shame, fear, embarrassment, and a sense of failure. Typically, participants had endured the problem behaviour of their family member for years, only seeking help when the situation became chaotic or unmanageable. Prior to seeking help for their family member, participants had not considered that they might benefit from support in their own right. Participants also lacked awareness of available supports and of the kinds of support that might best suit their needs.

Participants learned about available supports through family members, colleagues and social services, or were referred from peer-led support to counselling and other support services. All participants had at some point accessed either a drug education programme, family support, a residential treatment centre or (most commonly) addiction counselling. Other supports included Al-Anon, parent education initiatives, general counselling, yoga, church, and mindfulness. Informal supports, where accessed, were created through contact with formal supports. Semi-formal supports were more common and included general practitioners, Gardaí, teachers, and work colleagues. Most participants accessed more than one type of support for reasons including availability, preference, location, and logistics. All had sought informal or semi-formal support before coming into contact with formal supports.

For participants, perceived stigma, shame, embarrassment and concerns around confidentiality and anonymity were significant barriers to accessing support and to engaging with support once accessed. Additional barriers were an absence of local supports, long distance travel, childcare, and poor awareness of relevant issues among related professionals. A lack of interagency cooperation was further cited as a barrier.

Participants were positive about the formal support they received, but felt that both semi-formal and informal supports (including family) sometimes lacked relevant knowledge, empathy, and understanding. The benefits of accessing support included emotional support, better coping, enhanced wellbeing, and feeling less isolated and more informed. Participants also described increased self-esteem and confidence from family support and counselling. To overcome barriers to accessing support, participants suggested education and awareness programmes in schools and public spaces, as well as increasing the visibility of supports through various media. Participants further suggested better integration of formal supports and the upskilling of professionals providing semi-formal support.

Implications

The authors suggest that full implementation of the existing National Drugs Rehabilitation Framework and Protocols[7,8] for coordination and integrated working among drug and alcohol family support services would address many of the barriers identified by participants. They propose that better coordination of local services is needed to ensure affected family members can easily access support appropriate to their needs. They further propose that service provision would be enhanced though additional investment, wider availability of family support, and increased capacity within the sector to work with affected family members. The authors highlight the role of policymakers and national organisations in service development, promotion, education, awareness, and training of the workforce.

Help-seeking behaviours of family members continued

Conclusion

Persons affected by problem substance use in their family experience considerable stress and strain and are often isolated and unaware of supports available to them. The study has highlighted the support needs of this group, as well as the barriers they encounter in accessing support, including the stigma that surrounds problem substance use. It has also provided suggestions for enhancing the provision of supports for affected families and for challenging stigma. Findings of the study must be interpreted in light of the study limitations, however, which include the small sample size and the gender imbalance among participants.

Cathy Kelleher

1 McDonagh D, Connolly N and Devaney C (2018) 'Bury don't discuss': the help-seeking behaviour of family members affected by substance-use disorders. *Child Care in Practice,* [Early online] https://www.drugsandalcohol.ie/28867/

2 Gardner R (2006) Safeguarding children through supporting families. In P Dolan, J Canavan and J Pinkerton (eds), *Family support as reflective practice* (pp. 103–117). London: Jessica Kingsley.

3 Sheppard M (2009) Social support use as a parental coping strategy: its impact on outcome of child and parenting problems – a six-month follow-up. *Br J Soc* Work, 39(8): 1427–46.

4 Barnard M (2007) *Drug addiction and families.* London: Jessica Kingsley.

5 Salter G and Clark D (2004) *The impact of substance misuse on the family: a grounded theory analysis of the experiences of parents.* Swansea: WIRED and Department of Psychology, University of Wales.

6 Keyes KM, Hatzenbuehler ML, McLaughlin KA, Link B, Olfson M, Grant BF, *et al.* (2010). Stigma and treatment for alcohol disorders in the United States. *Am J Epidemiol,* 172(12): 1364–72.

7 National Drugs Rehabilitation Implementation Committee (2010) *National Drugs Rehabilitation Framework document.* Dublin: Health Service Executive. https://www.drugsandalcohol.ie/13502/

8 National Drugs Rehabilitation Implementation Committee (2011) *National protocols and common assessment guidelines to accompany the National Drugs Rehabilitation Framework.* Dublin: Health Service Executive. https://www.drugsandalcohol.ie/16717/

An Garda Síochána Policing Plan 2017

An Garda Síochána Annual Policing Plan 2018 identifies the main policing concerns for 2018 as prioritised by An Garda Síochána (AGS) and in support of the AGS Strategy Statement July 2016—2018.[1,2] It considers priorities identified by the Minister of Justice and Equality and the Policing Authority along with the views of external stakeholders and the general public. It contains several 'concrete measurable initiatives' (p. 2) and will attempt to implement several recommendations from the Garda Inspectorate Report *Changing policing in Ireland.*[3] As in previous plans, several areas have been highlighted by AGS in 2018: organisational development and capacity improvement; national and international security; confronting crime; roads policing; and community engagement and public safety.

Organisational development and capacity improvement

With the ongoing aim of renewing AGS culture and advancing the Modernisation and Renewal Programme 2016—2021,[4] AGS has prioritised the following areas: composition and structure of the Garda workforce; Garda resource deployment; supervision; improved data quality; cultural renewal; and enhanced governance.

National and international security

To ensure that Ireland is a safe and secure place to reside, work, visit and invest, AGS will continue to monitor domestic and international security by carrying out intelligence-led operations against terrorism, risk assessment, and operational preparation for major emergencies in conjunction with major emergency management partners. They will collaborate and build on relationships with other security partners, the Police Service of Northern Ireland (PSNI) and international agencies. AGS intends to fully participate in bilateral European and international security meetings and support associated security initiatives. Additionally, preparations and implementation of the Schengen Information System (SIS II) are ongoing. AGS also aims to develop a cybercrime and security strategy to increase the capacity to avert and act against cybercrime security incidents.

Confronting crime

AGS is committed to the prevention of crime along with advocating for the rights of victims exposed to crime. Initiatives put forward aim to help AGS achieve this outcome and include: implementing the EU Victims Directive; supporting victims of sexual crime and domestic violence as well as collaborating with other agencies to implement a national action plan. AGS plans to implement their National Crime Prevention and Reduction Strategy nationally and will carry on targeting assaults, burglaries and robberies using a multiagency and intelligence-led approach.[5] In addition, Operation Thor is to be refocused towards averting violent crime. Measures to prevent and investigate non-violent, financially motivated crime will include targeting fraud, corruption and bribery. Organised crime groups will be targeted using intelligence-led operations. Success will be appraised via submission of progress reports to the Policing Authority, higher controlled drugs detections and firearm seizures. In addition, it is hoped that the results of an evaluation of the Drug-Related Intimidation Reporting Programme will be available by the end of 2018.

Roads policing

Saving lives is viewed as essential to AGS. One area that can be focused on to achieve this is road safety by targeting key lifesaver offences, such as not wearing seatbelts, driving while on a mobile phone, speeding, and driving while under the influence of alcohol and drugs. Divisional Roads Policing Units are to be established and the increase in personnel in this area is ongoing. Inappropriate road-user behaviour will be targeted via increased use of social media to communicate road safety messages.

An Garda Síochána Policing Plan 2017 continued

In addition, AGS will collaborate with other agencies, such as the Road Safety Authority, Transport Infrastructure Ireland and road safety officers to reduce deaths and serious injuries.

Community engagement and public safety

An approach used by AGS that increases community engagement and public safety is community policing. Several initiatives are planned. For example, AGS will implement the first phase of a new integrated system – Segmentation, Targeting, Analysing, Responding, Tracking (START) and create a strategy to incorporate the Garda Reserve into community policing structures. It will draw on digital platforms to provide information on AGS and its ongoing operations. Offender management will be improved on by advancing and refining the current multiagency approach.

Key policing and security priorities 2018

Table 1 outlines a summary of AGS's key policing and security priorities for 2018. Responsibility for actioning and reporting on the progress of each initiative of this plan has been assigned to an assistant commissioner or executive director who will then report to the Garda Commissioner and the Policing Authority once a month. The acting commissioner believes that this plan will `redouble efforts to deliver a policing and security service that the people of Ireland are proud of' and he is `confident that AGS will deliver an excellent and continuously improving policing and security service for the people it serves' (p. 2).[1]

Ciara H Guiney

1 An Garda Síochána (2018) *An Garda Síochána Annual Policing Plan 2018*. Dublin: An Garda Síochána. https://www.drugsandalcohol.ie/29169/

2 An Garda Síochána (2016) *An Garda Síochána strategy statement July 2016–2018*. Dublin: An Garda Síochána. https://www.drugsandalcohol.ie/27305/

3 Garda Síochána Inspectorate (2015) *Changing policing in Ireland: delivering a visible, accessible and responsive service*. Dublin: Garda Síochána Inspectorate. Available online at http://www.gsinsp.ie/en/GSINSP/1286-ChangingPolicinginIreland_Low-Full.pdf/Files/1286-ChangingPolicinginIreland_Low-Full.pdf

4 An Garda Síochána (2015) *An Garda Síochána modernisation and renewal programme 2016–2021*. Dublin: An Garda Síochána. http://www.drugsandalcohol.ie/27306/

5 An Garda Síochána (2017) *Crime prevention and reduction strategy: putting prevention first*. Dublin: An Garda Sióchána. https://www.drugsandalcohol.ie/27147/

Table 1: Policing and security priorities 2018

Priorities	Areas targeted	
Confronting crime	Organised crime	· Drugs · Human trafficking · Cross-border crime · Brexit preparedness
	Crimes against the person and property	· Sexual offences · Illegal weapons · Robberies · Assaults · Domestic violence · Burglary
	Cybercrime	
	White collar crime/fraud	
Community policing and public safety	Victims	· Victim satisfaction · Vulnerable victims · Hate crime
	Major incident planning	
	Community policing and antisocial behaviour	
	Crime prevention	
	Garda visibility	
Roads policing	Safeguarding road users	
	Denying criminals the use of roads	
Organisational capacity improvement	Implementation of the code of ethics	
	Organisation development	· Modernisation and renewal programme · Civilianisation · Supervision · Cultural audit · Third-party reports
	Data quality, governance and stewardship	
	Quality of crime investigation	
Security priority of the Minister for Justice and Equality		
To safeguard the security of the State by protecting the State and its people from terrorism and any other security threats to the State		

Source: Adapted from AGS, 2018, p.23[1]

Let's get specific – a prevention forum

In November 2017, the Prevention and Education Subcommittee of Dublin's North Inner City Drug and Alcohol Task Force (NICDATF) held a forum on substance misuse prevention and education. It was opened by Minister of State Catherine Byrne TD and attended by youth and community workers and teachers, alongside a small number of young people. The forum was held in the context of the 2017 national drugs and alcohol strategy, *Reducing harm, supporting recovery*.[1] The new strategy had moved away from having prevention as one of a set of strategic pillars to prevention actions falling under a broader goal that sets out to promote and protect health and wellbeing.

The forum set out to discuss prevention in the new strategy and the work of and issues faced by those working in prevention and education. On 15 June 2018, NICDATF launched a report *Let's get specific*, which detailed the discussions at the forum.[2] The report is divided into four sections:

- The first describes participants' responses to the new strategy and their views on the broad context in which they were working.
- The second reflects the discussion on substance misuse prevention and education in schools, with a strong focus on the Social, Personal and Health Education (SPHE) programme.
- The third describes the work of youth and community services providing prevention education and therapeutic support and treatment to young people.
- The final section makes a set of recommendations.

Recommendations

The main body of the report presents participants' perceptions on each of the areas covered, including what they saw to be as the main challenges and obstacles to delivering effective prevention and education programmes. In the concluding section, the Prevention and Education Subcommittee of NICDATF makes 10 recommendations, which broadly reflect the views and experiences of forum participants. These are:

1 Work with the Department of Education to enhance the status of and support to the teaching of SPHE. This should include:
   - Proper staffing of its teaching. SPHE should not be treated as an 'add on' subject.
   - Provision of adequate training and support to SPHE teachers.
   - Leadership of school principals in ensuring proper timetabling of the subject; connecting the teaching of the subject with external support groups in the community; and sharing the lessons with, and involving, parents in training.

2 Address the funding reductions in recent years to community and youth projects in the area of drug misuse prevention and education. This should focus on enabling groups to upscale training outreach and peer-to-peer education work in community and school settings.

3 Support the development of more youth-friendly education materials that provide factually accurate information, including an emphasis on areas viewed as under-represented (e.g. cannabis and alcohol misuse; the link between drug misuse and sexual health; and the link between social media and mental health).

4 Ensure young people are heard, for example, through the establishment of a continuous feedback from young people on the effectiveness, or otherwise, of substance misuse strategies.

5 Build a stronger evidence base to show the impact of substance misuse education. Draw on evidence from international best practice. This should not put further pressure on community organisations or teachers but could be done through forming partnerships with interested educators and universities.

6 Start drug misuse education earlier through the pilot of primary-level programmes, learning from ongoing education work on wellbeing in the primary education and community sectors.

7 Promote stronger advocacy from Drug and Alcohol Task Forces on:
   - Areas of Government policy and legislation relating to substance misuse, for example, learning lessons from the Public Health (Alcohol) Bill 2015
   - The central question of social and economic inequality and its connection with substance misuse.

8 Provide support for an interagency collaborative approach to education, awareness, and intervention on substance misuse.

9 Continue to support the essential roles of the key stakeholders, including statutory agencies, the Department of Education, community and youth projects, schools, parents and carers.

10 Ensure that any actions relating to Dublin's north inner city respond appropriately to the particularly difficult and tense atmosphere there at this time.

Lucy Dillon

1 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. https://www.drugsandalcohol.ie/27603/

2 North Inner City Drug and Alcohol Task Force (2017) *Report of 'Let's get specific' prevention and education forum*. Dublin: North Inner City Drug and Alcohol Task Force. https://www.drugsandalcohol.ie/29220/

Prevention interventions targeting at-risk youth: Targeted Youth Funding Scheme

Based on the recommendations of a value-for-money and policy review,[1] the Department of Children and Youth Affairs (DCYA) is developing a single 'fit-for-purpose youth scheme'.

Value-for-money review

In 2014, the DCYA published a value-for-money and policy review of three youth programmes targeting youth at risk: the Special Projects for Youth (SPY); the Young People's Facilities and Services Fund (YPFSF); and the Local Drugs Task Force (LDTF) projects.[1] While the three programmes have different origins, they share similar objectives and target similar groups of young people. The programmes generally target 10–21-year-olds in areas characterised by problem drug use, educational disadvantage, criminal activity, unemployment, and homelessness. Preventing the onset of or reducing drug-taking is a common focus of the three programmes. The review highlighted the ongoing social and economic challenges being faced by young people in Ireland and concluded that 'there remains a valid rationale for the provision of youth programmes for young people who are disadvantaged' (p. 67).[1] However, the review was heavily critical of the governance structures underpinning the three programmes and the lack of conclusive evidence relating to their efficacy, that is, a lack of effective performance measurement. However, it also argued that 'there is promising academic support that, effectively harnessed, these programmes can make a difference' (p. 10).[1] It therefore called for 'significant reform' (p. 10)[1] of the programmes and of their performance governance arrangements and, to this end, made a set of 12 recommendations.

Single scheme

Since the review, work has been ongoing at the DCYA to implement its recommendations. In the meantime, the programmes have continued to be funded: in 2012, the combined spend on the three programmes was €39.7m and by 2017 this had reduced to €36.8m. To deliver on the recommendations, the DCYA has undertaken an extensive programme of work including reviewing evidence and stakeholder engagement. This is informing the development of a single funding scheme that aims to 'replace the existing funding programmes with a single fit-for-purpose youth scheme, targeting disadvantaged young people with evidence informed interventions and services that will secure good outcomes' (p. 4).[2] For the purpose of the design and development phase of the process, the new scheme is referred to as the Targeted Youth Funding Scheme (TYFS).

The purpose of the TYFS is 'to support young people to overcome adverse circumstances by strengthening their personal and social competencies' (p. 6).[2] Therefore, it is based on a belief that building on these so-called 'soft' outcomes will impact positively on outcomes such as employability, developing career aspirations, and decreasing violent behaviour and drug use. The programme will therefore primarily focus on intervening at the level of the individual young person. The TYFS has identified seven personal and social development competencies as core to the programme: communication skills; confidence and agency; planning and problem-solving; relationships; resilience and determination; self-discipline; and, emotional intelligence.

Within the three target groups identified for the programme are those young people experiencing economic and social and cultural disadvantage, including those living in communities with high concentrations of addiction, as well as those who are 'vulnerable or at risk', including those considered so because of substance use. Stakeholder engagement is ongoing in the restructuring of these programmes and it is expected that the first cycle of the new structure will begin in January 2020.

Lucy Dillon

1 Department of Children and Youth Affairs (2014) *Value for money and policy review of youth programmes.* Dublin: Government Publications. https://www.drugsandalcohol.ie/23242/

2 Department of Children and Youth Affairs (2018) Unpublished internal circular on 'Stakeholder engagement: Targeted Youth Funding Scheme. Scheme outline April 2018'.

Responding to excessive alcohol consumption in third-level (REACT): a study protocol

High levels of alcohol use have been found among third-level students in Ireland. In 2014, the Health Service Executive (HSE) commissioned a research team to develop a public health intervention to address alcohol use among third-level students. Responding to Excessive Alcohol Consumption in Third-level (REACT)[1] was developed in collaboration between the Health Matters team at University College Cork, the Irish Student Health Association, and the Union of Students in Ireland (USI).

REACT is currently being implemented in 15 higher education institutions across Ireland (personal communication, REACT project, June 2018). The aim of the programme is to 'strategically tackle harms associated with alcohol consumption among third-level students'. Evaluation of this programme is currently underway; therefore, evaluation findings from the programme are not yet available. However, a paper has been published outlining the study protocol for developing, implementing, and evaluating the programme.[2]

The REACT programme

REACT is defined as a multicomponent intervention. It is described by the paper's authors as forming part of the wider Health Promoting University ethos endorsed by the World Health Organization.[3] The concept of the Health Promoting University 'means much more than health education for students and staff – it means integrating health into the culture, processes and policies of the university' (p. 5). A defining feature of the programme is that it is an environmental rather than an educational initiative.

Development of the programme was based on a three-step process involving a review of international best practice, a knowledge exchange forum, and expert consultation. The programme 'seeks to establish a specially tailored accreditation and award system for third-level institutions (colleges/universities/institutes of technology) that make significant changes within their campuses to tackle the growing issue of excessive alcohol consumption among students' (p. 2).[2]

Table 1: Mandatory action points of the REACT Award Scheme

	Action point	Description
1	All incoming students are strongly encouraged to take an online brief intervention tool	A target of 33% of incoming first-year students to have completed e-PUB (or other brief intervention tool if already in place) must be met before a college/university/institute of technology is deemed to have achieved this mandatory action point. Statistics should be presented to a relevant college committee on an annual basis
2	Develop a college alcohol policy in line with the 'National Framework to Develop a College Alcohol Policy'	Develop a college alcohol policy in line with the 'National Framework to Develop a College Alcohol Policy'
3	President of the college commits to the REACT programme	The President of the college (or equivalent management figure) signs a 3 year commitment to the college actively pursuing the criteria set out by the REACT programmes Action Point List
4	Form a Steering Committee of staff and students, chaired by a senior college official, that meet twice a year (minimum) and review the Action Plan annually	Form a Steering Committee which will: a) Have student and staff representation b) Be chaired by a senior college official c) Have a member of the Gardaí, a member of the local council and a member of the Local Drugs and Alcohol Task Force as committee members d) Meet a minimum of twice a year e) Review the college Alcohol Action Plan annually
5	Safety issues in the context of alcohol must be considered while planning all large scale students events	An agenda item of alcohol and safety issues must be present and discussed on the agenda of all SU, Societies and Clubs planning meetings related to any large scale student entertainment events at which alcohol will be available, e.g. College Balls, Gigs, R&G, etc.
6	Establish a tracking and reporting mechanism for key alcohol related harm indicators	Establish a tracking and reporting mechanism that will track key alcohol related harm indicators, e.g. injuries, anti-social behaviour, harm to relationships, studies, etc.
7	The college completes its own evaluation of the effectiveness of the alcohol action plan every 3 years	The college devises and completes an evaluation strategy to monitor the effectiveness of the alcohol action plan every 3 years
8	Train relevant staff in Brief Intervention Training	Ensure key individuals in student health and the student experience are able to deliver Brief Intervention Therapy around alcohol misuse and have a clear understanding of the internal referral pathways

Source: http://reactalcohol.ie/

REACT continued

Participating third-level institutions are required to carry out activities from a suite of mandatory and optional action points. Lists of these are provided below (see Tables 1 and 2). The participating institution must complete all eight of the action points in Table 1 as well as 16 points from the actions in Table 2, including at least two action points of a 'three point' ranking. Institutions can then apply to the REACT team for their award. Once the application is received, an evaluator will be appointed to meet with the institution's steering committee to discuss the implementation and associated accreditation/award. The details of the content of the accreditation/award were under development at the time of writing.

Table 2: Optional action points of the REACT Award Scheme

	Action point	Description
1	Designate a specific college official to have overall responsibility for the REACT project **(1 point)**	Designate a specific college official to have overall responsibility for the college's REACT programme
2	Develop a calendar of events in conjunction with local Students' Union **(2 points)**	Develop a calendar of events in conjunction with local Students' Union which requires proactive planning
3	Develop reporting mechanism for tracking high risk promotions by local licensees **(3 points)**	Develop reporting mechanism for tracking high risk promotions by local licensees
4	REACT Training Toolkit is utilised at class rep training to provide them with relevant safety information **(1 point)**	a) The REACT Training Toolkit (available via the WebApp) is utilised for a session at class rep training annually with a special emphasis placed upon safety b) Members of Clubs and Societies for which this would hold relevance in event planning are invited to this training
5	Alcohol counselling service available to students **(3 points)**	Provide an alcohol counselling service to the student body
6	Hold an annual meeting with local stakeholders **(1 point)**	Hold a minimum of one meeting annually with local stakeholders (e.g. local Gardaí, local residents, local businesses, etc.) as a forum to discuss grievances and suggestions related to students excessive alcohol consumption
7	Develop a visible and accessible referral pathway to a range of internal and external alcohol support services for students **(2 points)**	Develop a visible and accessible referral pathway to a range of internal and external alcohol support services for students. In addition: a) The pathway will include and promote a self-referral route for students b) Training and information relating to the pathway is to be offered to front line staff of the college every two years
8	Provide alcohol free housing and alcohol free social spaces **(3 points)**	Provide: a) Alcohol free housing b) Alcohol free social spaces
9	Partnerships developed with relevant local community groups **(1 point)**	Partnerships developed with relevant local community groups (e.g. local council, healthy cities committee, etc.)
10	Provide late night transport to student accommodation **(2 points)**	Provide late night transport to student accommodation for college events/nights out
11	Develop and implement a Student Community Support system **(3 points)**	Develop and implement a Student Community Support system for key student weeks (e.g. R&G Week, Freshers' Week, etc.)
12	Allocate space for Alcoholics Anonymous **(2 points)**	Make contact with and allocate space for Alcoholics Anonymous to hold meetings for college students
13	Map local licensed premises **(2 points)**	Map and update (every 2 years) all local licensed premises
14	Require RSA training for all on campus bar staff **(2 points)**	Require Responsible Serving of Alcohol (RSA) training for all on campus bar staff
15	Use the Alcohol Use Disorders Identification Test (AUDIT) as preferred measure of drinking patterns and alcohol-related harm **(3 points)**	Use AUDIT scale when measuring drinking patterns and alcohol related harm in health research projects focused on students
16	Conduct robust qualitative alcohol related research with students **(3 points)**	Conduct a high level alcohol related qualitative research project with students
17	Enable PhD/Academic researcher to conduct a study on your Action Plan **(3 points)**	Enable PhD/Academic researcher to conduct a study on the effectiveness of the interventions within your Action Plan
18	Provide all of the relevant college data related to the Action Plan to the National REACT co-ordinator/researcher **(3 points)**	Provide all of the relevant college data related to the Action Plan to the National REACT co-ordinator/researcher for inclusion in national research

Source: http://reactalcohol.ie/

REACT continued

Implementation and evaluation

REACT will be implemented and evaluated in line with the UK Medical Research Council's framework guidelines, which aim to help researchers and research funders to recognise and adopt appropriate methods for working on complex interventions (those containing several interacting components). The framework identifies several phases involved in the process of developing and evaluating a complex intervention, although these phases may not necessarily follow a linear sequence: developing an intervention, piloting and feasibility, evaluating the intervention, and implementation.

The REACT evaluation will consist of a number of elements. To begin with, a baseline and follow-up cross-sectional study will be conducted to determine any potential impact of the REACT programme. This study will examine alcohol consumption levels and other related behaviours as well as attitudes among students. It will incorporate the AUDIT (Alcohol Use Disorders Identification Test) and other questions based on a review of national and international research.

The baseline study was conducted at the end of 2016 (n=1873), and the follow-up study is due to be repeated in the same institutions in the autumn of 2018.

Alongside the impact evaluation, a qualitative study will be conducted to explore perceived factors influencing the take-up and implementation of the programme. Research examining students' views on the programme and on alcohol more generally will be carried out in a separate study. The authors highlight that the REACT programme 'provides a structure to translate policy into practice and to tackle hazardous alcohol consumption and related harms among third-level students' (p. 7). The 15 institutions currently signed up to the programme are in the process of implementing the mandatory and optional action points. The REACT team are working on developing the accreditation framework for the programme and aim to have their first accreditation by 2019.[1]

Lucy Dillon

1 For further information on the programme, visit http://reactalcohol.ie/

2 Davoren MP, Calnan S, Mulcahy J, Lynch E, Perry IJ and Byrne M (2018) Responding to excessive alcohol consumption in third-level (REACT): a study protocol. *BMC Health Services Research,* 18(1): 364. https://www.drugsandalcohol.ie/29015/

3 Tsouros AD, Dowding G, Thompson J and Dooris M (eds) (1998) *Health promoting universities: concept, experience and framework for action.* p. 174. Copenhagen: World Health Organization Regional Office for Europe. https://www.drugsandalcohol.ie/29173/

Optimising treatment in opioid dependency in primary care

The majority of opioid agonist treatment (OAT) in Ireland is provided through general practitioners (GPs), who undergo additional training, and through the Methadone Treatment Programme (MTP), which has been running for 20 years. Over this period, however, misuse of over-the-counter (OTC) and prescription medication use has increased. Increases in waiting times for treatment and drug-related deaths have occurred despite a scaling up of OAT in Ireland. The aim of this study[1] was to make recommendations to improve OAT and MTP treatment.

Methods

A single focus group containing 11 pre-selected national key stakeholders and experts took part in a guided one-off discussion. A broad range of expertise was represented, including clinical, addiction and social inclusion management, harm reduction, homelessness, specialist GPs, and academics. Three participants came from national non-statutory agencies, while the majority of the panel oversaw OAT design and implementation. A written guide exploring relevant issues around OAT and MTP was used in the focus group discussion. Transcripts of the audio recording were subjected to content analysis to generate overall themes.

Results

Four themes emerged from the content analysis of the discussion on current barriers within treatment and possible solutions: OAT choices and patient characteristics; systemic barriers to optimal OAT service provision; GP training and registration in the MTP; and solutions and models of good practice: using what you have. The main barriers and solutions raised were as follows.

OAT choices and patient characteristics

- There was lack of choice in OAT; Suboxone® use is restricted, whereas methadone is widely available yet viewed more negatively by patients.
- There was a change in characteristics of those seeking OAT; with OTC opioid abuse becoming more prevalent, accessing treatment is proving difficult for the new cohort of patients both in terms of location and stigma associated with some addiction services.
- Treatment pathways for polydrug use are lacking.
- Patients' behavioural issues often require measures at methadone dispensing pharmacies. This was keenly felt in regard to all female practices supervising male patients.
- The age profile of long-term methadone users may limit the relevance of any new treatment models.
- The current long-term MTP was described as complex and overly medicalised (e.g. tapering) and requires a broader approach.

Systemic barriers to optimal OAT service provision

- Provision of OAT was described as urban-centric, creating a logistical barrier for rural patients.
- The sole route of treatment is often through large methadone clinics that may be off-putting for some patients.
- Complexities around patient's addresses can limit the available services.
- Waiting lists for treatment and the requirement for regular consultations exist.

Opioid dependency in primary care continued

- Stipulations on referring patients to Level 1 GPs[2] and restrictions in numbers managed by Level 1 GPs exist.

GP training and registration in the MTP

- Complexity around registration with the Health Service Executive (HSE) and the negative perception of OAT were viewed as affecting the uptake of Level 1 and 2 training.
- GP registrars not exposed to the opioid-dependent cohort were seen to be less willing to be involved in training and OAT.
- Level 1 and 2 structures were viewed as too complex for new GPs entering employment in services that do not currently have MTP.
- Difficulties around becoming a Level 2 prescriber exist.
- In some areas, GPs were seen as unwilling to take on complex patients due to a lack of resources.

Solutions and models of good practice: using what you have

- The training of all GPs in methadone prescribing and other OAT was seen as a way to change attitudes.
- Supports, such as counselling, that are available in clinics should be available in some capacity to GP services.
- Informal support meetings within GP practices or telemedicine to deal with the complexity of some cases should be available.
- Family support systems should be used from the outset, in addition to shared care and key working.
- The potential for community pharmacies and nurses to contribute to care, including necessary vaccinations, should be realised.

Conclusions

This study was a first step in identifying barriers to optimal OAT provision. Key experts identified a number of possible solutions that the Irish College of General Practitioners (ICGP) will seek to advance in the relevant arenas and expand upon through further independently run research.

Limitations

The authors acknowledge a number of limitations to the research, including the use of a single focus group containing 11 pre-selected experts; the sample not likely to be nationally representative of experiences or opinions; no patient voices were included; and involvement of members of the ICGP's Substance Misuse Programme in discussion and facilitation may have limited the views shared by others in the group.

Michael O'Sullivan

1 Van Hout MC, Crowley D, McBride A and Delargy I (2018) Optimising treatment in opioid dependency in primary care: results from a national key stakeholder and expert focus group in Ireland. *BMC Family Practice,* 19(1): 103. https://www.drugsandalcohol.ie/29270/

2 Level 1 refers to GPs trained in addiction treatment but not to an advanced level. Level 2 registration refers to GPs with advanced addiction specialist training.

Reducing the harms of cocaine use in Ireland

On 17 July 2018, a new campaign developed by the Ana Liffey Drug Project and the Health Service Executive (HSE) was launched to raise awareness of the dangers of using cocaine (powder and crack) and on how to reduce the harms associated with snorting, smoking or injecting cocaine.[1] The Republic of Ireland currently ranks fourth highest in the European Union for cocaine use among young adults. In addition, cocaine remains the third most common drug reported among people presenting to treatment services in Ireland; in 2016, 12.3% of cases reported problem cocaine use, the highest proportion since 2010. While the campaign will stress that it is always safest not to take unknown or illicit drugs at all, if a person chooses to use cocaine, the campaign provides harm reduction advice. This includes the following:

- When buying, know the source and avoid using alone.
- Use one drug at a time.
- Start with a small test dose and leave at least two hours between doses.
- Grind cocaine to remove small lumps; use a sterile straw and do not share.
- Carry a condom as cocaine use may increase sex drive and lead to unprotected sex.

Research indicates that regular clubgoers and people that are part of the club/dance music scene have higher rates of drug use compared to the general population. With this in mind, the awareness campaign will target clubs and public event spaces, colleges, and addiction services with information about cocaine powder. In addition, drug services, clinics, and Drug and Alcohol Task Forces will be targeted with information about crack.

Minister of State for Health Promotion and the National Drugs Strategy, Catherine Byrne TD, welcomed the campaign and stated:

> *This is a very important campaign, focusing on providing information and raising awareness about cocaine among drug users and health professionals .... Through our national drugs strategy, 'Reducing Harm, Supporting Recovery', we are working to strengthen early harm reduction responses to current and emerging trends and patterns of drug use, which would benefit people who use drugs, their families and the community.*

Seán Millar

1 Health Service Executive (2018) *Cocaine – reduce the harms.* Dublin: Health Service Executive. Available online at: https://www.hse.ie/eng/services/news/media/pressrel/cocaine-reduce-the-harms.html

Opioid substitution treatment for heroin-dependent adolescents

Opioid dependence is a major health concern across the world. The most recent prevalence estimates of opiate use in the Republic of Ireland indicate that there were 18,988 opioid users in Ireland in 2014, giving a rate of 6.18 per thousand population aged 15–64 years (95% CI: 6.09–6.98).[1] Six per cent of this estimated population was under 24 years of age. Although recent trends suggest that the prevalence of problem opiate use in Ireland may have stabilised, it should be noted that estimates remain high, with other comparable studies suggesting that rates of use remain among the highest in Europe. Opioid substitution treatment (OST) is the main first-line treatment intervention for heroin dependence among adults. Nevertheless, while OST has been thoroughly evaluated in adult populations, few studies have examined its use in younger age groups, and there are concerns that OST is underutilised in adolescents with heroin dependence.

A recent Irish study investigated changes in drug use among adolescents receiving OST and also examined treatment attrition during the first 12 months of treatment.[2] In this study, published in the BMC journal *Pediatrics*, data on all heroin-dependent patients (aged under 18.5 years) commencing OST were examined from one outpatient multidisciplinary addiction treatment service in Dublin. Drug use was monitored twice weekly using a urine drug screen (UDS). Change in the proportion of UDS negative for heroin was examined using the Wilcoxon signed-rank test. Attrition was explored via a Cox regression multivariate analysis.

Results

It was found that of 120 patients who commenced OST (51% female, mean age 17.3 years), 33% (n=39) persisted with OST until month 12. Of these patients, heroin abstinence was 21% at month 3 and 46% at month 12, although heroin use declined significantly from baseline to month 3 ($p<0.001$) and from month 3 to month 12 ($p=0.01$). Use of other drugs did not change significantly. Among factors associated with heroin abstinence, the study observed the following:

- None of the patients who had a previous psychiatric admission were abstinent ($p=0.02$).
- All of the patients who were using cocaine during month 12 were also using heroin ($p=0.02$).
- Abstinence was not significantly associated with a higher medication dose ($p=0.88$).
- Early reductions in heroin use, as evidenced by provision of at least one heroin negative sample during induction, tended to be associated with reduced likelihood of heroin abstinence at month 12 ($p=0.07$).

Cox regression analyses indicated that patients who had no children, grew up in families with two parents, were in an intimate relationship with another heroin user, and who were abstinent from cocaine in pre-treatment drug screens demonstrated significantly lower rates of unplanned exit from treatment.

Conclusions

The authors concluded that the study confirmed that adolescents on OST can achieve substantial reductions in heroin use, with many doing so very early in treatment. In addition, after a year of treatment, almost one-half of adolescent heroin users were heroin-abstinent. The authors state that these findings should act as source of optimism for clinicians. Nevertheless, patient dropout from treatment remains a challenge and cocaine use before and during treatment may be a negative prognostic factor.

Seán Millar

1 Hay G, Jaddoa A, Oyston J, Webster J, Van Hout MC and Rael dos Santos A (2017) *Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods*. Dublin: National Advisory Committee on Drugs and Alcohol. https://www.drugsandalcohol.ie/27233/

2 Smyth BP, Elmusharaf K and Cullen W (2018) Opioid substitution treatment and heroin dependent adolescents: reductions in heroin use and treatment retention over twelve months. *BMC Pediatrics*, 18: 151. https://www.drugsandalcohol.ie/29019/

Tabor Group annual report, 2017

The Tabor Group is a provider of residential addiction treatment services in Ireland. It aims to offer hope, healing, and recovery to clients suffering from addictions through integrated and caring services. In addition to three residential facilities, the organisation provides a continuing care programme to clients who have completed treatment in order to assist with their recovery. It also offers counselling to families whose loved ones are struggling with an addiction. In June 2018, the Tabor Group published its annual report.[1] This article highlights services provided by the Tabor Group to individuals with a substance use addiction in 2017.

Tabor Lodge: residential addiction treatment centre

Tabor Lodge is a residential addiction treatment centre for the treatment of people addicted to alcohol, drugs, gambling, and food. It is situated 15 miles south of Cork city. Tabor Lodge is guided by the Minnesota Model of addiction treatment in delivering its treatment programme. This model is characterised by the understanding that addiction is primarily a substance use disorder. The primary focus of the treatment programme is to educate clients on the dynamics of this disorder as they manifest in the life of the individual. Another important focus of the treatment programme is to assist clients develop the skills necessary to manage their disorder while going forward in their lives.

Tabor Group continued

A total of 213 clients (67% male) were admitted to Tabor Lodge for residential treatment of addiction in 2017, of whom 183 completed treatment. A breakdown of the specific drug of choice for admissions in 2017 is shown in Table 1. The report noted that clinical staff at Tabor Lodge have observed a changing profile of clients presenting for treatment in recent years, with mental health challenges and a history of childhood trauma becoming more evident.

Table 1: Specific drug of choice for clients admitted to Tabor Lodge: residential addiction treatment centre, in 2017

Drug of choice	Number of clients	Percentage of clients
Opiates	18	8%
Cocaine	23	11%
Cannabis	9	4%
Alcohol	138	65%
Stimulants	3	1%
Hypnotic and sedatives	9	4%
Other substances	1	0.5%

Source: Tabor Group (2018)[1]

With this in mind, staff at Tabor Lodge have become more informed about childhood trauma as a contributing factor to the development of addiction, and as a hindering factor in efforts to manage addiction disorders. In 2017, Tabor Lodge responded to the greater prevalence of clients presenting for treatment with history of childhood trauma by initiating a training programme. This is to ensure Tabor Lodge becomes more 'trauma informed' as an agency treating adults vulnerable to the ongoing debilitating impact of childhood trauma.

Fellowship House: men's residence extended treatment centre

The extended treatment programme for men is based on the Hazelden Minnesota Model and promotes 'total abstinence'. The aim is to build on and consolidate the work of recovery which has already begun in primary treatment – even if that treatment was not in the recent past and the client is struggling to maintain sobriety.

Table 2: Specific drug of choice for clients admitted to Fellowship House: men's residence extended treatment centre, in 2017

Drug of choice	Number of clients	Percentage of clients
Alcohol	43	88%
Ecstasy	43	88%
Cannabis	44	90%
Cocaine	42	86%
Prescribed medication	36	73%
Heroin	13	27%
Methadone	9	18%
Speed	36	73%
LSD	28	57%
Other/Headshop	23	47%

Source: Tabor Group (2018)[1]

In 2017, some 49 clients were admitted to Fellowship House for extended treatment: 13 of these were referred directly from Tabor Lodge and 36 were referrals from other centres around Ireland. A total of 36 individuals completed the programme. A breakdown of the specific drug of choice for admissions to Fellowship House in 2017 is shown in Table 2. The report observed that cannabis remains high at 90%, with alcohol and ecstasy coming a close second at 88%. The report also noted that a majority of clients admitted for treatment are presenting with polydrug use, specifically the use of alcohol with other drugs.

Renewal: women's residence extended treatment centre

Renewal works with women who have completed a primary 28-day treatment programme. It is a 12-week residential extended treatment programme where clients learn to find routine, balance and structure. Renewal is the only Minnesota Model extended treatment centre for women based in Ireland and was opened in 1999.

In 2017, some 46 clients were admitted to Renewal, of which 25 completed the programme. Almost 60% of these clients were aged between 18 and 35 years. A breakdown of the specific drug of choice for admissions to Renewal in 2017 is shown in Table 3. In this year, all of the clients admitted presented with a history of alcohol abuse. However, the report also noted that there has been a considerable rise in the number of young women presenting with alcohol addiction alone.

Table 3: Specific drug of choice for clients admitted to Renewal: women's residence extended treatment centre, in 2017

Drug of choice	Number of clients	Percentage of clients
Alcohol	46	100%
Ecstasy	21	46%
Cannabis	31	67%
Cocaine	26	57%
Prescribed medication	24	52%
Heroin	7	15%
Methadone	3	7%
Speed	15	39%
LSD	6	13%

Source: Tabor Group (2018)[1]

In addition to group therapy, lectures and one-to-one counselling, the programme at Renewal also arranges family conferences, which help clients to reconnect with their families as well as educating families about addiction and offering them support. The programme also works in partnership with Tusla, the Child and Family Agency, as many women have children in care and need help reconnecting and rebuilding the parent/child relationship.

Seán Millar

1 Tabor Group (2018) *Tabor Group annual report 2017*. Cork: Tabor Group. https://www.drugsandalcohol.ie/29138/

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**

PREVALENCE AND CURRENT SITUATION

Alcohol-related presentations to emergency departments in Ireland: a descriptive prevalence study

McNicholl B, Goggin D and O'Donovan D (2018) *BMJ Open,* 8(5): e021932
https://www.drugsandalcohol.ie/29070/

The aim was to determine the prevalence of alcohol-related presentations in all 29 emergency departments (EDs) in Ireland and compare with non-alcohol-related presentations in order to identify opportunities for improvements in the quality of patient care and related data collection.

Alcohol-related presentations are a significant burden on EDs and ambulance services, especially in the early hours of Sunday mornings. Addressing the alcohol-related burden on EDs requires improvements in data collection and information systems, the development of appropriate interventions and related referral services and better preventive actions for alcohol-related harm.

Opioid substitution treatment and heroin dependent adolescents: reductions in heroin use and treatment retention over twelve months

Smyth BP, Elmusharaf K and Cullen W (2018) *BMC Paediatrics,* 18(1): 151.
https://www.drugsandalcohol.ie/29019/

Opioid dependence is a major health concern across the world and does also occur in adolescents. While opioid substitution treatment (OST) has been thoroughly evaluated in adult populations, very few studies have examined its use in adolescents. There are concerns that OST is underutilised in adolescents with heroin dependence. We sought to measure changes in drug use among adolescents receiving OST and also to examine treatment attrition during the first 12 months of this treatment.

We found that heroin dependent adolescent patients achieved significant reductions in heroin use within three months of starting OST and this improved further after a year of treatment, about half being heroin abstinent at that stage. Patient drop out from treatment remains a challenge, as it is in adults. Cocaine use before and during treatment may be a negative prognostic factor.

'An inside job': an autobiographical account of desistance

Hart W and Healy D (2018) *European Journal of Probation,* Early online.
https://www.drugsandalcohol.ie/29373/

This article presents an autobiographical account of one man's journey towards a crime-free life. The narrative reveals a change process that is at once personal and universal, and describes the external forces that shaped his pathway to desistance as well as his experiences of personal fortitude and agency. In addition, it highlights the role of probation supervision as a catalyst for change. The autobiographical account is accompanied by a reflective academic commentary that situates these personal life experiences within the wider desistance literature.

Maternal alcohol consumption during pregnancy and the risk of autism spectrum disorders in offspring: a retrospective analysis of the Millennium Cohort Study

Gallagher C, McCarthy FP, Ryan RM and Khashan AS (2018) *Journal of Autism and Development Disorders,* 48(11): 3773–82.
https://www.drugsandalcohol.ie/29334/

The objective of this retrospective analysis of the longitudinal Millennium Cohort Study was to examine whether maternal alcohol consumption in pregnancy (MACP) is associated with the development of childhood autism spectrum disorders (ASD).

Alcohol consumption during pregnancy was not associated with the risk of developing ASD in this study cohort.

Recent publications continued

Piloting online self-audit of methadone treatment in Irish general practice: results, reflections and educational outcomes

Van Hout MC, Crowley D, McBride A and Delargy I (2018) *BMC Medical Education,* 18(1): 153.
https://www.drugsandalcohol.ie/29273/

The purpose of this audit is to assess the quality of care provided to patients against an agreed set of national standards, enhance learning, and promote practice improvement and reflective practice. The aim was to present an online MTP self-audit and evaluate results from a 12-month pilot among GPs providing methadone maintenance treatment (MMT) in Ireland.

Results from this audit demonstrate a high level of compliance with best practise MMT guidelines by Irish GPs providing MMT. The online self-audit process was well received and encouraged reflective practice. The audit process hinged on the individual GP's ability to review and critically analyse their professional practice, and manage change. This model of audit could be adapted and used to monitor the management of other chronic illnesses in general practice.

Optimising treatment in opioid dependency in primary care: results from a national key stakeholder and expert focus group in Ireland

Van Hout MC, Crowley D, McBride A and Delargy I (2018) *BMC Family Practice,* 19: 103.
https://www.drugsandalcohol.ie/29270/

The aim was to explore the views of national statutory and non-statutory stakeholders and experts on current barriers within the National Methadone Treatment Programme (MTP) and broader opioid agonist treatment (OAT) delivery structures in order to inform their future design and implementation.

The study identified a series of improvement strategies which could reduce barriers to access and the stigma associated with OAT, optimise therapeutic choices, enhance interagency care planning within the MTP, utilise the strengths of community pharmacy and nurse prescribers, and recruit and support methadone prescribing GPs in Ireland.

A prospective, observational study investigating the use of carbon monoxide screening to identify maternal smoking in a large university hospital in Ireland

Reynolds CME, Egan B, Kennedy RAK, O'Malley EG, Sheehan SR and Turner MJ (2018) *BMJ Open,* 8(7): e022089.
https://www.drugsandalcohol.ie/29376/

This study evaluated breath carbon monoxide (BCO) testing in identifying maternal smokers as well as the difference between disclosers and non-disclosers of smoking status. We also investigated if other extrinsic factors affected the women's BCO levels in pregnancy.

Based on self-report and BCO levels, a quarter of women presenting for antenatal care continued to smoke, but only 60% reported their smoking to midwives. BCO measurement is an inexpensive, practical method of improving identification of maternal smoking, and it was not affected by extrinsic sources of BCO. Improved identification means more smokers can be supported to stop smoking in early pregnancy potentially improving the short-term and long-term health of both mother and child.

POLICY

Ireland's Public Health (Alcohol) Bill: a critical discourse analysis of industry and public health perspectives on the Bill

Calnan S, Davoren MP, Perry IJ and O'Donovan Ó (2018) *Contemporary Drug Problems,* 45(2): 107–126.
https://www.drugsandalcohol.ie/28974/

The proposal to introduce a Public Health (Alcohol) Bill marks a significant development in Ireland's alcohol policymaking landscape. While the Bill has generated support from public health advocates, it has also raised considerable opposition, particularly from industry. This analysis aims to examine the debate around this Bill using the theoretical framework of critical discourse analysis and applying Carol Bacchi's *What's the Problem Represented To Be* critical mode of analysis. A key objective is to analyze the current prevailing representations of alcohol and its regulation in Ireland but also to consider what they reveal about the underlying governing rationality in relation to alcohol regulation. In particular, it questions whether the Bill signals a shift in the official governing rationality regarding alcohol regulation.

The analysis illustrates how alcohol is problematized in markedly different ways in the debates and how such debates are often underpinned by multifaceted elements. Despite such differences, it argues that there are still signs of a neoliberal rhetoric emerging within the public health discourses, raising a question over whether the Bill and its supporting discourses signal a paradigmatic shift or are more indicative of a policy embracing hybrid forms of rule.

Harmonising alcohol consumption, sales and related outcomes data across the UK and Ireland: an insurmountable barrier to policy evaluation?

Jordan J-A, McCann M, Katikireddi SV and Higgins K (2018) *Drugs: Education, Prevention and Policy,* Early online.
https://www.drugsandalcohol.ie/29377/

We aimed to assess the comparability of Northern Ireland (NI) and Republic of Ireland (RoI) alcohol-related data to determine their suitability for evaluating the effectiveness of alcohol policies on alcohol consumption, sales, and related outcomes.

The NI and RoI consumption and sales data were found not to be comparable enough for use in a natural experiment study; comparability for hospital admission data was acceptable. Key barriers to comparability included variations in population coverage and lack of overlap in questionnaire topics. Data access issues made it difficult to fully determine data comparability for alcohol-related crime and deaths. By contrast, NI alcohol-related data were more comparable with other UK countries, making comparisons for the purpose of policy evaluation possible. RoI would benefit from identifying another economically and culturally similar country with comparable alcohol-related data.

Recent publications continued

RESPONSES

Age-related differences in alcohol attention bias: a cross-sectional study

Melaugh McAteer A, Hanna D and Curran D (2018) *Psychopharmacology,* 235(8): 2387–93.
https://www.drugsandalcohol.ie/29272/

Addiction models theorise that alcohol attention bias (AAB) for alcohol-related cues develops through a process of classical conditioning and that attentional processes shift from controlled to automatically modulated responses. At the point of automaticity, alcohol cues grab the attention of problem drinkers beyond conscious control and can trigger alcohol use. To fully understand this shift, AAB should be thought of as developing on a continuum from when alcohol use commences. Despite this, little is known about AAB differences in younger populations who are at an early stage in their exposure to alcohol and related cues.

This cross-sectional approach provides an insight into AAB across a key developmental period. It highlights that influential processes underpinning AAB may change and how rapidly it may approach automaticity. The implications of these findings are discussed.

Different patterns of alcohol consumption and the incidence and persistence of depressive and anxiety symptoms among older adults in Ireland: a prospective community-based study

Carvalho AF, Stubbs B, Maes M, Solmi M, Vancampfort D, Kurdyak PA, Brunoni AR, Husain MI and Koyanagi A (2018) *Journal of Affective Disorders,* 238: 651–58.
https://www.drugsandalcohol.ie/29271/

The associations of different patterns of alcohol consumption and the incidence and persistence of depressive and anxiety symptoms in older age remain unclear.

Problem drinking may increase the risk of incident probable depression and anxiety among older females. Furthermore, problem drinking led to a higher likelihood of persistent depressive symptoms in older female participants. Interventions targeting problem drinking among older females may prevent the onset and persistence of depression in this population, while also decreasing the incidence of anxiety symptoms.

Do public expenditures on health and families relate to alcohol abstaining in adolescents? Multilevel study of adolescents in 24 countries

Vieno A, Altoè G, Kuntsche E and Elgar FJ (2018) *Drug and Alcohol Review,* 37 (Suppl 1): S120–S128.
https://www.drugsandalcohol.ie/29379/

Several European countries have observed an increase in the proportion of adolescents that abstain from drinking alcohol in the last decade. The reasons for this trend remain underexplored. We hypothesised that more generous government expenditures on health services and benefits to families with children relate to a positive trend in abstainers.

More generous expenditures on health services and family benefits relate to more adolescents abstaining from alcohol.

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

Managing editor: Brian Galvin
Copy-editing: O'Hanlon Media

Health Research Board
Grattan House
67–72 Lower Mount Street
Dublin 2
D02 H638
T: 01 234 5168
E: drugnet@hrb.ie
W: www.hrb.ie