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In this issue

Evidence review on dual diagnosis

See page 3

06 Medical use of cannabis

09 Civil society and drug
policy

14 Codeine poisonings

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Launch of new Hidden Harm initiative

On 25 January 2019, the Health Service Executive (HSE) and Tusla, the Child and Family Agency jointly launched the Hidden Harm strategic statement, *Seeing through hidden harm to brighter futures*¹ and the *Hidden Harm practice guide*² in the Plaza Hotel in Tallaght, Dublin. A separate information leaflet, *Opening our eyes to Hidden Harm*,³ was also published to support frontline staff working with children impacted by parental drug or alcohol misuse.

These publications outline how the two State organisations will work together to identify and support children who are adversely affected by parental substance misuse. Joint training for HSE and Tusla staff working in this area is due to be developed in 2019.



From L to R: Minister for Children and Youth Affairs, Dr Katherine Zappone TD, and Minister of State with responsibility for Health Promotion and the National Drugs Strategy, Catherine Byrne TD, at the launch of the Hidden Harm initiative

Contents

COVER STORY

Launch of new Hidden Harm initiative	1
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POLICY AND LEGISLATION

HRB evidence review on dual diagnosis treatment service	3
Medical use of cannabis and cannabinoids: Q&A for policymaking	6
Civil society involvement in policymaking	9
Taking stock: a decade of drug policy	11

PREVALENCE AND CURRENT SITUATION

Trends in alcohol and drug admissions to psychiatric facilities	12
Global, regional and country level estimates of HCV infection among recent injecting drug users	13
Rates of reported codeine-related poisonings and codeine prescribing following new national guidance in Ireland	14
Parole Board annual report, 2017	15

RESPONSES

Updated international standards on drug use prevention	16
International Nurses Society on Addictions (IntNSA) Europe	18
Evaluation of three J-ARC pilot projects	19
Cross-border organised crime: threat assessment 2018	20
Resilience in the face of trauma: implications for service delivery	21
Evaluation of Tabor Group addiction services	22
Barriers and enablers to HCV screening and treatment in Irish prisons	23
Merchants Quay Ireland annual review, 2017	25
DOVE Clinic, Rotunda Maternity Hospital annual report, 2017	26
Twentieth Annual Service of Commemoration and Hope	28

UPDATES

Recent publications	29
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The policy, research and other documents covered in this issue of *Drugnet Ireland* have all been retrieved by the HRB National Drugs Library and may be accessed on its website www.drugsandalcohol.ie

In brief

All policy decisions involve a certain amount of anticipation and speculation, informed or otherwise. It is useful to know the range of possible outcomes so that resources can be allocated effectively and preparations made for disruptions to established patterns. Policymaking in the drugs area is sometimes reactive to changes in behaviour in certain populations, some of which may be predictable but often appear, at least to policymakers, as sudden aberrations from the expected norm.

A recent initiative¹ from the Directorate-General for Justice and Consumers at the European Commission provides a forum for debate among all stakeholders who can contribute to future-oriented policy thinking on substance use. Routine monitoring has been the mainstay of evidence-based drug policy for two decades. The indicators based on these data are now complemented by environmental, cultural, and economic information, not just to provide a wider perspective but also to find ways to respond more rapidly to an ever-changing situation.

The EMCDDA's trendspotter studies have been designed to take advantage of this wider information spectrum, and trendspotting methodology is itself a new approach to data collection and evidence synthesis. This approach will inform policy decisions around the implications for law enforcement and health services. By drawing on expertise across a range of disciplines, we will be able to refine the tools we use to both assess the current situation and observe trends over shorter time periods that would not be possible if we relied solely on routine monitoring data.

Certain drug use patterns are recognisable across Europe but each region, country, and even municipality has its own peculiar variation in drug-using behaviour. While increasingly sophisticated analytical tools will enable more refined and timely pictures of the global situation to be drawn, governments charged with implementing strategy need to examine how to adapt these tools to the local or national situation. Epidemiological analysis and law enforcement data have helped us build robust and comparable national reports. The very nature of drug-using behaviour means that these information sources will only tell us part of the story and their capacity to predict future patterns is limited. By using other kinds of data and finding ways to integrate these into established analytical systems, we will be better placed to consider what might happen and more equipped to respond to change.

¹ The FuturiZe project is a European project to boost knowledge exchange and collaboration among the primary stakeholder.

Hidden harm continued

The adverse experiences of children living with parents who misuse alcohol or other drugs have been termed 'hidden harm' because these children often remain unknown to services. Children living with parents who misuse substances are at greater risk of emotional and physical neglect and of developing mental health and substance misuse problems later in life. Through the National Hidden Harm Project, the HSE and Tusla have committed to work together to improve services and outcomes for children affected by parental problem alcohol and other drug use in Ireland.

The publications were officially launched by Minister for Children and Youth Affairs, Dr Katherine Zappone TD, and Minister of State with responsibility for Health Promotion and the National Drugs Strategy, Catherine Byrne TD. The keynote speech was given by Joy Barlow MBE. Joy Barlow is

an international expert in the field of hidden harm and was a member of the national steering group involved in producing the documents launched at the event. Dr Aisling Gillen, service director from Tusla, and Joe Doyle, planning specialist from the HSE National Social Inclusion Office, also spoke at the launch.

Claire O'Dwyer

- 1 HSE and Tusla (2019) *Hidden Harm strategic statement: seeing through hidden harm to brighter futures*. Dublin: HSE and Tusla. <https://www.drugsandalcohol.ie/30190/2/StrategicGuide.pdf>
- 2 HSE and Tusla (2019) *Hidden Harm practice guide: seeing through hidden harm to brighter futures*. Dublin: HSE and Tusla. <https://www.drugsandalcohol.ie/30190/1/PracticeGuide.pdf>
- 3 North South Hidden Harm Group (2019) *Opening our eyes to Hidden Harm: empowering frontline workers to support children and young people affected by parental problem alcohol and other drug use*. Dublin: HSE and Tusla. https://www.drugsandalcohol.ie/30190/3/Leaflet_Jan_16th.pdf

POLICY AND LEGISLATION

HRB evidence review on dual diagnosis treatment service

The Health Research Board (HRB) recently published a review entitled *Treatment services for people with co-occurring substance use and mental health problems: a rapid realist synthesis*.¹ This report is part of the HRB Drug and Alcohol Evidence Review series and was undertaken by a team from the Georgia Health Policy Center. The three initial research questions guiding the review were:

- What interventions improve treatment and personal functioning outcomes for people with co-occurring substance use and mental health problems and in what circumstances do they work?
- What aspects of integrative programmes for the treatment of co-occurring substance use and mental health problems trigger positive system outcomes and in what circumstances do these outcomes occur?
- What existing models of care for adults with co-occurring substance use and mental health problems lead to positive treatment outcomes and successful service integration?

A number of systematic reviews have examined interventions responding to specific mental health conditions or substances. These reviews were limited as they focused on particular substances or particular mental health conditions. While the evidence suggests that greater integration of mental health and addiction services leads to improved treatment outcomes, recent studies from the United States suggest that the capacity of services to provide an effective response for clients with co-occurring problems is very limited. The purpose of the HRB

realist review was to understand what aspects of the integrative process made it more likely that better treatment outcomes would be achieved. In other words, how can we get an understanding of what works for whom in what circumstances so that the integration of services benefits the users of these services.

The HRB asked the review team to take a realist approach to studying the literature on the topic. This means that they sought to identify the characteristics, or mechanisms, that are more likely to result in successful implementation of evidence-based treatments and the contexts in which this change occurs. An important aspect of the realist approach is to understand the context in which service providers and others will benefit from the knowledge contained in the review. The review team met with a number of knowledge users at an early point in the review process and, based on a thematic analysis of the discussions at these meetings, it generated 10 theory statements to guide the literature search, data extraction, and analysis (see Table 1). This theory-driven approach is an essential part of the realist synthesis process.

The literature search involved two stages, the first concentrating on studies on mental health and substance use treatment, integration of health programmes and services, and articles on integrated dual diagnosis models of care. The second stage broadened the search and looked for studies relevant to the topics of peer support, inclusion in service and care decisions, and recognition of the value of lived experience. The review team synthesised the data from the selected articles and aligned the context, mechanism, and outcomes found in the literature with each research question.

The 10 theory statements were grouped into outcome areas of **integration, access, and individual and family treatment outcomes**, and the findings of the review are presented by these outcome areas.

Evidence review on dual diagnosis treatment service continued

Table 1: Final theory statements for rapid realist synthesis

Number	Theory statement
1	Integration of existing services, particularly community-based services, supports access to care and minimises barriers faced with creation of new service lines.
2	Integrated treatment requires training and cross-training of substance use and mental health service providers at multiple levels.
3	Improved coordination between providers (substance use, mental health, and primary care) will break down administrative silos and improve access to timely diagnosis, care, and treatment.
4	Services must be tailored to the local context and the individual's needs and circumstances to be most effective.
5	Including service users and families in service and care decisions results in better outcomes for individuals and their families.
6	A knowledge of local efforts already in place and co-production with service providers and individuals with lived experience is needed to develop practice-informed strategies and policies that take known facilitators and implementation challenges into consideration.
7	Resources (financial and otherwise) must accompany strategy and policy to enable integration and improve service delivery and individual outcomes.
8	When treatment takes a holistic view and includes housing and social supports, individual outcomes are improved.
9	A holistic model to mental health is needed to improve mental health outcomes, particularly among individuals with co-occurring mental health and substance use disorders.
10	Peer support facilitates recovery and positive outcomes for individuals with co-occurring mental health and substance use disorders.

Table 2: Four-level framework providing a structure to organise potential action

Level	Potential action
Policy/System	<ul style="list-style-type: none"> • Create incentives in payment to providers for integrating care of individuals with co-occurring diagnosis • When developing service payment agreements, include deliverables that recognise the long path to recovery • Analyse the system as it relates to access to psychological services and align providers with service needs • Examine payment structure for peer mentors, coaches, and instructors • Explore how resources can be allocated to support a holistic approach to care (e.g. housing, supportive employment)
Organisation/Provider	<ul style="list-style-type: none"> • Build a knowledgeable, integrated workforce that keeps the individual at the centre • Develop a common language among different provider types, consumers, and families • Examine training modes and build in time to support provider training and cross-training to build competence and confidence • Build a culture of hope
Service/Treatment	<ul style="list-style-type: none"> • Create a learning community among the current integrated programmes • Conduct a realist evaluation of the current work and use the learnings to improve current programmes and build others • Allocate resources to support the creation of new integration pilot programmes that include resources for programmes, technical assistance, and peer support from current integrated programmes • Use the evidence from this review to guide future programme development
Individual/Family	<ul style="list-style-type: none"> • Build systems for co-production at each level of the system: policy, provider, treatment design, and individual care

Evidence review on dual diagnosis treatment service continued

Main findings

Integration

Each of the three outcome areas is associated with a different context. The mechanisms in improved integration are associated with the provider context. Alignment of organisational and financial resources with strategy and policy is needed for integration of services but it does not guarantee success. A culture of hope and an empowering collaborative climate help to build providers' confidence in their ability to implement changes in services and to address the needs of those with comorbid problems. Providers' belief that change is possible and enthusiasm for implementing these changes serve as catalysts for the change that integrated care requires. Staff confidence and hope is also developed when training is delivered in an environment that supports co-production and values the knowledge of individuals with lived experience.

When financial resources are applied in an empowering collaborative climate, formal partnerships can be developed across organisations and an open dialogue supporting a common language can develop. In this atmosphere, intermediary outcomes, such as unified case management, coordination of care, and shared treatment plans, are more likely to result and enable better integration of services.

Access

The context in relation to access mechanisms is mental health or substance use services undergoing change and seeking to work with providers of different kinds of services. In this context, staff knowledge and increased confidence related to training is associated with prompt diagnosis and consequently increased access to treatment. Staff adoption of a client-centred approach and displays of kindness are associated with increased patient engagement.

Individual and family treatment outcomes

The context for this category of outcomes is the care setting. A dominant theme under this category is the importance of engagement in treatment. Conditions that are associated with engagement are a supportive social network, progress in self-management behaviours, and stability in basic social and employment needs. A care system that works with the individual to establish a secure and stable environment makes engagement in treatment and recovery more likely.

The literature also reveals three more difficult-to-observe mechanisms that are part of this complex system: trust, flexibility, and hope. There are specific actions and orientations that contribute to trust. For example, creating an environment that is intentional about displaying simple acts of kindness will help build trust. Purposefully building flexibility into treatment through co-design will help build the conditions necessary for recovery. Building a culture of hope among providers, family, and clients through instilling confidence, self-esteem, and empowerment is critical to recovery.

Initial recommendations

The findings of this realist review and the wisdom gained from local knowledge users provide ideas on how to build an

integrated system. Local integrated programmes provide a starting place for learning and integrating knowledge about treatment and building a culture of co-production that supports putting the individual at the centre of the system.

The four-level framework that emerged from this project provides a structure to organise potential steps (see Table 2). At the policy/system level, high-leverage steps may focus on the alignment of resources. At the organisation/provider level, a focus on building a knowledgeable workforce is important. Initial recommendations, included in the table for each level, are focused on a few preliminary actions that may have high leverage and build on what currently exists. A next useful step could be a collaborative session with local Irish knowledge users to meaningfully mine the findings for appropriate actions and would be in keeping with the co-production recommendation.

Conclusion

The realist review and synthesis begins to answer the overarching question of how can integration using effective models of care improve outcomes for individuals with co-occurring mental health and substance use disorders. Integration is not a single concept related to a specific treatment or relationship among providers, but rather a complex, multifaceted portfolio of interrelated parts of a system. Central to the development of integrated models is a four-level framework for integration that is co-produced by policymakers, providers, and clients at the policy, organisation or provider, treatment, and individual levels. Policies and resources need to be aligned to create incentives for providing integrated care, while a knowledgeable, coordinated workforce keeps the individual at the centre.

Brian Galvin

- 1 Minyard K, Manteuffel B, Smith CM, Attell BK, Landers G, Schlanger M and Dore E (2019) *Treatment services for people with co-occurring substance use and mental health problems. A rapid realist synthesis*. HRB Drug and Alcohol Evidence Reviews 6. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/30376>



Medical use of cannabis and cannabinoids: Q&A for policymaking

The medical use of cannabis and cannabinoids is a complex and challenging field. There is a wide range of issues to be considered by policymakers and other stakeholders when making decisions about the best approach to take. In December 2018, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published a report on the topic to help support this process – *Medical use of cannabis and cannabinoids: questions and answers for policymaking*.¹ It is supported by a background paper: *A summary of reviews of evidence on the efficacy and safety of medical use of cannabis and cannabinoids*.²

The report focuses on four main areas in relation to the medical use of cannabis and cannabinoids: a review of the evidence for their medical use across a number of conditions; the relevant regulatory frameworks; the approaches countries have used to allow access to them; and the regulatory challenges faced. This is a detailed report and just a selection of the key findings is presented below.

In what is a very fast-moving field characterised by an often hotly contested debate, this report has sought to provide an objective look at current evidence, practice and experience. (p. 34)¹

Which substances are being discussed?

Broad terms such as ‘medicinal cannabis’ are often used when discussing this topic. The report highlights the need to define in a clearer way the kinds of substances involved. A broad typology is presented which makes a distinction between medicinal products that have a marketing authorisation (i.e. they have been authorised by a regulatory body as a medicinal product) and other cannabis preparations that have not been authorised for medical use (see Figure 1).

What evidence is there that cannabis and cannabinoids have medical uses?

A summary of the evidence on the medicinal properties of cannabis and cannabinoids from systematic reviews of randomised controlled clinical trials is presented in the first part of the report.^{1,2} The report notes that interest in potential medical uses was only revived in the 1990s following the discovery of a cannabinoid system in the brain. This discovery suggested that cannabinoids could be used to treat chronic pain and neurological disorders such as multiple sclerosis and epilepsy. Therefore, it is acknowledged that there are gaps in the current evidence base and large well-conducted studies are scarce. See Table 1 for a summary of the key findings of the review of systematic reviews.

What approaches have countries used?

Overall, the report highlights the variation in approaches taken to allow access to cannabis and cannabinoids for medicinal

use both within Europe and globally. They varied not only in terms of the actual products or preparations allowed, but also the regulatory frameworks adopted to control their provision. Three broad types of approach were identified, with countries often using more than one in parallel.

- 1 Allowing the use of medicinal products containing cannabinoids:** Some countries have given market authorisation to medicinal products, thereby making them available for prescription.
- 2 Allowing the medical use of unauthorised products or preparations:** Special access schemes have been established in some countries to allow for the medical use of unauthorised products or preparations. For example, it has been done as an interim measure while awaiting the findings of a clinical trial for a product or its authorisation. Others are made available on compassionate grounds and on a case-by-case basis. Physicians’ reluctance to prescribe for ethical and medico-legal reasons has presented major challenges to this approach.
- 3 De novo stand-alone medical cannabis programmes:** Some countries have set up programmes that are outside the medicines regulatory systems. For example, in the United States the regulatory requirements for medicines were avoided by passing referendums allowing access to cannabis for broadly defined medical reasons. The authors note that this approach does not facilitate the conduct of clinical trials or establish an evidence base on which to assess the impact of these programmes.

What are the regulatory challenges?

The final part of the report highlights some of the regulatory challenges in allowing the medical use of cannabis and cannabinoids – in this context the authors are not talking about medicinal products rather cannabis preparations. They identify a number of questions, including:

- What types of products or preparations should be allowed?
- What forms should be allowed? For example, raw cannabis, magistral preparations made by a pharmacist, or others such as standardised cannabis extracts or oils?
- What routes of administration will be permitted? For example, oral or vaporised forms?
- For which medical conditions should treatment be available? Governments could limit access to those experiencing medical conditions for which there is evidence of efficacy, or take a broader approach where approval would be given for any conditions which some patients have reported benefits.
- Who would be allowed to prescribe the products? Would this be limited to a specialist physician or would any medical practitioner be able to do so?
- How would the government deal with any possible reluctance of practitioners to prescribe cannabis for any ethical or medico-legal reasons?
- Who will pay for the products or preparations? The patients, national healthcare system or health insurance schemes?
- What types of quality standards should be applied to the products? How would they be monitored and enforced?
- How will the necessary pharmacovigilance schemes and data collection for the International Narcotics Control Board be organised?

Medical use of cannabis continued

Table 1: Summary of the evidence for the medical use of cannabis and cannabinoids

Disease/symptoms	Products tested	Strength of evidence	Limitations
Nausea and vomiting associated with cancer chemotherapy	Cannabinoids	Weak	Few studies testing against newer, more effective anti-emetics. Newer chemotherapy regimens produce less nausea. Little evidence available about use in other types of nausea.
Appetite stimulant in patients with AIDS-related wasting	Dronabinol/THC	Weak	Fewer AIDS-related cases available to treat now. Little evidence available about use to stimulate appetite in people with other conditions.
Muscle spasm in patients with multiple sclerosis	Nabiximols	Moderate	Patients report reductions, but more limited impact on clinician ratings.
CNCP, including neuropathic pain	Cannabis and cannabinoids	Moderate	Small (but statistically significant) effect compared with placebo.
Palliative care for cancer	Cannabinoids	Insufficient	Larger, better-designed trials are needed.
Intractable childhood epilepsy	Cannabidiol	Moderate	Evidence for use in adjunctive therapy in people with Dravet or Lennox-Gastaut syndrome. More studies are needed to look at dosage, interactions and use in people with other forms of epilepsy.
Other medical uses, such as sleep disorders, anxiety disorders, depression, degenerative neurological disorders, and inflammatory bowel disease	Cannabis and cannabinoids	Insufficient	Some evidence for short-term effects in some conditions (e.g. sleep disorders) but larger, better-designed trials are needed, with longer follow-up.

Source: EMCDDA, 2018, p. 14¹

THC = tetrahydrocannabinol; CNCP = chronic non-cancer pain. CBD = cannabidiol.

Table 2: Availability of medicinal products containing cannabis or cannabinoids in Ireland (February 2019)

Product	Nabiximols	Nabilone	Dronabinol
Under which Schedule is it regulated? ^a	4, part 1	2	1
Can it be prescribed in Ireland?	Yes	Yes	Yes
Does it have marketing authorisation in Ireland?	Yes	No	No
Does it require a ministerial licence to be prescribed?	No	No	Yes
Can it be bought in Ireland?	Yes ^b	Yes ^c	No
Does it need to be purchased abroad and imported on a case-by-case basis?	No	Yes	Yes

Source: Department of Health, personal contact

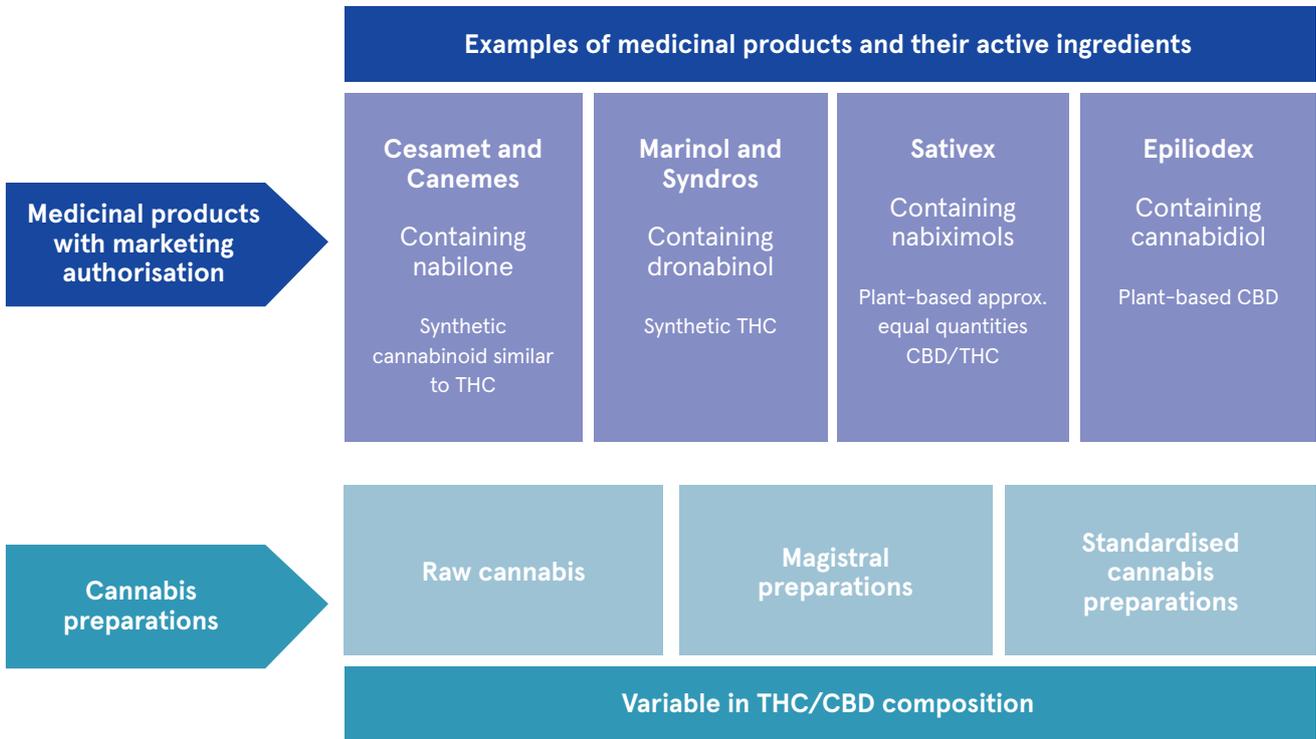
^a The Misuse of Drugs Regulations 1988 fall under the Misuse of Drugs Acts, which have been amended on several occasions since 1988. They divide controlled drugs into five schedules according to their 'potential for abuse and their therapeutic usefulness' (<http://www.hpra.ie/homepage/controlled-substances/controlled-substances/legislation>). They apply varying controls on their production, supply, importation, and exportation. Schedule 1 controlled drugs have the most restrictions imposed; Schedule 5 the least.

^b Nabiximols can be sourced by a pharmacist via wholesalers.

^c Nabilone can be sourced by a pharmacist via wholesalers and imported as an exempt medicinal product (EMP). However, difficulties arose over its supply, and in 2016 the Primary Care Reimbursement Service (PCRS) advised that it would not be approved for new patients. See PCRS circular 039/16: www.hse.ie/eng/staff/pcrs/circulars/pharmacy/exemptmedicinalproductarrangements0392016.pdf

Medical use of cannabis continued

Figure 1: Cannabis and cannabinoids used for medical purposes – a broad typology



Source: EMCDDA, 2018, p. 8¹

Concluding comment

As with other EU countries, this is a topic that has attracted a lot of attention in Ireland and which is currently evolving under the work of the Expert Reference Group to advise on the development of a Medical Cannabis Access Programme.³ While Ireland is not specifically mentioned in the report when it discusses the approaches currently being used, the findings suggest a fit with a combination of allowing the use of medicinal products containing cannabinoids and allowing the use of unauthorised products or preparations (see Table 2 and Box 1).

Lucy Dillon

- 1 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2018) *Medical use of cannabis and cannabinoids: questions and answers for policymaking*. Luxembourg: Publications Office of the European Union. <https://www.drugsandalcohol.ie/30034/>
- 2 Hall W (2018) *A summary of reviews of evidence on the efficacy and safety of medical use of cannabis and cannabinoids*. Lisbon: European Monitoring Centre for Drugs and Drug Addiction. <https://www.drugsandalcohol.ie/30208/>
- 3 For further information, visit: <https://health.gov.ie/cannabis-for-medical-use/>
- 4 See Dáil Éireann debates: <https://www.oireachtas.ie/en/debates/question/2018-11-29/164/>

Access to other cannabis products (containing tetrahydrocannabinol (THC) and cannabidiol (CBD)) in Ireland, February 2019

Can cannabis products that contain THC be accessed in Ireland?

Yes. Under Ireland's Misuse of Drugs legislation, products containing THC are strictly controlled and possession is unlawful, except under ministerial licence. Under the legislation, it is open to the Minister for Health to consider granting a licence to an Irish-registered medical practitioner for medical cannabis for a named patient. As of 29 November 2018, 12 such licences had been granted.⁴

From where are cannabis products containing THC sourced?

Where a product containing THC has been prescribed and a licence secured, it has to be sourced from outside Ireland. It is a matter for the prescriber and their patient to source it. It is understood that patients who have been prescribed such products have sourced them from a pharmacy in the Netherlands.

Can cannabis products that contain CBD be accessed in Ireland?

CBD is not controlled under Ireland's Misuse of Drugs legislation. Therefore, products containing only CBD do not require a ministerial licence for use.

Civil society involvement in policymaking

Civil society involvement (CSI) in the development and implementation of drug policy is widely considered best practice and promoted at both international and national levels. For example, a focus on the value of CSI is evident in both the *EU drugs strategy 2013–2020*¹ and the *EU action plan on drugs 2017–2020*.² One of the 15 objectives of the latter is to ‘ensure the participation of civil society in drugs policy’. It is also a key part of Ireland’s national drugs strategy, *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*.³

In line with this strategic approach, the Civil Society Involvement in Drug Policy (CSIDP) project is supported by the European Commission under its European Civil Society Involvement Project.⁴ It comprises a group of organisations working in the field of CSI at national and European levels.⁵ It aims to support CSI in the development and implementation of drug policies at national and European levels. To do so, it has set out to provide stakeholders with guidance to stimulate and support effective CSI, as well as raise awareness on the relevance and importance of CSI at national and European levels. It has produced three outputs that should be of interest to both those in Ireland working in the area of drug policy and civil society organisations (CSOs):

- An assessment report of CSI in drug policy in EU member states⁶
- A national action plan report on Ireland⁷
- A road map for effective CSI in drug policy.⁸

Benefits of CSI

It is useful to reiterate the internationally recognised benefits of a CSI approach to policy which are outlined in these reports. By engaging with CSOs, policymakers get an understanding of what is happening on the ground. They are then better placed to develop timely policies that are relevant to the ever-changing drug situation in their country. The exchange of information also encourages innovative thinking and new approaches to tackling problems, as well as an insight into the challenges and opportunities experienced by those working under existing policy structures. CSI can increase buy-in for a particular policy by both those who will be required to implement them and those at which they are aimed – ‘when civil society is involved, popular legitimacy increases’ (p. 7).⁸ It can lead to empowerment and increased participation among people who use drug services and hold policymakers accountable in ensuring that their civil and human rights are protected.

Assessment report and national action plan

The assessment report set out ‘to gain a better insight and create a better understanding of the nature and extent of civil society involvement in drug policy at the national level’ (p. 4).⁶ Across the member states, it looks at three elements: the extent to which civil society features in national drug strategy documents; the number of CSOs and the level of CSI in various

areas of policy development and implementation; and an analysis of the barriers and facilitators to CSI.

European experience

The bulk of the report focuses on the second element. It is an account of responses to a detailed questionnaire aimed at making an assessment of CSI in national drug policy in general, and the development and implementation of each country’s drug strategy.⁹ It examines different levels of involvement (information, consultation, dialogue and partnership) (see Figure 1) across the different policy areas (prevention, treatment, harm reduction, law enforcement and legal framework). As could be expected, there was a lot of variation across the member states, making it challenging to draw comparisons and conclusions from the data. Despite this, three of the top-line findings, when considering the majority of the member states, were:

- Harm reduction represents the drug policy field with the highest level of CSI, and the fields of law enforcement and the legal framework are those with the lowest level.
- The level of CSI is generally higher during the implementation phase of policy than the development phase.
- There seems to be a lack of formal structures that support regular CSI in the development and implementation of drug policy.

Irish experience

Overall, the findings suggest that Ireland fares well in its experience of CSI. It does not appear to face the challenges that exist in some other member states. For example, the full range of levels of CSI in Ireland is reported to exist, from information to partnership, and it is seen as having a ‘somewhat high’ level of CSI in drug policy (see Figure 2). This positive picture of Ireland as an environment where there is CSI in drug policy is echoed in the *National Action Plan (NAP) Report for Ireland*.^{7,10} It notes that CSOs ‘have long been involved in the response to drugs and drug use in Ireland’ (p. 6)⁷ and found that there were good structures in place to facilitate CSI in drug policy – in particular those developed under the national drugs strategy, *Reducing harm*.

In general, it is fair to say that the new strategy has been positively received by civil society actors, that state structures are open and supportive of civil society participation, and that there has been a good amount of work focused on participation in the first year of the strategy’s implementation. (p. 13)⁷

However, it was also noted that there was a need to provide supports to ensure that these structures were used to their full effect in delivering CSI. Existing structures could be improved to increase direct participation and ownership by stakeholders and citizens, including people who use drugs (PWUD), members of the Travelling community and other minority communities, and young people. There was also a call to ensure that key decisions linked with the national drugs strategy are made within the relevant participative structures, and that there is CSI on any working groups established under the strategy.

Road map

The CSIDP’s road map is aimed at both policymakers and CSOs.⁸ Its main objective is ‘to provide guidance through the

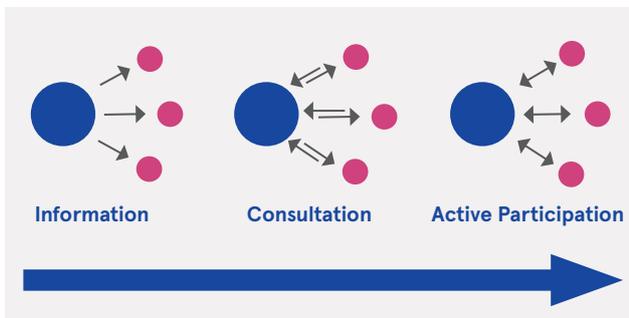
Civil society continued

Civil society: This can be thought of as the associational life operating in the space between the state and the market – that is, not the public sector and not the private sector. Typically, it is understood to include the activities of non-governmental, voluntary and community organisations, but can also include individual participation.

Civil society organisations (CSOs): Those organisations operating in civil society.

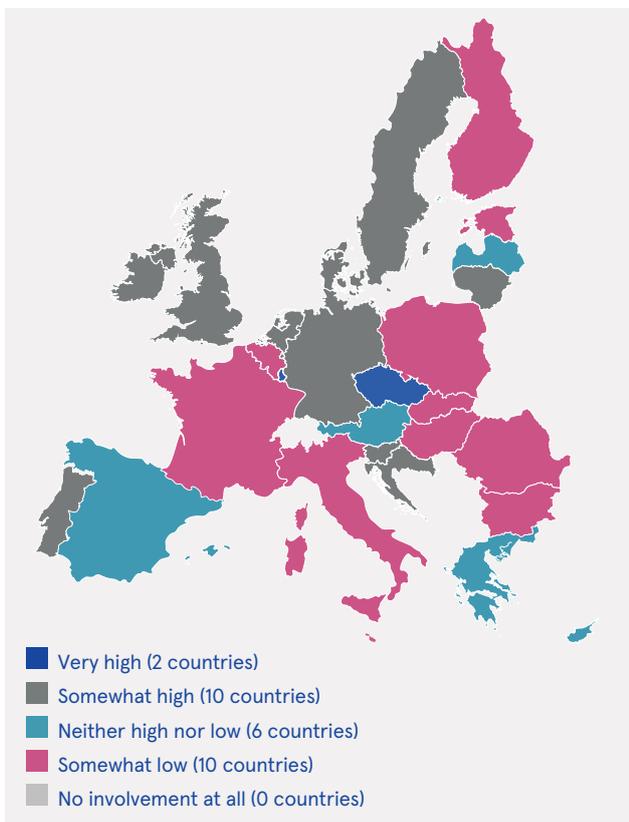
Civil society involvement (CSI): The process or practice of including civil society in policy development, setting, and implementation.

Figure 1: Defining information, consultation and active participation



Source: Lahusen et al. (2018) *Civil society involvement in drug policy – a road map*, p. 16

Figure 2: Level of CSI in drug policy in general by country



Source: Lahusen et al. (2018) *Civil society involvement in drug policy in EU member states. Assessment report*, p. 13

different steps of developing and implementing effective and sustainable civil society structures in the field of drug policy on the local, regional and national level, as informed by the best available evidence' (p. 5). The road map is divided into three parts:

- 1 How to assess current levels of CSI in drug policy in a country.
- 2 What policymakers can do to enhance CSI – from implementing different mechanisms of CSI to funding CSOs and research.
- 3 What CSOs can do to enhance CSI – from addressing possible structural issues to planning advocacy activities.

The authors emphasise the need for input from both policymakers and CSOs if the CSI is to be meaningful. It is recognised that policymakers might be more hesitant about working in this way, so CSOs need to be proactive and be prepared to take a leading role in getting the process going. Essentially, the authors recommend two main things: an assessment of the existing level of CSI; and a structured approach to improving areas that are not working so well, with mutual agreement on actions that need to be carried out by policymakers and CSOs accordingly. The road map contains numerous toolkits and guidance sources for stakeholders to draw on. A detailed description of the guidance is beyond the scope of this article and it is recommended that those working in this field access the full report.

Lucy Dillon

- 1 Council of the European Union (2012) *The EU drugs strategy 2013–2020*. Brussels: Council of the European Union. <https://www.drugsandalcohol.ie/19034/>
- 2 European Commission (2017) *EU action plan on drugs 2017–2020*. Brussels: Council of the European Union. <https://www.drugsandalcohol.ie/27680/>
- 3 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/>
- 4 For further information, visit: <https://csidp.eu/>
- 5 Ana Liffey Drug Project (ALDP) is a member of the group.
- 6 Lahusen H, Verthein U and Martens M-S (2018) *Civil society involvement in drug policy in EU member states. Assessment report*. Amsterdam: De Regenboog Groep/Correlation Network. <https://www.drugsandalcohol.ie/29890/>
- 7 Keane M, Crook L and Vieru C (2018) *Ireland National Action Plan Report*. Dublin: Ana Liffey Drug Project.
- 8 Lahusen H, Keane M, Crook L, Košir M, Schiffer K, Ronconi S, et al. (2018) *Civil society involvement in drug policy – a road map*. Amsterdam: De Regenboog Groep/Correlation Network. <https://www.drugsandalcohol.ie/29890/>
- 9 The questionnaire was completed by representatives of one or more of the following bodies across the member states: a CSO, National Focal Point of the Reitox network, and administrative bodies with responsibility for drug policy. In Ireland, data were collected from a representative of the first two bodies.
- 10 An activity of the CSIDP was for five partner agencies to carry out a national action plan in their home countries: Bulgaria, Ireland, Italy, the Netherlands, and Portugal.

Taking stock: a decade of drug policy

The International Drug Policy Consortium (IDPC) is a global network of 180 non-governmental organisations.¹ It focuses on issues related to drug production; trafficking and use; and promoting objective and open debate on the effectiveness, direction and content of drug policies at national and international levels. The network supports evidence-based policies that are effective at reducing drug-related harm. As part of this work and in the context of the role identified by the work of the United Nations Office on Drugs and Crime (UNODC) for civil society involvement in drug policy,² the IDPC has published *Taking stock: a decade of drug policy*.³ This report 'evaluates the impacts of drug policies implemented across the world over the past decade, using data from the United Nations (UN), complemented with peer-reviewed academic research and grey literature reports from civil society' (p. 7).³

2019 target date

The report focuses on the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, which was adopted by UN member states in 2009.² It includes measures to enhance international cooperation, identifies problems and areas requiring further action, as well as goals and targets in countering the world drug problem. The year 2019 was set as the target date for member states to 'eliminate or reduce significantly and measurably' five target areas: the illicit cultivation; demand; production, trafficking and use of internationally controlled substances; the diversion and illicit trafficking of precursors; and money laundering (p. 14).² IDPC argues that despite the Commission on Narcotic Drugs (CND) session due to take place in March 2019 and which aims to take stock of progress made on this plan, 'no comprehensive review of the impacts of drug policies worldwide has yet been undertaken' (p. 7).³ IDPC's report seeks to fill this gap.

Findings

The report is a detailed presentation of the data exploring progress not only against the five target areas, but also in assessing progress towards the broader priorities of the UN – protecting human rights, promoting peace and security, and advancing development. The overall conclusion of the report is that the five target areas set in the 2009 Political Declaration and Plan of Action have not been achieved. Furthermore, it found evidence that many counterproductive policies have been put in place and they have made the situation worse, including when considering the UN's broader priorities. The authors identify three main issues when reflecting on the evaluation of global drug policies:

- There is a need to conduct more thorough and regular research on the broader range of impacts of drug policies at local, national, regional and international levels.
- Where formal evaluations are being carried out, they tend to rely on government reporting. IDPC would encourage a more comprehensive and balanced approach, whereby civil society and academic research would also be included. It argues that this is particularly important for sensitive issues related to drug policy and human rights.
- Member states should reconsider what is being measured when assessing the impact of drug policy. IDPC suggests a

move away from targets that focus solely on the illegal drug market towards an approach that takes account of the key UN Charter commitments to health, human rights, development, peace and security.

Recommendations

In the final part of the report, IDPC identifies new indicators for measuring the success of global drug policy and makes a set of recommendations which it hopes will 'provide a useful starting point for further discussions as to which goals and metrics could be considered for the post-2019 global drug strategy' (p. 12).³ The recommendations as they appear in the report (p. 13³) are:

- The international community should consider adopting more meaningful goals and targets in line with the 2030 Agenda for Sustainable Development, the UNGASS Outcome Document and international human rights commitments, and move away from targets seeking to eliminate the illegal drug market.
- Post-2019, member states should meaningfully reflect upon the impacts of drug control on the UN goals of promoting health, human rights, development, peace and security – and adopt drug policies and strategies that actively contribute to advancing the 2030 Agenda for Sustainable Development, especially for those most marginalised and vulnerable.
- Global drug policy debates going forward should reflect the realities of drug policies on the ground, both positive and negative, and discuss constructively the resulting tensions with the UN drug control treaties and any human rights concerns associated with drug control efforts.

Beyond 2019, UN member states should end punitive drug control approaches and put people and communities first. This includes promoting and facilitating the participation of civil society and affected communities in all aspects of the design, implementation, evaluation and monitoring of drug policies.

Concluding comment

The report highlights the complexities involved in developing, implementing, and evaluating a plan like this globally, with such disparate political, economic and social contexts and responses to the situation at national level. However, it also provides valuable insights into measures and indicators that might be considered at national level to assess the impact and consequences of policy choices. Ireland is mentioned specifically in a number of places in the report. This tends to be when illustrating a health-led approach to dealing with drug use: explicitly addressing the issue of chemsex in our national strategy; providing naloxone training for prisoners; exploring decriminalisation for personal use; having a pilot project on medical cannabis; and CityWide's 'Stop the Stigma' campaign.⁴

Lucy Dillon

- 1 For further information, visit: www.idpc.net. CityWide Drugs Crisis Campaign and Ana Liffey Drug Project are members of the IDPC network.
- 2 United Nations Office on Drugs and Crime (UNODC) (2009) *Political declaration and plan of action on international cooperation towards an integrated and balanced strategy to counter the world drug problem*. Vienna: UNODC. <https://www.drugsandalcohol.ie/30219/>
- 3 International Drug Policy Consortium (IDPC) (2018) *Taking stock: a decade of drug policy – a civil society shadow report*. London: International Drug Policy Consortium. <https://www.drugsandalcohol.ie/29843/>
- 4 CityWide's campaign messages and materials can be accessed at: <https://www.citywide.ie>

PREVALENCE AND CURRENT SITUATION

Trends in alcohol and drug admissions to psychiatric facilities

Activities of Irish psychiatric units and hospitals 2017,¹ the annual report published by the Mental Health Information Systems Unit of the Health Research Board, shows that the number of new admissions to inpatient care for alcohol disorders has continued to stabilise.

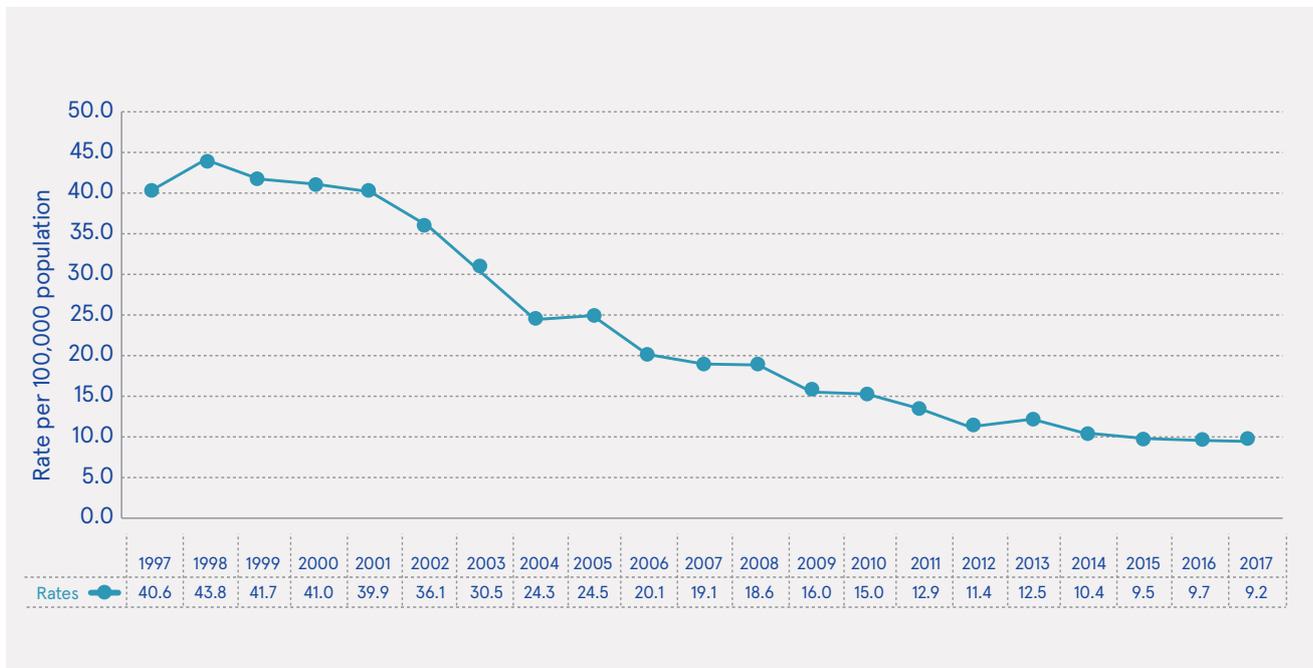
In 2017, some 1,147 cases were admitted to psychiatric facilities with an alcohol disorder, of whom 437 were treated for the first time. Figure 1 presents the rates of first admission between 1997 and 2017 for cases with a diagnosis of an alcohol disorder. The admission rate in 2017 was similar to the previous year, while trends over time indicate an overall decline in first admissions. One-third of cases hospitalised for an alcohol disorder in 2017 stayed just under one week, while 31% of cases were hospitalised for between one and three months, similar to previous years.

In 2017, some 896 cases were admitted to psychiatric facilities with a drug disorder. Of these cases, 414 were treated for the first time. Figure 2 presents the rates of first admission between 1997 and 2017 of cases with a diagnosis of a drug disorder. Although the rate decreased slightly in 2017, there has been an overall increase in the rate of first admission with a drug disorder since 2011. It should be noted that the report does not present data on drug use and psychiatric comorbidity, so it is not possible to determine whether or not these admissions were appropriate.

Other notable statistics on admissions for a drug disorder in 2017 include the following:

- Less than one-half of cases hospitalised for a drug disorder stayed under one week (46%), while 99% were discharged within three months. It should be noted that admissions and discharges represent episodes or events and not persons.
- 13% of first-time admissions were involuntary.
- Similar to previous years, the rate of first-time admissions was higher for men (13.7 per 100,000) than for women (3.8 per 100,000).

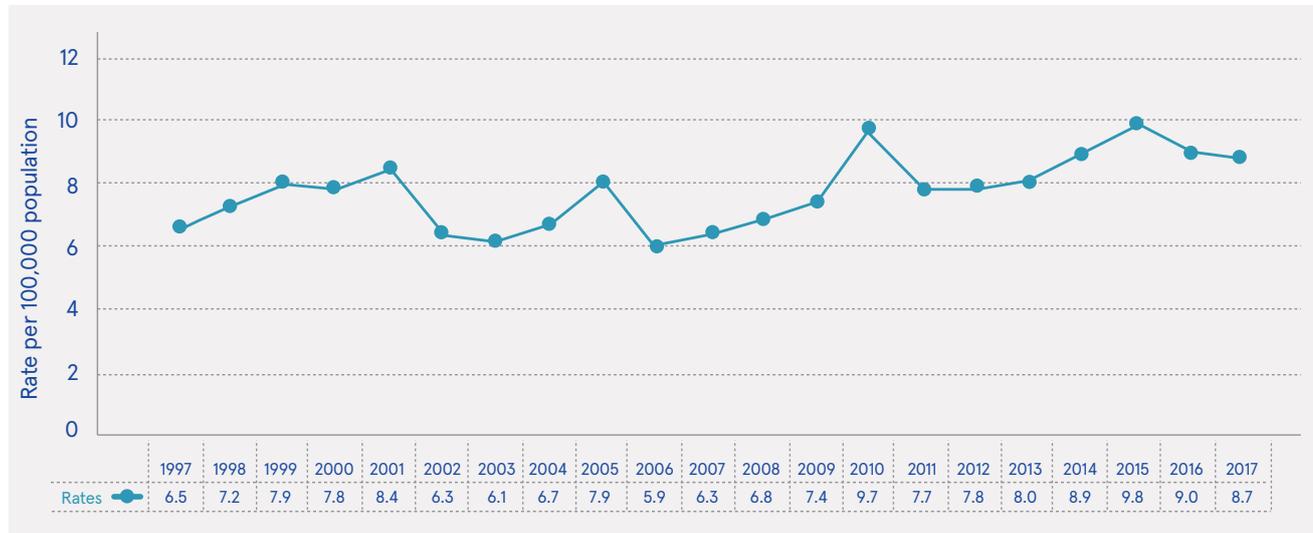
Figure 1: Rates of psychiatric first admission of cases with a diagnosis of an alcohol disorder per 100,000 of population in Ireland, 1997–2017



Source: Daly and Craig, 2018

Admissions to psychiatric facilities continued

Figure 2: Rates of psychiatric first admission of cases with a diagnosis of a drug disorder per 100,000 of population in Ireland, 1997–2017



Source: Daly and Craig, 2018

Seán Millar

1 Daly A and Craig S (2018) *Activities of Irish psychiatric units and hospitals 2017: main findings*. HRB Statistics Series 38. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/29345/>

Global, regional and country level estimates of HCV infection among recent injecting drug users

The World Health Organization has set a goal to eliminate hepatitis C virus (HCV) as a global public health threat by 2030. Targets include reducing new HCV infections by 80% and the number of HCV deaths by 65%, and increasing HCV diagnoses from 20 to 90% and eligible people receiving HCV treatment from <5 to 80%.¹ Unsafe injecting drug use is the main route of HCV transmission in developed countries.² Consequently, people who inject drugs (PWID) represent a priority population for HCV elimination, given the high prevalence and incidence in this group.

There are no previous global estimates of HCV prevalence among people with recent injecting drug use. Data on these are needed in order to monitor the progress of global HCV elimination efforts and to identify high-burden settings which should be targeted. A recent study estimated the prevalence and

number of people with recent injecting drug use living with HCV, and the proportion of people with recent injecting drug use among all people living with HCV infection, at global, regional and country levels.³

In this research, published in the journal *Addiction*, data from a global systematic review of injecting drug use and HCV antibody prevalence among people with recent (previous year) injecting drug use were used to estimate the prevalence of people with recent injecting drug use living with HCV. These data were then combined with a systematic review of global HCV prevalence to estimate the proportion of people with recent injecting drug use among all people living with HCV.

Results

Global and regional estimates

Globally, it was estimated that in 2015, 39.2% (95% CI: 31.6–47.0) of people with recent injecting drug use had HCV viraemic infection, representing 6.1 million subjects (95% CI: 3.4–9.2) with recent injecting drug use living with HCV infection. Of the 71.1 million (95% CI: 62.4–79.4) people living with HCV infection, it was estimated that 8.5% (95% CI: 4.6–13.1) were recent injecting drug users, with the greatest proportion in North America (30.5%), Latin America (22.0%) and Eastern Europe (17.9%).

European and Irish estimates

Global, Eastern/Western European and Irish estimates are shown in Table 1. For the Republic of Ireland, it was estimated that in 2015, 56% (95% CI: 52.5–59.4) of subjects with a history of recent injecting drug use had HCV infection, representing 5,000 (95% CI: 3,500–6,000) individuals. Of the total number of people with

HCV infection among recent injecting drug users continued

Table 1: Global, European and Irish estimates of the prevalence of HCV viraemic infection among people with recent injecting drug use, the number of people with recent injecting drug use living with HCV viraemic infection, the total population living with HCV viraemic infection, and the proportion of people with recent injecting drug use among the total population with HCV viraemic infection

	Prevalence of HCV viraemic infection among people with recent injecting drug use (%)	Number of people with recent injecting drug use living with HCV viraemic infection (n)	Total population living with HCV viraemic infection (n)	Proportion of people with recent injecting drug use among the total population with HCV viraemic infection (%)
Global	39.2 (31.6–47.0)	6,063,500 (3,434,500–9,246,000)	71,146,000 (62,472,000–79,404,000)	8.5 (4.6–13.1)
Eastern Europe	48.6 (42.0–55.2)	1,466,500 (699,500–2,377,000)	8,181,000 (6,304,000–8,250,000)	17.9 (8.2–30.9)
Western Europe	39.9 (35.7–44.1)	402,500 (264,500–557,000)	2,347,000 (1,969,000–3,289,000)	17.2 (9.9–30.4)
Republic of Ireland	56.0 (52.5–59.4)	5,000 (3,500–6,000)	29,500 (20,000–42,500)	16.2 (10.0–28.9)

Source: Grebely *et al.*, 2019

HCV infection in Ireland in that year (n=29,500, 95% CI: 20,000–42,500), it was estimated that 16.2% (95% CI: 10.0–28.9) were individuals who had recently injected drugs.

Conclusions

The authors noted that there were wide variations among regions and countries with regard to HCV prevalence among recent injecting drug users and the proportion of injecting drug users among the total population with HCV infection. They suggest the research highlights that concerted efforts will be required in countries with large numbers of people infected with HCV in order to achieve global HCV elimination among PWID.

Seán Millar

- 1 World Health Organization (WHO) (2017) *Global hepatitis report, 2017*. Geneva: WHO. <https://www.drugsandalcohol.ie/27177/>
- 2 Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D, *et al.* (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet*, 378(9791): 571–83. <https://www.drugsandalcohol.ie/15845/>
- 3 Grebely J, Larney S, Peacock A, Colledge S, Leung J, Hickman M, *et al.* (2019) Global, regional, and country-level estimates of hepatitis C infection among people who have recently injected drugs. *Addiction*, 114(1): 150–66. <https://www.drugsandalcohol.ie/29394/>

Rates of reported codeine-related poisonings and codeine prescribing following new national guidance in Ireland

The risks of misusing opioid medication have been well documented^{1,2,3} and include a wide range of problematic consumption outside of medical guidelines. Misuse can include consumption to induce psychoactive effects, use in combination with other drugs to alter their effects, or self-medication by increasing or lengthening duration of dosage without or against medical advice. Such risky behaviour can lead to adverse consequences, including dependence and/or poisoning. Despite the known risks, many countries, including Ireland, continue to

permit codeine (an opiate to treat pain) to be available without prescription, over-the-counter (OTC).

In order to address the public health issue of opioid misuse, in 2010 the Pharmaceutical Society of Ireland (PSI) issued guidance in relation to the supply of codeine-containing products. The guidance, *Non-prescription medicinal products containing codeine: guidance for pharmacists on safe supply to patients*⁴, provided pharmacists with criteria to be adhered to when selling codeine, such as ensuring that codeine medicines only be supplied when deemed necessary by the pharmacist following consultation and only when a non-opioid analgesic has not proven sufficient to relieve the patient's symptoms. If codeine is dispensed, the maximum dosage is a three-day supply following which the patient should be medically reviewed.

Methods

In order to measure the impact of these guidelines, a recent study, published in the journal *Pharmacoepidemiology and Drug Safety*,⁵ examined two sets of data.

- 1 The National Poisons Information Centre (NPIC) database was used to assess poisoning rates related to codeine-containing products. NPIC advises healthcare professionals and the public on enquiries relating to poisonings. This database allowed the authors to quantify the reported incidences of

Codeine-related poisonings

continued

codeine-containing products during the period 2005–2016. Using NPIC data, all codeine-related poisonings (non-prescription and prescription) were plotted to measure occurrence pre- and post-2010 (when the guidance was issued).

- The pharmacy claims database of the Health Service Executive Primary Care Reimbursement Service (HSE PCRS) was used to calculate trends in codeine prescriptions during the same period. This database contains information on all payments made to pharmacists in lieu of products dispensed to primary care patients entitled to reduced cost medicines. For the purposes of the study, all non-prescription co-codamol products (paracetamol and codeine) and two prescription only co-codamol products dispensed by pharmacies under the HSE PCRS scheme were considered. This would identify if there was an increase in those seeking alternative products or prescriptions for codeine-containing products due to the restriction in access to OTC codeine.

Results

Poisonings

Of the 1,851 reported codeine-related poisonings during the period 2005–2016, some 1,346 (73%) were available over the counter. Women made up the majority of case subjects (63%). Paracetamol and codeine was the most frequently reported combination (30%). Intentional poisoning was the most frequently reported event resulting in the poisoning and this remained unchanged when comparing the period 2011–2010.

The majority of referral calls made to NPIC were from hospitals (51%), followed by general practitioner/family doctor (30%), and 16% from the public. Overall, during the period 2005–2016, there was a 53% decrease in reported codeine-related poisonings. Non-prescription (OTC) codeine poisonings decreased by 62% during this period.

In the year following the introduction of the guidelines (2011), a significant decrease (33%) was evident in poisonings involving non-prescription (OTC) codeine, after which there was little change in the rate of poisonings.

Prescriptions

Using a similar timeline (2006–2015), analysis of the HSE PCRS data showed no significant change in the number of reimbursements for prescription codeine-containing products or alternative OTC opioid medications when comparing before and after the introduction of the guidance.

Conclusion

The new guidance on codeine supply coincided with an initial reduction in reported codeine poisoning cases, particularly OTC cases, and this may have been related to the restriction of same. However, the overall reduction was in keeping with previous trends, although of a larger magnitude. The rate of decline did not continue and has plateaued. There was no concurrent increase in the prevailing rate of prescription claims for these products or potential substitutes.

The data highlight the impact of the guidelines and show that they are effective but only for a limited period of time, and, as such, further restrictions on codeine-related products may be required to improve public health outcomes.

Anne Doyle

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Parole Board annual report, 2017

In October 2018, the Parole Board published its annual report.¹ This was the 16th annual report since the board was established in 2001. The aim of the Parole Board is to review the cases of prisoners who have received either 'determinate' sentences greater than or equal to eight years or life sentences and to provide guidance on how these sentences are managed. The current report provided an overview of the board's activities for 2017.

Issues relating to mental health among prisoners

Within the report, the problem of mental health in prisoners

was highlighted. The board has acknowledged and provided support for recommendations put forward by the late Judge Michael Reilly in 2016.²

Parole Board process

With the aim of increasing understanding of the Parole Board process, presentations in prisons across Ireland were made by board members. Prisoners were given the opportunity to take part in discussions and give feedback on the process. The board intends to continue these presentations with the aim of going to each prison biannually.

Parole Board process review

Delays between Parole Board reviews and not observing timelines were identified as issues that were not acceptable. It is hoped that these problems will be addressed once the Parole Bill 2016,³ which is currently progressing through the Houses of the Oireachtas, is enacted. This Bill provides for parole hearings

Parole Board annual report, 2017

continued

to occur within six months of the initial review date.

Prison visits

In 2017, the Parole Board met with groups of life-sentenced prisoners in eight prisons to discuss and clarify what was involved in the parole process and to encourage them to engage with the rehabilitation process.

Victims and families

The report highlighted that prior to a prisoner review, correspondence was frequently received from victims and/or their families disclosing the level of pain and emotional suffering experienced as a result of the prisoner's actions. These are taken into consideration before a recommendation is made.

Statistics

The report highlighted important statistics for 2017. Overall, there was a total caseload of 346. This figure included new cases and cases at second or subsequent stages of the review process. In addition, the following were noted:

- 66 cases were referred to the board for review, of which two were on remand for drug offences.
- 48 of the 66 prisoners invited to participate accepted an invitation to take part in the review process; one prisoner was on remand for drug offences.
- Three prisoners declined to take part, two of which were on determinate sentences.
- 15 invitations were not responded to, all of these were on determinate sentences. A possible explanation put forward for non-engagement is that prisoners in receipt of determinate sentences are automatically eligible for a 25% reduction in sentence.

The Parole Board met 11 times and 114 case recommendations

were made to the Minister for Justice and Equality:

- 102 case recommendations were accepted in full.
- 21 of these case recommendations were life-sentenced prisoners who were granted parole on a phased basis.
- Three cases were accepted conditionally or in part.
- Nine decisions were pending at year-end.
- 32 prisoners were reviewed for the first time.
- 82 prisoners were reviewed as part of second or subsequent reviews.
- 114 interviews were carried out by board members, of which 32 were first reviews. Interviews are not viewed as essential for second or subsequent reviews; however, the board believes that an interview is sometimes in the best interests of the prisoner.

Minister for Justice and Equality Charlie Flanagan TD acknowledged the level of work carried out by the Parole Board and thanked the chairman, Mr John Costello, and board members for their important contribution to the rehabilitation process.⁴ In addition, Minister Flanagan reiterated his verbal commitment to progress the Parole Bill 2016 through the Oireachtas to enable the Parole Board to achieve statutory status. This was welcomed by the Irish Penal Reform Trust.⁵

Ciara H Guiney

- 1 The Parole Board (2018) *Annual report 2017*. Dublin: The Parole Board. <https://www.drugsandalcohol.ie/29764/>
- 2 Reilly M (2016) *Healthcare in Irish prisons*. Dublin: Department of Justice and Equality. <https://www.drugsandalcohol.ie/26885/>
- 3 Parole Bill 2016. Available online at <https://www.oireachtas.ie/en/bills/bill/2016/29/>
- 4 Department of Justice and Equality (2018) *Press release: Minister Flanagan publishes Parole Board annual report 2017*. Available online at <http://www.justice.ie/en/JELR/Pages/PR18000311>
- 5 Irish Penal Reform Trust (2017) *Press release: Parole Board annual report 2017*. Dublin: Irish Penal Reform Trust. Available online at <http://www.iprt.ie/contents/3338>

RESPONSES

Updated international standards on drug use prevention

In 2013, the United Nations Office on Drugs and Crime (UNODC) published the first edition of its *International standards on drug use prevention*.¹ The standards present an overview of the international evidence for prevention interventions and policies. A second, updated version produced in collaboration with the World Health Organization (WHO) is now available.²

The authors note that the standards are presented in a context where there is a renewed emphasis on the health and wellbeing of people in international approaches to dealing with drug issues. These are, for example, in the United Nations (UN) Sustainable Development Goals to be achieved by 2030³ and the *Outcome document from the 2016 United Nations General Assembly Special Session on the world drug problem* (UNGASS).⁴ This has raised the profile of prevention in global drug policy and reinforces the need for prevention strategies to be based on a sound evidence base, which is sometimes lacking. The primary objective of prevention is defined as:

...to help people, particularly but not exclusively of younger age, to avoid or delay the initiation of the use of psychoactive substances, or, if they have started already, to avert the development of substance use disorders (harmful substance use or dependence). (p. 2)²

Drug prevention standards continued

Methodology

The standards draw on a number of evidence sources. At their core is a summary of the current scientific evidence base gathered by means of an overview of recent systematic reviews, combined with the findings of a similar exercise upon which the first edition is based. They also draw on international expertise through the work of an international group of experts, and refer to existing guidance, in particular that of WHO.

The document should be a useful reference for policymakers and practitioners interested in the area of prevention. It does not go as far as making recommendations about specific programmes, instead it gives a brief description of:

- The intervention or the policy, its main activities and theoretical basis
- The available evidence from the systematic reviews on the intervention or policy, in particular its effects on primary (substance use) and secondary (mediating factors/intermediate outcomes of prevention) outcomes
- The existing WHO guidance on the strategies
- The characteristics of the strategies associated with efficacy and/or effectiveness, or lack thereof
- A list of any relevant guidelines or tools for further information.

Interventions and policies are grouped by the developmental stage of the target group: pregnancy, infancy and early childhood (0–5 years); middle childhood (6–10 years); early adolescence (11–14 years); adolescence (15–18/19 years); and adulthood (20+ years).

An effective prevention system

In the final section of the report, the authors outline the characteristics of an effective national drug prevention system, which has the overarching goal to support the healthy and safe development of individuals. They describe it as delivering ‘an integrated range of intervention and policies based on scientific evidence, in multiple settings, targeting relevant ages and levels of risk’ (p. 50).² It would have strategies that have ‘a mix of environmental and developmental components, with a minor component focusing on information’ (p. 50).² To be effective, the system needs to be underpinned by strong structural foundations. There are a number of elements to this, including:

- **A supportive policy and legal framework** that is health-centred and which ensures the availability of controlled drugs for medical and scientific purposes, while preventing diversion and non-medical use. Elements of the framework would include: national (quality) standards for drug prevention interventions and policies; national professional standards for prevention policymakers and practitioners, possibly with an accreditation system; and policies requiring schools and employers to implement evidence-based programmes or policies.
- **Scientific evidence and research** are key elements when making decisions about the elements of a prevention system, and ensuring those being delivered are having the desired impact.
- **Coordination of multiple sectors and levels** are required with clearly defined roles and responsibilities. This needs

to be supported by effective infrastructure, for example, a clear mechanism that would provide decision-makers with strong technical assistance to guide them in implementing evidence-based policies and interventions.

- **Training of policymakers and practitioners** in prevention needs to be supported on an ongoing basis. The Coordinator Series of the Universal Prevention Curriculum⁵ is identified in this context.
- **Commitment to provide adequate resources and to sustain the system in the long term.** This includes (financial) support for the interventions and those delivering them; the technical assistance required to support implementation and continuous quality improvements; and the academic and research institutions responsible for monitoring and evaluating the activities.

Concluding comment

The prevention element of Ireland’s drug and alcohol strategy, *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*⁶ fits well with the general approach outlined in the standards in terms of the national strategy’s overall health-centred objective: ‘To promote and protect health and wellbeing’ (p. 7). Similar to the primary objective of the standards, the Irish strategy

aims to protect the public from threats to health and wellbeing related to substance misuse by preventing early use of alcohol and other drugs among young people, influencing behaviour and challenging social norms and attitudes, and providing targeted interventions aimed at minimising harm for those who have already started to use substances. (p. 17)⁶

The standards should be useful in providing an overview of the range of interventions for which there is evidence of effectiveness and the nature of support required to deliver an effective system of prevention.

Lucy Dillon

- 1 United Nations Office on Drugs and Crime (UNODC) (2013) *International standards on drug use prevention*. Vienna: UNODC. <https://www.drugsandalcohol.ie/19481/>
- 2 United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO) (2018) *International standards on drug use prevention*. 2nd edn. Vienna: UNODC. <https://www.drugsandalcohol.ie/30048/>
- 3 For further information on the goals, visit: <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>
- 4 United Nations Office on Drug and Crime (2016) *Outcome document of the 2016 United Nations General Assembly Special Session on the world drug problem*. Vienna: United Nations Office on Drug and Crime. <https://www.drugsandalcohol.ie/27442/>
- 5 For further information, visit: <https://www.issup.net/training/universal-prevention-curriculum>
- 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. <http://www.drugsandalcohol.ie/27603/>

International Nurses Society on Addictions (IntNSA) Europe

On Sunday, 26 August 2018, a special ceremony linked to the 10th International Council of Nurses (ICN) Nurse Practitioner/Advanced Practice Nurses (NP/APN) conference took place at De Doelen Congress Centre in Rotterdam, the Netherlands. Addiction nurses from around the world gathered for the inauguration of the International Nurses Society on Addictions (IntNSA) Europe and the launch of the new website of the Netherlands Chapter of IntNSA.¹

During the four days of the conference, IntNSA members from the United States (US), the United Kingdom (UK), the Netherlands and Ireland, along with colleagues from the Drug and Alcohol Nurses of Australasia (DANA) and service-user representatives from the Netherlands, contributed to several of the conference workshops and presentations. Their objective was to increase awareness of education, best practice, and the role of the specialist nurse when addressing the needs of people who use drugs and alcohol. As the largest professional group in healthcare, nurses are uniquely placed to address the needs of this population across the continuum of care.

During the conference, the Dutch Minister for Health, Hugo de Jonge, announced that advanced nurse practitioners (ANP) in the Netherlands will be allowed to work as fully autonomous practitioners. In the Netherlands, ANPs in addiction treatment can admit and discharge service users as well as initiate the prescribing of diamorphine and/or other substitute medications such as methadone. The value of specialist

addiction nurses and specifically nurse prescribers in the UK, the US and Australia has also been realised, where they have significantly increased access to cost-effective and gold standard services.²

In Ireland, we have a small number of trained nurse prescribers working in addictions, most of whom are not prescribing or else prescribing in a limited capacity. The new national drugs strategy³ has stipulated that the development of nurse prescribing should be explored further. This may lead to the necessary legislative changes being made to facilitate the development of this role, as has been done in other jurisdictions.

More recently, the Nursing and Midwifery Planning and Development Units (NMPDUs) have funded research, led by Professor Catherine Comiskey from Trinity College Dublin, into the role of the nurse and 'what service users want' from nurses. From this, it is hoped that the full potential of the nurses to meet the needs of service users will be acknowledged and further developed. The Ireland Chapter of IntNSA is represented on our National Steering Committee and on the National Implementation Committee for the new national drugs strategy, and continues its involvement in international research.

Peter Kelly

- 1 For further information, visit the website: <https://www.intnsaholland.com>
- 2 For further information on the role of the nurse working in drug and alcohol treatment services in the UK, visit: <https://www.gov.uk/government/publications/role-of-nurses-in-alcohol-and-drug-treatment-services>
- 3 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/>



From L to R: Professor Trish Hafford-Letchfield, Middlesex University London; Dr Ginny Focht-New, IntNSA US; Jackie Middeldorp, ANP, IntNSA Netherlands; Dr Chris Loth, IntNSA Netherlands; Dana Murphy-Parker, IntNSA US; Dr Stephen Strobbe, president of IntNSA Global; Yvonne Slee, ANP, president of IntNSA Netherlands; Dick van Etten, ANP, IntNSA Netherlands; Professor Carmel Clancy, IntNSA UK; Dr Adam Searby, secretary of DANA; Peter Kelly, IntNSA Ireland

Evaluation of three J-ARC pilot projects

The Joint Agency Response to Crime (J-ARC) is a multiagency response to the management and rehabilitation of offenders. It was established by An Garda Síochána, the Irish Prison Service, the Probation Service, and the Department of Justice and Equality in 2014. The main aim of J-ARC is to stop crime and increase safety in society by targeting prolific offenders that are considered guilty of the majority of crimes. J-ARC presented the findings of an evaluation of the effectiveness of three pilot initiatives – ACER3, STRIVE, and Change Works – that were developed to reduce offending behaviour.¹ Table 1 provides an overview of the main features of the three programmes.

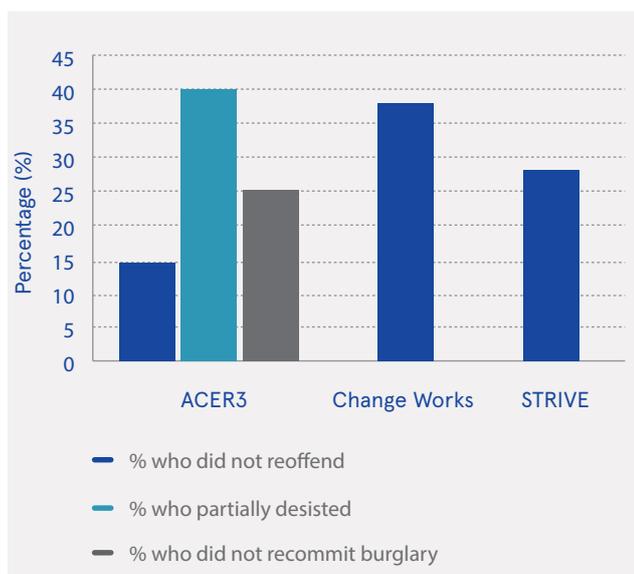
Methodology

The evaluation involved a desk-based review, although a mixed methods approach was utilised across programmes and included structured surveys, face-to-face interviews with clients and practitioners, focus groups observation, and case studies.

Results

Despite the small sample sizes, the available data allowed for an in-depth analysis of whether or not J-ARC was operating efficiently. The main finding was that J-ARC programmes were having a positive impact on offenders. Figure 1 shows the percentage of offenders who did not reoffend across the three J-ARC projects. The proportion of targets that did not reoffend was highest for Change Works, followed by STRIVE, then ACER3. It was not possible to determine which programme was more successful statistically. Other issues that also made comparison between programmes difficult included operational definitions for reoffending, evaluation periods, and differing offences targeted across projects.

Figure 1: Percentage of offenders who did not reoffend



Source: J-ARC Evaluation Framework Working Group, 2018, pp. 28–29

Note: Reoffending is defined as ‘detection’ in ACER3; as a ‘new offence/charge’ in Change Works; and as a ‘recorded offence’ in STRIVE.

Limitations

As acknowledged by the authors, a number of limitations were evident across the programmes.

- Sample sizes were small; hence, it was difficult to make strong statistical conclusions.
- No evaluation plan was identified at the start; hence, data collected were not gathered with evaluation in mind.
- No control group was utilised, so it was not possible to compare outcomes between those that received the intervention and those that did not.

Despite these limitations, it is important to note that these evaluations were the first ones carried out by J-ARC and were done when the programme was still in development phase. The outcomes of these evaluations will inform the existing evidence base for future evaluations.

Recommendations

Based on the evaluations of the three programmes, a number of recommendations were made that could be applied across J-ARC projects.

- The programme should be continued and expanded.
- The existing resources should be reviewed to enable an increase in J-ARC targets.
- Procedures should be developed to allow effective evaluation, data collection, and monitoring of J-ARC targets.
- There should be outcome monitoring and agreement on operational definitions.
- There should be a cost analysis of the J-ARC project.
- The initial selection and deselection should be reviewed and monitored.
- There should be clarification of the lead agency role and implementation of a process to consider changes in responsibility as the target status evolves.
- A secure and visible IT system should be in place to enable information sharing.
- There should be a clear benefits model outlining services available to targets.
- There should be early identification and involvement of stakeholders.
- An evaluation framework should be developed for future J-ARC projects.
- There should be training and communication to increase awareness and normality of J-ARC.

Evaluation of three J-ARC pilot projects continued

Table 1: Summary of the key features of the three J-ARC pilot projects

	ACER3	Change Works	STRIVE
Number of targets during the evaluation period*	10 targets in both locations (20 in total). Two targets were replaced	50 'priority' targets at programme launch in Q1 2015; 51 'priority' targets at end of Q2 2017	18 key individuals during the time of the evaluation
Location of targets	D24 & D8 Tallaght & Kevin St stations	Dublin Metropolitan Region	East Ballymun
Criminal profile of targets**	Burglary and related offences	Violent and harmful behaviour	Most prolific offenders (total crimes) in specific area
Location of intervention	Various locations	Bridge Centre	Various locations around East Ballymun
Start date of the project	Q2 2015	Q1 2015	January 2015
Other agencies involved	Local drug treatment services along with training and employment programmes	Bridge Project team	Ballymun Social Regeneration Subcommittee, Job Centre, DSP, DCC and Local Drugs Taskforce
Initial timescale of the project	2-year pilot	2-year pilot	2-year pilot
Evaluation period	May 2015–Dec 2016	Jan 2016–Aug 2017	Jan 2015–Dec 2015 & July 2016–Dec 2016

Source: J-ARC Evaluation Working Group, 2018, p. 9

* The number of targets can fluctuate over time as people move in or out of the programme.

** Criminogenic behaviour and pathway treatments are clearly different for violent/harmful offenders compared to prolific offenders. This means comparing and evaluating Change Works with ACER3 and STRIVE may be challenging, although the latter two will have clear commonalities.

DSP = Department of Social Protection; DCC = Dublin City Council.

Ciara H Guiney

1 J-ARC Evaluation Framework Working Group (2018) *Critical review of initial evaluations on the three J-ARC pilot projects*. Dublin: Department of Justice and Equality. <https://www.drugsandalcohol.ie/29722/>

Cross-border organised crime: threat assessment 2018

In September 2018, An Garda Síochána (AGS) and the Police Service of Northern Ireland (PSNI) published their biannual cross-border organised crime threat assessment.¹ The aim of the report was to provide insight into criminal activity on the island of Ireland.

Abuse of Common Travel Area

The Common Travel Area (CTA), which exists between the Republic of Ireland (ROI) and the United Kingdom (UK), permits

the free movement of goods, money, people and information. The CTA has mainly had a positive impact on individuals residing in both areas. However, the land border (approx. 224 miles) that lies between ROI and Northern Ireland (NI) is currently open and not subject to checks by customs or law enforcement. This leaves ROI and NI exposed to criminal activities, such as trafficking contraband and immigration crime, carried out by organised crime groups (OCGs). Another challenge noted is that the land border will also separate the UK from the European Union (EU) post-Brexit. In the event of the UK successfully leaving the EU, it is likely that OCGs will adapt to any changes that arise in the CTA; hence, cross-border criminality is expected to increase. That said, interagency cooperation will continue to target any abuse of the CTA that arises.

Organised crime groups

It is estimated that approximately 50% of OCGs have strong relationships and interactions on both sides of the border. Cross-border activity by mobile organised crime groups (MOCGs) are considered an all-island problem and have significant impact on

Cross-border organised crime: threat assessment 2018 continued

domestic burglary in both jurisdictions. The majority of MOCGs are thought to originate in Dublin and involve extended family networks. They have extensive skills, are organised, sophisticated and forensically aware, and illustrate elevated risk-taking behaviour on roads. At this stage, it is not known whether Brexit will have an impact on these groups. The Cross Border Joint Agency Task Force has allocated resources to address criminality by MOCGs via joint interagency action.

Cross-border organised crime: drugs

Similar to the 2016 assessment, the report has highlighted that drugs and drug-related criminality has remained a concern throughout the island. Although 'traditional' drug importation routes are unchanged, the emergence of the dark web along with new psychoactive substances (NPS) and misuse of prescription medications have resulted in changes in drug abuse and OCG criminality.

'Traditional' drugs remain prominent. For example:

- Cannabis continues to be the most prevalent drug used/abused on the Island. At €29/£20 per gram, it is viewed by OCGs involved in wholesale importation and supply as profitable. Cannabis herb blocks or cultivated cannabis plants are mainly seized in ROI. However, other products, for example, cannabis resin and cannabis oil, have also been detained. Irish national OCGs are deeply implicated in this area controlling routes and grow houses.
- Improved economic conditions recently have resulted in increased demand for cocaine and MDMA. Although it is possible to sell these drugs on the darknet, they do form a small part of OCG importations. OCGs that participate in 'poly drug dealing' are mainly smaller than 'traditional wholesale importers'. As a result, they can pose issues for law enforcement when trying to target the problem (p. 7).
- Heroin continues to be a problem across Ireland. While the most problematic area is Greater Dublin, in recent years similar problems have arisen in small urban centres and rural towns and villages. The majority of opiate users reside in Dublin (71%) and are over 35 years of age (>50%). Heroin issues in ROI are viewed as 'stable and entrenched' (p. 7). While in NI, the most problematic area is Belfast city centre, where drug use can be observed every day on the streets.
- In contrast to previous assessments, crack cocaine has recently emerged as an issue for law enforcement agencies

and communities. For now, it is not viewed as a nationwide issue, but it is believed that it will need to be targeted in the future.

- Synthetic opioids have been a characteristic of Irish OCG activity since 2016. Although reported seizures of these products are low, only 0.02 mg of synthetic opioid carfentanil is needed to produce a fatal overdose. While this is not a crisis in ROI and NI currently, there is evidence to suggest that OCGs are selling products on the premise that they are heroin but in actual fact are heroin mixed with synthetic opioids and/or bulking agents.
- Another problem is that some OCGs are introducing synthetic opioids into the drug supply chain that is placing drug users at considerable risk. This problem has been identified as an area that requires ongoing attention and monitoring.
- Prescription medication is an issue across ROI and NI and involves the importation, manufacture and sale of pharmaceutical products. Benzodiazepines are popular in individuals using heroin, managing pain and trying to improve cognitive and/or physical function.
- Another emerging trend is the use of amphetamines by individuals attending tertiary education. Targeting the illicit sale of these products is more and more challenging. However, as prescription drug abuse increases so too will be the issues around it.

Cross-border activity

Primarily, the cross-border elements of drug crime across Ireland centres on relationships between OCGs in ROI and NI in the areas of control and supply. Although the links between ROI and NI OCGs are extensive, collaboration among foreign national OCGs are stronger, as they see Ireland as one market.

The most important supply route on the island is between Dublin and Belfast. This is due to excellent infrastructure linking both areas via motorways and transport systems. Irish OCGs make it possible for NI OCGs to access European drug markets, such as Spain, the Netherlands, and the UK. In consequence, joint collaborations between the PSNI and AGS often involve collaborating with international agencies with the aim of stopping drug supply routes north and south of the border.

Ciará H Guiney

- 1 Police Service of Northern Ireland and An Garda Síochána (2018) *Cross border organised crime: threat assessment 2018*. Belfast and Dublin: Department of Justice (UK) and Department of Justice and Equality (ROI). <https://www.drugsandalcohol.ie/29908/>

Resilience in the face of trauma: implications for service delivery

Psychological trauma, such as adverse childhood experiences (ACEs), can have significant effects on an individual's physical and emotional health. There is a relationship between

exposure to childhood trauma/ACEs and future negative health outcomes as well as increased risk of alcoholism, drug abuse, depression, and homelessness.

Recent research examined the role of trauma and the implications for those affected on how they interact with services in Ireland.¹ The study enrolled a group of women utilising a number of different services in Limerick. The women were profiled through research commissioned by the PALLS (Probation and Linkage in Limerick Scheme) project, as having considerable resilience and capacity for survival. The women all had significant experiences of childhood adversity and trauma. The aim of the work was to better understand the role of

Resilience in the face of trauma

continued

trauma, particularly how it affects the women's interaction with service providers, and how service providers could incorporate this knowledge into service delivery.

The objectives of this research were to gain a better understanding of the needs and experiences of the women utilising local drug, homeless and criminal justice services. The research was conducted through semi-structured interviews of female service users in eight different service providers in Limerick. The interviews used two frameworks to inform their questions: the National Drugs Rehabilitation Implementation Committee's standards for care planning² and the ACE study and definitions provided by the Centers for Disease Control and Prevention.³

An online survey was also part of the research, which was distributed to frontline staff in the different drug and alcohol services, homeless services, and the Probation Service.

Results

The women answered questions on ACEs, with the majority having experienced high rates of ACE when compared with the general population. The women interviewed were frequently affected by nearly all forms of childhood trauma and to a far more significant degree than the general population. For example, these women were seven times more likely to have grown up in a household where there was a family member incarcerated and 3.6 times more likely to have grown up in a household where there was domestic violence. Overall, these women were 10 times less likely to have no ACE at all, when compared with the general population.

The findings were then examined in relation to the needs of these women. Particular themes emerged from the interviews, where women expressed concerns about a range of issues. These included concerns over parenting, such as the fear of losing custody of their children, which resulted in a reduced

willingness to engage with a service. In relation to problem drug and alcohol use, some women expressed the need for gender-specific services and for safe accommodation to aid in the recovery from problem substance use. Self-reported mental health issues were high among this group of women and they identified a number of barriers to accessing appropriate services. These included fear of child protection services, lack of trust in the service provider, and a need to access mental health services quickly.

Differing views emerged between the service providers and the service users on the perceptions of the services provided in relation to factors of trauma-informed care, such as feeling valued, respected, safe, cared for, understood, and trusted. The service users and providers were both asked to rate services on these qualities. Service providers marked themselves higher for all the factors than the clients did, with the biggest difference observed in the value of respect.

By acknowledging the role of trauma in individuals who go on to develop substance abuse, criminality and homelessness issues, and their subsequent interactions with these services, new evidence-informed strategies can be developed. These would be of use to services that are engaging with trauma survivors. Services can examine how they themselves interact with trauma survivors in order to improve how they deliver care to these women. This is to include an assessment of themselves as an organisation and to implement practices that create an environment where service users can engage, heal and grow.

Helen Kennelly

- 1 Dermody A, Gardner C, Davis S, Lambert S, Dermody J and Fein M (2018) Resilience in the face of trauma: implications for service delivery. *Irish Probation Journal*, 15: 161–78. <https://www.drugsandalcohol.ie/30005/>
- 2 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/>
- 3 Further information is available at <https://www.cdc.gov/>

Evaluation of Tabor Group addiction services

The Tabor Group, a provider of residential and community-based addiction treatments in Ireland, has conducted and published the results of an external evaluation of their services.¹ The Tabor Group comprises three residential units: Tabor Lodge (primary treatment centre), Fellowship House (secondary treatment centre for males) and Renewal (secondary treatment centre for females) using the Minnesota Model, as well as supported accommodation in the community. In 2017, some 213 patients were admitted to their residential unit, Tabor Lodge, for treatment as well as providing structured support for their families.

Aims/objectives and methodology

The evaluation was commissioned with the aim of assessing the effect of Tabor treatment programmes across all their facilities and to provide an independent examination of the efficacy of these programmes and the 'goodness of fit' of the treatment model.

The evaluation comprised both desk-based research and primary data collection. The desk-based research involved an analysis of their annual reports from the period 2013–2017. The data collection was performed in two ways: there was a qualitative data component, involving interviews and focus groups, and a quantitative data component carried out through online anonymous submissions. The data collection took place from September 2017 to June 2018.

In total, there were 58 submissions for the evaluation. This included 34 individual interviews, 7 focus group participants, and 17 individual written submissions.

Tabor Group addiction services

continued

Results

Desk-based analysis results

The results of the desk analysis were compiled from annual reports from 2013 to 2017 and were intended to demonstrate the similarities and differences between the three services in the Tabor Group. Treatment figures were also examined in comparison with national and European treatment numbers. Trends in demographics, referrals, service utilisation, and presentation of complex needs across the three services were compiled to examine similarities and differences between the three different services.

Qualitative results

The qualitative results combined both the results from the individual interviews and the focus groups. The qualitative analysis asked three questions across a range of service users, family members, and staff/board members. These questions were:

- What works?
- What does not work?
- What changes would you like to see happen within Tabor Group?

The responses to these questions were quite varied, as they were taken from significantly different viewpoints; however, certain themes and responses repeatedly emerged.

Service users were mostly satisfied with their interaction with the Tabor Group services, noting that the aftercare provided was good. However, there was a mixed response when asked about the model of treatment, often stating that it was very confrontational. The majority also felt that the 28-day treatment programme was not long enough. Another issue identified was a break in the continuum of care from the residential unit to the other two services. Clients felt that this was a vulnerable period in the treatment and not helpful.

Family members were extremely satisfied with the support services provided, stating that the services provided were

comprehensive and of great value. However, a recurring issue for family members was the financial barrier to treatment.

Staff responses to the interviews/surveys indicated that perhaps they were undervalued as part of the wider organisation. They also felt that the administration elements are particularly time-consuming and therefore impacted on their clinical time. Staff felt that the Tabor Group has a particularly good reputation; however, they had concerns that the three components of the Tabor Group are seen as separate services, rather than a collective organisation.

Recommendations

As a result of the external evaluation, particular issues/areas have been identified. A number of recommendations have been suggested for consideration, particularly in the following areas:

- **Strategic management and governance:** Some of these issues include the advice that the board should provide leadership for the direction of the organisation. The senior management team could be restructured to improve equality between the three groups. There is a need to improve the communication that financial assistance is available through the Health Service Executive, as well as developing a communication strategy.
- **Staffing issues:** The findings of the evaluation report should be communicated to staff in a series of meetings to discuss results. Staff members should have a review of their training needs and the clinical director should follow up that annual staff appraisals are conducted.
- **Programme issues:** As a number of clients raised concerns about the confrontational counselling practice, known as the 'hot seat', and that research has shown that it is associated with a higher dropout and relapse rate, this practice should be discontinued. The 28-day limit for Tabor Lodge should be reviewed on a case-by-case basis, to extend this limit where needed. Trauma-informed care could also be incorporated into the core treatment model. Also, a seamless progression from primary care to secondary care needs to be developed in order to become the norm.

Helen Kennelly

1 Ivers J-H and Barry J (2018) *An evaluation of Tabor Group*. Cork: Tabor Group. <https://www.drugsandalcohol.ie/30084/>

Barriers and enablers to HCV screening and treatment in Irish prisons

Hepatitis C infection (HCV) is a major global epidemic with an estimated 399,000 people dying annually from HCV-related liver failure and cancer.¹ Unsafe injecting drug use is the main route of HCV transmission in developed countries, with an estimated 20 million people who inject drugs (PWID) infected

worldwide.² Over one-half of Irish prisoners report a history of opiate use, with 43% reporting a history of injecting.³ A 2000 study estimated the prevalence of HCV infection in the Irish prison population at 37%, increasing to 81% in those with a history of injecting drug use.⁴ With recent advances in treatment regimes, HCV is now a curable and preventable disease and prisons provide an ideal opportunity to engage this hard-to-reach population. However, despite increased access to primary healthcare while in prison, many HCV-infected prisoners do not engage with screening or treatment.

A recent Irish study aimed to identify barriers and enablers to HCV screening and treatment in Irish prisons.⁵ In this research, published in the *BMC Harm Reduction Journal*, four focus groups took place in Mountjoy Prison for males and in the Dóchas Centre medium-security prison for adult females at the Mountjoy Campus in Dublin. Participants were recruited at

HCV screening in prison continued

both sites by open invitation through posters and directly by custodial and healthcare staff. Focus groups were facilitated by an experienced team of facilitators and included a series of open-ended questions covering the following areas: experience of community-based and prison-based HCV screening and treatment; barriers and enablers to uptake; challenges related to incarceration and release; inter-prison variations in healthcare delivery; and the role of security staff and peers in prison HCV management.

Results

The following themes related to barriers and enablers to both HCV screening and treatment emerged.

Barriers

Lack of knowledge

All focus groups identified lack of knowledge as a major block to engagement with HCV treatment services. Prisoners were aware of their own lack of knowledge and were often confused about the different types of hepatitis. In addition, many prisoners were confused about the mode of transmission.

Fear of liver biopsy and treatment and concerns regarding confidentiality

Many prisoners spoke about their fear of treatment and the negative stories they had heard from other inmates. In addition, prisoners expressed concerns regarding confidentiality, with some believing that non-medical staff had access to their medical records. Many explained how prisoners were often called on the prison landing for certain blood tests and hospital appointments and that this revealed their medical status to the other prisoners and security staff.

Fear of being stigmatised and systematic barriers

In addition to concerns about confidentiality, prisoners indicated that there was a fear of being stigmatised by other prisoners and staff if they became aware of their HCV status. Several participants described a double stigma: the first associated with HCV status, and the second being a prisoner in a hospital setting. In particular, the practice of handcuffing male prisoners for security reasons while attending outpatient appointments was identified as increasing the chances of experiencing stigma and shame. Many prisoners also expressed frustration at the many systemic blocks to screening and treatment. These included delays in having bloods taken in addition to further long delays in receiving results.

Enablers

Opt-out screening at committal and in-reach hepatology and fibroscanning

Screening on committal was seen by most inmates as an enabler to treatment, describing it as 'more private' and 'more suitable'. However, some participants were concerned that adapting to new surroundings on committal was already a stressful time – with some inmates also having to manage withdrawals. Participants identified the presence of in-reach hepatology services at both locations as a facilitator to engagement with treatment, given that the availability of on-site specialist hepatology reduced the need for prisoners to attend hospital outpatients. In addition, the majority of prisoners

expressed satisfaction with access to, and the experience of, fibroscanning – with many highlighting that they had better access to fibroscanning within prison than in the community.

Stability of prison life and peer support

All focus group participants agreed that prison eliminated many of the blocks experienced by this cohort in the community, in particular with regard to homelessness, personal motivation, competing priorities, and access to healthcare and drug treatment. Moreover, participants identified peer educators as a potential facilitator to HCV screening and treatment, as a number of prisoners had experienced mass HIV and TB screening programmes involving Red Cross peer workers while serving previous sentences and described it as facilitating their engagement.

Conclusions

The authors noted that although Irish prisons are a key setting to identify and treat HCV-infected PWID, this can only be achieved by the elimination of identified barriers to HCV screening and treatment in Irish prisons. It is hoped that the barriers and enablers to HCV screening and treatment reported by Irish prisoners in this research will inform both national and international public health HCV elimination strategies.

Seán Millar

- 1 World Health Organization (WHO) (2017) *Global hepatitis report, 2017*. Geneva: WHO. <https://www.drugsandalcohol.ie/27177/>
- 2 Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais DC, Horyniak D, *et al.* (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet*, 378(9791): 571–83. <https://www.drugsandalcohol.ie/15845/>
- 3 Drummond A, Codd M, Donnelly N, McCausland D, Mehegan J, Daly L, *et al.* (2014) Study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prisoner population. Dublin: National Advisory Committee on Drugs and Alcohol (NACDA). <https://www.drugsandalcohol.ie/21750/>
- 4 Allwright S, Bradley F, Long J, Barry J, Thornton L and Parry JV (2000) Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: results of a national cross sectional survey. *Br Med J*, 321(7253): 78–82. <https://www.drugsandalcohol.ie/6741/>
- 5 Crowley D, Van Hout MC, Lambert JS, Kelly E, Murphy C and Cullen W (2018) Barriers and facilitators to hepatitis C (HCV) screening and treatment – a description of prisoners' perspective. *Harm Reduct J*, 15: 62. <https://www.drugsandalcohol.ie/30075/>

Merchants Quay Ireland annual review, 2017

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and drug users. There are 22 MQI locations in 12 counties in the Republic of Ireland (see Figure 1). In September 2018, MQI published its annual review for 2017.¹ MQI aims to offer accessible, high-quality and effective services to people dealing with homelessness and addiction in order to meet their complex needs in a non-judgmental and compassionate way. This article highlights services provided by MQI to drug users in Ireland in 2017.

Drug services

Health Promotion Unit

This unit provides drug users with information about the risks associated with drug use and the means to minimize such risks. MQI offers drug users a pathway into treatment and the possibility of living a life without drugs. The main focus is on reducing the harms associated with injecting drug use; fostering the motivation to become abstinent; and giving advice on HIV, hepatitis B virus and hepatitis C virus infection prevention. In 2017, some 2,583 individuals used the service (an increase of 3% on 2016), of which 443 were new clients.

As part of the MQI health promotion remit, a total of 2,691 safer injecting workshops were undertaken with injecting drug users in 2017, an increase of 26% on 2016. There were 25,358 needle exchange visits, an increase of 3% on 2016.

Naloxone provision

Along with partners in the Health Service Executive, the National Family Support Network and the Ana Liffey Drug Project, MQI was front and centre in the national rollout of the Naloxone Demonstration Project in 2015. Naloxone is an antidote for opioid overdose that reverses the depressant effects of opiates such as heroin. To date, more than 400 drug users have been prescribed naloxone, and an external evaluation concluded that the scheme was a success. Work on this initiative is ongoing and MQI hopes that eventually all opiate drug users in Ireland will have access to this life-saving drug.

Community benzodiazepine detoxification

In response to a need identified in 2017, MQI undertook to facilitate community benzodiazepine detoxifications in collaboration with Granby MQI GP Services. A total of 45 clients accessed this programme in 2017. MQI notes that many of these clients have since moved on to become drug-free, have gained employment, and/or have accessed education programmes in addition to accessing residential rehabilitation programmes.

Community Engagement Team

The Community Engagement Team works to cultivate and strengthen relationships between MQI and the local community. The team picks up and safely disposes of drug-related litter as well as offering some of the most vulnerable people (who are rough sleeping or reluctant to engage with services) street-based advice and referral into the services they need. A total of 11,951 items of drug-related litter were disposed of by this team in 2017.

Drug Rehabilitation Scheme – Riverbank Centre, Dublin

As part of their Community Employment Scheme, MQI provides a stabilisation programme which seeks to establish a regular pattern of discipline and daily attendance in order to help clients stabilise and reduce their drug use and prepare them for mainstream training and employment. In 2017, some 26 individuals participated in the programme; most were aged between 18 and 39 years of age. Links with the Education and Training Boards facilitate the accredited educational component for this programme, which helps people gain momentum into education and employment.

Family Support Group

MQI offers one-to-one advice and support to family members on the realities of drug use and how they can best cope and provide optimum support to drug users. MQI also runs a Family Support Group (FSG), which meets every week and provides a forum where parents, as well as other close relatives and friends of drug users, are offered support and advice on a range of issues. Participants provide support for each other, and the group is continually open to new members. The weekly FSG is linked to the National Family Support Network, which offers an opportunity to raise issues at a national level. MQI's FSG in Dublin worked with over 40 individuals throughout 2017.

Midlands services

Drug and Alcohol Treatment Supports Project

The MQI's Drug and Alcohol Treatment Supports (DATS) team provides a community-based drug and alcohol treatment support service for individuals over 18 years of age and their families in the Midlands area (Counties Longford, Westmeath, Laois and Offaly). Each county has a dedicated drug and alcohol worker to coordinate the care of individuals and families experiencing problems due to drug and/or alcohol use. In 2017, the team based in the Midlands provided support to 460 people, with a total of 4,906 interventions carried out.

Drug Rehabilitation Scheme – Athlone

Supported by Athlone Community Taskforce; the Adult Education Centre; the Probation Service; Longford and Westmeath Education and Training Board; and South Westmeath Employment, Education and Training Services, this programme allows clients to participate in activities and educational qualifications at an appropriate level on the National Framework of Qualifications. The scheme also provided individuals with addiction and other rehabilitation supports, for example, crisis intervention supports, group work, and key working. In 2017, some 22 participants were engaged on this programme.

Rehab and detox treatment services

St Francis Farm Rehabilitation Programme and Detox Services

The St Francis Farm (SFF) Rehabilitation Service offers a 13-bed therapeutic facility with a 14-week rehabilitation programme set on a working farm in Co. Carlow. At SFF, MQI provides a safe environment where service users can explore the reasons for their drug use, adjust to life without drugs, learn effective coping mechanisms, and make positive choices about their future. There were 52 clients admitted to the SFF Rehabilitation Service during 2017, of whom 27 completed the programme. The 10-bed residential detoxification service at SFF delivers methadone and combined methadone/benzodiazepine detoxes for both men and women. The detox activity programme includes individual care planning, therapeutic group work,

MQI annual review, 2017 continued

psychoeducational workshops, fitness training, and farm-work activities. There were 65 clients admitted for detox service during 2017, of whom 56 completed the programme.

Prison-based services

Addiction Counselling Service and Mountjoy Drug Treatment Programme

MQI, in partnership with the Irish Prison Service, delivers a national prison-based Addiction Counselling Service (ACS) aimed at prisoners with drug and alcohol problems. This service provides structured assessments, one-to-one counselling, therapeutic group work, and multidisciplinary care, in addition to release-planning interventions with clearly defined treatment plans and goals. Services offered include:

- Brief interventions
- Motivational interviewing and motivational enhancement therapy
- A 12-step facilitation programme
- Relapse prevention and overdose reduction
- Cognitive behavioural therapy
- Harm reduction approaches
- Individual care planning and release planning.

In 2017, some 2,547 prisoners accessed the ACS and the MQI team delivered 10,252 one-to-one counselling sessions. The MQI ACS also coordinated and contributed to the delivery of a structured, multiagency eight-week Detox and Drug Treatment Programme (DTP) in the Mountjoy Prison Medical Unit. During 2017, the DTP assisted 44 prisoners in detoxing from methadone and benzodiazepines.

Seán Millar

- 1 Merchants Quay Ireland (2018) *Merchants Quay Ireland: Homeless & Drugs Services: annual review 2017*. Dublin: MQI.
<https://www.drugsandalcohol.ie/29674/>

Figure 1: MQI locations in Ireland



- 1 Dublin
- 2 Shelton Abbey, Co. Wicklow
- 3 St Francis Farm, Co. Carlow
- 4 Cork Prison
- 5 Limerick Prison
- 6 Co. Offaly
- 7 Co. Westmeath
- 8 Portlaoise, Co. Laois
- 9 Co. Longford
- 10 Castlerea Prison, Co. Roscommon
- 11 Loughran House, Co. Cavan
- 12 Leixlip, Co. Kildare

Source: MQI annual review, 2017

DOVE Clinic, Rotunda Maternity Hospital annual report, 2017

The DOVE Clinic in the Rotunda Hospital, Dublin was established to meet the specific needs of pregnant women who have, or are at risk of, blood-borne or sexually transmitted bacterial or viral infections in pregnancy. Exposure may also occur through illicit drug use. Figures from the clinic for 2017 were published in the hospital's annual report in 2018.¹

Figure 1 shows the number of women who booked into the DOVE Clinic for antenatal care each year during the period

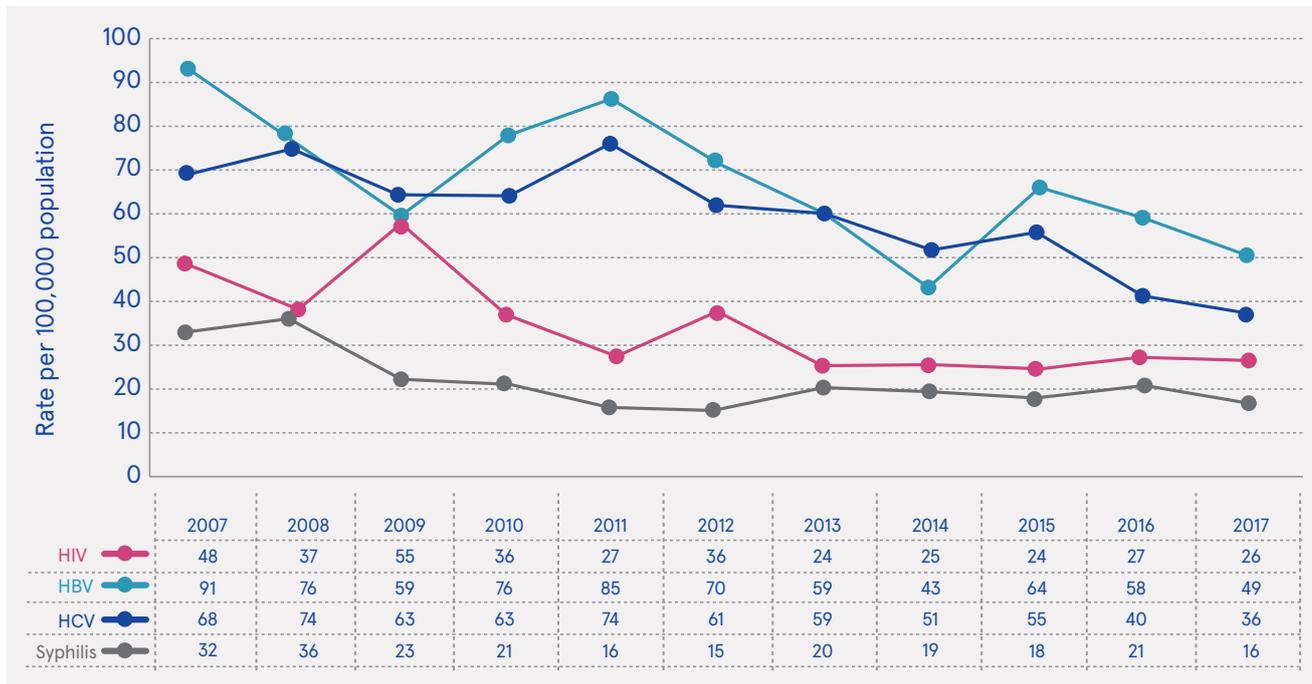
2007–2017. It also shows the diagnosis of these women. During 2017, some 123 women booked into the DOVE Clinic for antenatal care. Of these:

- 26 (21%) women were positive for HIV infection.
- 49 (40%) women were positive for hepatitis B (HBV) surface antigen.
- 36 (29%) women were positive for hepatitis C (HCV) antibody.
- 16 (13%) women had positive treponemal serology (syphilis).

It should be noted that these numbers refer to patients who booked for care during 2017. Table 1 summarises the outcome of patients who actually delivered during 2017. Of these patients, 23 were HIV-positive, 49 were HBV-positive, and 38 were HCV-positive. During 2017, 100 women were referred to the Drug Liaison Midwife (DLM) service, including 56 women

DOVE Clinic annual report continued

Figure 1: DOVE Clinic bookings, by year, 2007–2017



Source: Rotunda Hospital, 2018

Table 1: Deliveries to mothers attending the DOVE Clinic who were positive for HIV, HBV, HCV or syphilis, or who were attending the drug liaison midwife, 2017

Mother's status	HIV-positive	HBV-positive	HCV-positive	Syphilis-positive	DLM
Total mothers delivered	23	49	38	21	62
Total mothers delivered <500 g (including miscarriage)	2	0	0	0	0
Total mothers delivered >500 g	21	49	38	21	62
Live infants	21	49	39**	21	61
Miscarriage	2	0	0	0	0
Stillbirth	0	0	0	1	1
Infants <37 weeks' gestation	3	0	7	3	12
Infants ≥37 weeks' gestation	18	49	32	18	50
Caesarean section	8	15	14	11	15
HIV, HBV, HCV or syphilis-positive infants	0	0*	0*	0	–
Maternal median age	33	31	33	33	–

Source: Rotunda Hospital, 2018

* Final serology test not yet available for all infants.

** One set of twins.

DLM = drug liaison midwife.

who had a history of opiate addiction and were engaged in a methadone maintenance programme. There was a total of 62 deliveries to mothers under the DLM service in 2017.

Seán Millar

1 Rotunda Hospital (2018) *The Rotunda Hospital, Dublin annual report 2017*. Dublin: Rotunda Hospital. <https://www.drugsandalcohol.ie/30085/>

Twentieth Annual Service of Commemoration and Hope

The National Family Support Network (NFSN)¹ is an autonomous self-help organisation that provides support to families and respects the experiences of families affected by substance misuse in a welcoming non-judgemental atmosphere. On Friday, 1 February 2019, the NFSN held its 20th Annual Service of Commemoration and Hope. This spiritual, multidenominational service is held in remembrance of loved ones lost to substance misuse and related causes and to publicly support and offer hope to families living with the devastation that substance misuse causes. The service was preceded by a procession from the 'Home' memorial on Sean MacDermott Street, Dublin, to the nearby Church of Our Lady of Lourdes, led by the band of An Garda Síochána.

Those in attendance included Ms Catherine Byrne TD, Minister of State at the Department of Health with responsibility for Health Promotion and the National Drugs Strategy; Comdt Caroline Burke, aide-de-camp to An Taoiseach; representatives from An Garda Síochána, including Chief Supt Sean Ward and Det Supt Brian Woods; Archbishop Diarmuid Martin, Bishop Eamonn Walsh and other religious representatives; as well as family members, friends, and many people involved in substance misuse work. Music was provided by soprano Nickola Hendy, Cathal Holland and the Gardiner Street Gospel Choir.

Work of NFSN

In her address to the gathering, Sadie Grace, coordinator of the NFSN, spoke directly to family members, stressing that they are not alone in their grief. Data from the National Drug-Related Deaths Index (NDRDI) show that over 700 people die directly or indirectly due to drug use on an annual basis. She highlighted the NFSN's many achievements, including advocating strongly for accurate figures on drug-related deaths, which had culminated in the establishment of the NDRDI in 2005. The NFSN had also advocated for the rollout of the naloxone programme, which was set up to help reverse the effects of opiate overdose through training, in recognition and response to overdose due to opiates, in addition to appropriate administration of naloxone.

She acknowledged the assistance given by Archbishop Martin in helping the NFSN support families financially with funeral costs. Sadie highlighted the impact that drug-related deaths can have, especially the stigma and shame felt by families, and the need for specific bereavement support. This need was supported by research carried out by Dr Sharon Lambert, whose findings showed that drug-related deaths must be classified as special deaths that require specific bereavement support. The NFSN advocated for the inclusion of an action in the current drugs strategy for provision of bereavement support, specifically for drug-related deaths. The first addiction-specific bereavement support counselling was set up in September 2018 by the NFSN in Dublin's north inner city, but needs to be available nationwide.

Sadie stressed that respite was a crucial lifeline for families and, on a positive note, announced that the NFSN has secured funding for their annual respite conference.

In relation to drug-related intimidation, she said that 'meaningful action' needed to be taken and that drug-related intimidation is affecting families all over Ireland. Sadie finished by offering families hope. She stressed that the work of the NFSN will continue to advocate for better services for families and that their loved ones need person-centred, accessible and early intervention. The NFSN will continue to fight for family support to be accessible throughout Ireland. She invited any family member affected by a drug-related death to contact the NFSN for help with their bereavement.

Impact of drug-related deaths

In her address, Minister Byrne emphasised the ongoing valuable work of the NFSN. She acknowledged and extended her sympathy to the bereaved families present. In addition, she stressed her commitment as Minister of State to continue to highlight the impact of drug-related deaths and welcomed the health-led approach and actions on family support included in the new strategy.²

Dr Sharon Lambert called for a public campaign to help decrease the stigma related to drug and alcohol addiction. Highlighting findings from her bereavement report, she stated that the stigma linked to drug-related deaths leads to complicated bereavement. A drug-related death must be treated as a special death that requires specialised bereavement support and if not provided it can leave a legacy of trauma for generations. She also stressed the need for treatment services to include family members in addiction treatment, as people accessing treatment are too unwell to assess and engage in their treatment on their own.

In his address, Archbishop Martin spoke of the lack of respect for life within the drug trade with too many young lives lost to drugs. He acknowledged the support that women provide to other women in their grief and the ongoing support given by the NFSN.

For many families, this service was the first time that they could openly grieve for loved ones lost to drug use and related causes. The volume of family support groups was evident, with over 70 support groups from across the island of Ireland represented at this year's service, a stark reminder that drug-related deaths affect families throughout the whole of Ireland. The NFSN runs a 10-week bereavement programme twice a year and family members can contact the NFSN and avail of assistance from this group.

Ena Lynn

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

2 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/>



National Drugs Library

UPDATES

Recent publications

POLICY

Support for evidence-based alcohol policy in Ireland: results from the Community Action on Alcohol Pilot Project

Davoren MP, Lane D, Kirby J, Gibney K, Kinsley G, Hope A, *et al.* (2019) *Journal of Public Health Policy*, 40(1): 76–90.
<https://www.drugsandalcohol.ie/29899/>

The aim of this research was to examine the level of support for evidence-based alcohol control policy among the Irish population.

The majority of individuals (>50%) supported alcohol policy measures. These individuals are more likely to be low-risk drinkers, older individuals, and report alcohol-related issues in their local area. In the context of Ireland's Public Health (Alcohol) Bill, this research signals support for evidence-based strategies including minimum unit pricing and a reduction and separation of alcohol sales outlets.

RESPONSES

Resilience in the face of trauma: implications for service delivery

Dermody A, Gardner C, Davis S, Lambert S, Dermody J and Fein M (2018) *Irish Probation Journal*, 15: 161–78.
<https://www.drugsandalcohol.ie/30005/>

This research was commissioned to facilitate a better understanding of the women's needs [presenting to homeless, probation and drug treatment services in Limerick city], with a view to enabling services to be more responsive. This paper presents a brief literature review of trauma and trauma-informed care, outlines the research findings and makes recommendations for future service design and delivery.

How suicide-bereaved family members experience the inquest process: a qualitative study using thematic analysis

Spillane A, Matvienko-Sikar K, Larkin C, Corcoran P and Arensman E (2019) *International Journal of Qualitative Studies on Health and Well-being*, 14, (1).
<https://www.drugsandalcohol.ie/30204/>

The current study aimed to explore how suicide-bereaved family members (n=8) experienced the inquest process, through qualitative semi-structured interviews.

Key recommendations include informing family members of the main aspects and purpose of the inquest process beforehand, adapting the process to maximise the privacy and comfort of the bereaved relatives, and restricting graphic evidence being heard, where possible, to minimise distress experienced by family members.

Smoking cessation support and obstetric outcomes in an Irish maternity hospital

McDonnell BP, Keogan S, Clancy L and Regan C (2019) *European Journal of Obstetrics, Gynecology, and Reproductive Biology*, 232: 1–4.
<https://www.drugsandalcohol.ie/30003/>

Although recommendations exist for the management of pregnant smokers, information on the antenatal care of Irish smokers in pregnancy has not been described. We reviewed the care given to smokers in a large urban maternity hospital.

Maternal cigarette smoking appears to be a largely tolerated risk factor in the population studied, despite being associated with poor obstetric outcomes. We identified an absence of smoking cessation services and a lack of intervention and structure around care pathways.

Prospective study of provided smoking cessation care in an inpatient psychiatric setting

Burns A, Lucey JV, Strawbridge J, Clancy L and Doyle F (2018) *Journal of Psychosomatic Research*, 11: 524–31.
<https://www.drugsandalcohol.ie/29874/>

This study aimed to evaluate current levels of cessation care provided, and 3-month quit-rates, in one such setting in Ireland.

Despite a high current smoking prevalence among psychiatric inpatients, and similar motivation and quit rates to other populations, current cessation care rates are low. Smoking cessation care needs to be prioritised in psychiatric settings.

Recent publications continued

PREVALENCE AND CURRENT SITUATION

A profile of psychiatric in-patient admissions with no fixed abode (NFA) 2007–2016

Daly A, Craig S and O'Sullivan E (2019) *Irish Medical Journal*, 112: 853.
<https://www.drugsandalcohol.ie/30179/>

This paper examines admissions for the last ten years for those recorded as of no fixed abode (NFA) on the National Psychiatric In-Patient Reporting System (NPIRS).

The paper concludes the need to use routinely collected data to help understand and address the need of specific homeless sub-groups particularly those on institutional circuits that include psychiatric in-patient facilities. To enable this it recommends the implementation of the individual health identifier as a matter of urgency.

Barriers to progressing through a methadone maintenance treatment programme: perspectives of the clients in the Mid-West of Ireland's drug and alcohol services

Moran L, Keenan E and Elmusharaf K (2018) *BMC Health Services Research*, 18(1): 911.
<https://www.drugsandalcohol.ie/30195/>

To date, very few studies have specifically investigated the reasons why a cohort of clients remain 'trapped' in the high risk, specialist clinical setting.

To optimise the functioning of the MMTP [Methadone Maintenance Treatment Programme], three tasks need to be fulfilled: 1) Reduce the incidences of ACEs [adverse childhood experiences], 2) Diagnose and treat clients with a dual diagnosis, 3) Educate clients, their families, the public and allied health care professionals on all aspects of OUD [opioid use disorder]. A cross-departmental, inter-governmental approach is needed to address opioid misuse as a societal issue as a whole.

Five-year standardised mortality ratios in a cohort of homeless people in Dublin

Ivers J-H, Zgaga L, O'Donoghue-Hynes B, Heary A, Gallwey B and Barry J (2019) *BMJ Open*, 9(1): e023010.
<https://www.drugsandalcohol.ie/30198/>

The aim of this study was to calculate standardised mortality ratios (SMRs) for a cohort of homeless people in the Dublin region over a 5-year period and to examine leading causes of death.

Mortality rates among homeless persons are exceptionally high. Services and programmes, particularly housing and those targeting overdose and alcoholism, are urgently needed to prevent premature mortality in this vulnerable population.

Twenty years of the methadone treatment protocol in Ireland: reflections on the role of general practice

Delargy I, Crowley D and Van Hout MC (2019) *Harm Reduction Journal*, 16(1): 5.
<https://www.drugsandalcohol.ie/30173/>

Twenty years of the MTP [methadone treatment protocol] has been the mainstay of harm reduction services in Ireland. It has provided a network of specially trained GPs who provide methadone to over 10,000 patients across Ireland within a structured framework of training, quality assurance and remuneration. With the ongoing commitment of Irish specialists in the field of addiction medicine, further improvements to support and treat patients can be made.

Rates of reported codeine-related poisonings and codeine prescribing following new national guidance in Ireland

Kennedy C, Duggan E, Bennett K and Williams DJ (2019) *Pharmacoepidemiology and Drug Safety*, 28:(1): 106–11.
<https://www.drugsandalcohol.ie/30150/>

The aims of this study were to examine a national database to assess codeine poisonings before and after the new guidance for pharmacists while also evaluating rates of codeine prescriptions following the introduction of restrictions on supply.

New guidance on codeine supply coincided with an initial reduction in reported codeine poisoning cases. This reduction was in keeping with the previous trend. However, this was without an increase in the prevailing rate of prescription claims for these products or potential substitutes. Policymakers may consider further restriction of codeine products to improve public health outcomes.

Profiling frequent attenders at an inner city emergency department

Uí Bhroin S, Kinahan J and Murphy A (2019) *Irish Journal of Medical Science*, Early online.
<https://www.drugsandalcohol.ie/30155/>

The primary aim was to describe the prevalence of FAs [frequent attenders] at an inner city ED [emergency department]. A subgroup analysis was undertaken for high and very high FAs to establish demographics and other factors which might cause them to attend frequently.

This retrospective review is the most detailed assessment of Irish FAs undertaken to date. Further studies are required to examine the Irish hospitals most at need of Case Management Strategy Programmes which we postulate could minimise the risk of adverse outcomes for these patients and improve overall ED efficiency.

Recent publications continued

Intention to reduce drinking alcohol and preferred sources of support: an international cross-sectional study

Davies EL, Maier LJ, Winstock AR and Ferris JA (2019) *Journal of Substance Abuse Treatment*, 99: 80–87.
<https://www.drugsandalcohol.ie/30183/>

This paper aimed to assess intentions to reduce drinking and the preferred sources of support among a large international sample of people who drink alcohol.

Interest in online interventions for harmful drinking is significant and highest among people who drink at low risk. Online tools should offer brief screening and feedback, ensuring that people with high risk drinking patterns are referred to more specialist services.

Method of self-harm and risk of self-harm repetition: findings from a national self-harm registry

Cully G, Corcoran P, Leahy D, Griffin E, Dillon C, Cassidy E, *et al.* (2019) *Journal of Affective Disorders*, 246, 843–50.
<https://www.drugsandalcohol.ie/30170/>

This study examined risk of hospital presented self-harm repetition according to specific characteristics of self-harm methods.

Self-harm method and the associated risk of repetition should form a core part of biopsychosocial assessments and should inform follow-up care for self-harm patients. The observed differences in repetition associated with specific characteristics of IDO [intentional drug overdose] underline the importance of safety planning and monitoring prescribing for people who have engaged in IDO.

An online survey of Irish general practitioner experience of and attitude toward managing problem alcohol use

Collins C, Finegan P and O’Riordan M (2018) *BMC Family Practice*, 19(1): 200.
<https://www.drugsandalcohol.ie/30133/>

This study aimed to explore Irish general practitioners’ (GPs) current practice of and attitudes towards the management of problem alcohol use.

GPs in this survey reported widespread experience of screening and intervention, however, many still felt ineffective. In order to maximise the potential impact of GPs, a clearer understanding is required of what interventions are effective in different scenarios. Furthermore, GPs are only part of the solution in terms of addressing alcohol consumption. The services available in the broader health care system and Government alcohol related policy needs to further support GPs and patients.

Probation officers’ judgements: a study using personal construct theory

Mullineux JC, Taylor BJ and Giles ML (2019) *Journal of Social Work*, 19(1): 41–59.
<https://www.drugsandalcohol.ie/30176/>

Social workers and probation officers are frequently called upon to make judgements about the likelihood of re-offending. However, whilst the use of risk assessment instruments is now commonplace, the cognitive processes through which these judgements are made are rarely explicit.

It is suggested that the design and implementation of assessment tools should be undertaken in the light of the constructs used in making professional judgements which inform the relevant decision making.

Grey matter volume differences associated with extremely low levels of cannabis use in adolescence

Orr C, Spechler P, Cao Z, Albaugh M, Chaarani B, Mackey S, *et al.* (2019) *Journal of Neuroscience*, 39(10): 1817–27.
<https://www.drugsandalcohol.ie/30177/>

In the current study, we used voxel-based morphometry to compare grey matter volume (GMV) in 46 fourteen year old human adolescents (males and females) with just one or two instances of cannabis use and carefully matched THC-naïve [Δ -9-tetrahydrocannabinol] controls.

This study presents evidence suggesting structural brain and cognitive effects of just one or two instances of cannabis use in adolescence. Converging evidence suggests a role for the endocannabinoid system in these effects. This research is particularly timely as the legal status of cannabis is changing in many jurisdictions and the perceived risk by youth associated with smoking cannabis has declined in recent years.

Harms from a partner’s drinking: an international study on adverse effects and reduced quality of life for women

Callinan S, Rankin G, Room R, Stanesby O, Rao GN, Waleewong O, *et al.* (2018) *American Journal of Drug and Alcohol Abuse*, 45(2): 170–78.
<https://www.drugsandalcohol.ie/30127/>

The aim of this study was to identify the proportion of heterosexual intimate partner relationships with a heavy drinking male that resulted in reported alcohol-related harm and to investigate the impact of this on well-being in 9 countries.

Harms to women from heavy drinking intimate partners appear across a range of subgroups and impact on a wide range of women, at least demographically speaking. Women living with a heavy drinking spouse experience higher levels of anxiety and depression symptoms and lower satisfaction with life.

Recent publications continued

Alcohol industry involvement in policymaking: a systematic review

McCambridge J, Mialon M and Hawkins B (2018) *Addiction*, 113(9): 1571–84.

<https://www.drugsandalcohol.ie/30180/>

The aim of this study was to summarize the substantive findings of studies of alcohol industry involvement in national or supranational policymaking, and to produce a new synthesis of current evidence.

Alcohol industry actors are highly strategic, rhetorically sophisticated and well organized in influencing national policymaking.

Non-steroidal anti-inflammatory drugs use, knowledge, and behaviours around their use and misuse in Irish collegiate student-athletes

O'Connor S, McCaffrey N, Whyte E, Moran K and Lacey P (2018) *The Physician and Sportsmedicine*, Early online.

<https://www.drugsandalcohol.ie/30014/>

Non-steroidal anti-inflammatory drugs (NSAIDs) are commonly used by athletes to treat injuries but are also reportedly misused as performance or recovery aids. This study aimed to investigate NSAID use, knowledge, and behaviour regarding use and misuse of NSAIDs in Irish student-athletes.

Education strategies to improve student-athletes' knowledge of appropriate use and side effects of NSAIDs are recommended, particularly for those with high levels of stress and athletic identity.

EU anti-smoking graphic warnings on cigarette packets: semiotics and the issue of gender under-representation

O Doherty D, Houghton F, McInerney D, Duncan B and Houghton D (2018) *Irish Journal of Medical Science*, Early online.

<https://www.drugsandalcohol.ie/30002/>

Smoking remains the leading cause of preventable mortality globally and is responsible for significant morbidity. The mandatory introduction of combined anti-smoking graphic and text warnings on tobacco products within the European Union (EU) therefore has been welcomed as an important element of the necessary war on tobacco. Emerging evidence suggests that such warnings are an effective tool, particularly when combined with plain packaging.

Prevalence of potentially inappropriate prescribing in older people in primary care and its association with hospital admission: longitudinal study

Pérez T, Moriarty F, Wallace E, McDowell R, Redmond P and Fahey T (2018) *BMJ*, 363: k4524.

<https://www.drugsandalcohol.ie/29966/>

The aim of this study was to determine whether hospital admission is associated with potentially inappropriate prescribing among older primary care patients (aged ≥65 years) and whether such prescribing was more likely after hospital admission than before.

Hospital admission was independently associated with potentially inappropriate prescribing. It is important to determine how hospital admission may affect appropriateness of prescribing for older people and how potential adverse consequences of admission can be minimised.

The global burden of disease attributable to alcohol and drug use in 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016

GBD 2016 Alcohol and Drug Use Collaborators (2018) *Lancet Psychiatry*, 5(12): 987–1012.

<https://www.drugsandalcohol.ie/29880/>

We aimed to use data from the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2016 to calculate global and regional estimates of the prevalence of alcohol, amphetamine, cannabis, cocaine, and opioid dependence, and to estimate global disease burden attributable to alcohol and drug use between 1990 and 2016, and for 195 countries and territories within 21 regions, and within seven super-regions. We also aimed to examine the association between disease burden and Socio-demographic Index (SDI) quintiles.

Alcohol and drug use are important contributors to global disease burden. Effective interventions should be scaled up to prevent and reduce substance use disease burden.