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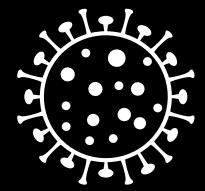
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Impact of Covid-19

Covid-19 pandemic presents particular challenges for people who are using drugs and for those providing services to vulnerable populations. Social distancing requirements are hampering effective operation of services and many treatment centres are temporarily closed. Many national and international organisations have highlighted the additional dangers faced by users of drugs services and have produced guidelines for drug treatment and harm reduction practitioners.



Coronavirus COVID-19

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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

As this issue of *Drugnet Ireland* goes to print, we are in the 11th week of the extraordinary measures introduced by the Government in response to the Covid-19 crisis. This global pandemic is affecting most of the world's population in some way. Many have lost loved ones, are ill themselves, or enduring severe difficulties through loss of income. Most of the citizens of scores of countries across the world are largely confined to their own homes and many face the isolation of quarantine. Our healthcare workers and those in essential services face additional threats to their health every day. The gratitude expressed to them and the countless instances of kindness and care since this emergency began are reassuring signs of decency and a sense of community. These will be essential resources as we face the difficult months ahead.

We are also aware of the further dangers faced by socially excluded groups, already enduring poor health outcomes and having poor access to healthcare services. We know that restrictions in services and in contacts with vulnerable people are exacerbating the everyday life challenges faced by people with substance use problems. People who are homeless and people who use drugs often have multiple comorbidities and early mortality compared with the general population.¹ The older cohort of opioid users are particularly vulnerable because of their high level of pre-existing health problems. There is a high prevalence of chronic obstructive pulmonary disease, asthma, and cardiovascular disease among people who inject drugs and use cocaine. These chronic medical conditions will put clients of drug treatment services at particular risk for serious respiratory illness if they become infected with Covid-19.

These are the marginalised groups most relevant to the concept of inclusion health. This is an approach to health service delivery and research that emphasises the need to arrange healthcare to improve outcomes for the most at-risk groups in society. At a time like this, we also recognise it is not just a social exclusion or human rights issue. The vulnerabilities of one group affect us all, and the current crisis will not pass until all are free from risk. The values that underpin the idea of inclusion health are essential to the idea of public health.

This is also a time in which we are keenly aware of the importance of accurate, scientifically based, and credible information. Evidence must be communicated freely and clearly so that all citizens can play their part in responding to the crisis. International health institutions, monitoring agencies, and non-governmental organisations have produced guidelines, assessments of the situation, and advice that will prove valuable to all those who provide services to those most at risk of harm from drug use. These organisations have been enabled to produce these resources because they draw on a solid base of knowledge created by epidemiologists, treatment specialists, and others in the health, social science, and policy fields.² Using this evidence effectively will be essential to achieving good outcomes for our most marginalised citizens in the days and weeks ahead.

1 Ní Cheallaigh C, Cullinan S, Sears J, et al. (2017) Usage of unscheduled hospital care by homeless individuals in Dublin, Ireland: a cross-sectional study. *BMJ Open*, 7(11). <https://www.drugsandalcohol.ie/28307/>

2 The National Drugs Library has combined all the Covid-19-related material in its repository and made these available through a special link on the homepage of the library website. <https://www.drugsandalcohol.ie/31779/>

Impact of Covid-19 continued

Services have recognised that they have to adapt frontline services very quickly to prioritise and support the public health response to Covid-19. Tony Duffin, CEO of Ana Liffey Drug Project, which provides low threshold harm reduction support in Dublin and Limerick, explains:

We closed our drop-in services and stopped all group work as we could not maintain a safe physical distance for clients and staff. We focussed our efforts on working on outreach in the streets explaining Covid-19, providing our Needle & Syringe Programme and explaining how to stay safe on both counts. In the very early days of the Covid-19 crisis many of the people we met on outreach simply did not know about Covid-19, i.e. no knowledge of the latest advice, what the restrictions were or how the service provision landscape had changed. Our team spent a lot of time explaining the situation, supporting people around their fears & frustrations and getting them linked into treatment and housing options.¹

The Health Service Executive (HSE) has published guidelines for general practitioners and pharmacies providing services in regard to people who are at greater risk at this time.² These include those who have not yet commenced opiate substitution treatment; those who are homeless or in insecure accommodation; those at risk of overdose having acquired a greater than usual amount of drugs; or those who are using drugs alone. There are also increased risks from polydrug use, including alcohol and non-prescription medications, and practitioners have particular concerns in regard to failures to attend a prescriber or pharmacy as planned.

POLICY AND LEGISLATION

Ireland and the human rights of people who use drugs

The Ana Liffey Drug Project (ALDP) has published a report, *Ireland and the human rights of people who use drugs*,¹ that discusses the Government's proposed health diversion approach (HDA) to the possession of drugs for personal use within the context of human rights.

Irish policy context

Ireland's current national drugs strategy reflects a more human rights-based approach than previous strategies.² While human rights are only specifically mentioned once in the document, features that indicate a strategy aligned with human rights include:

- It takes a health-led approach to drug use.
- It is underpinned by the values of compassion, respect, equity, inclusion, partnership, and evidence-informed.
- It incorporates human rights in some elements; for example,

The HSE guidelines suggest how the assessment process for potential opiate substitution treatment clients can be shortened and how assessments, clinical reviews, and prescription management can if necessary be undertaken remotely. Assistance for those who present with benzodiazepine or alcohol withdrawal symptoms is also covered. The guidelines also provide advice on what factors should be considered when doctors are making choices about medication and administration of naloxone, a drug that reverses the effects of opioid overdose. Merchants Quay Ireland, which manages low threshold services, are running brief sessions in its Dublin city centre premises, providing instructions on how to administer naloxone.

It will be some time before the full impact of the global pandemic on people who use drugs will be fully known. It is important that we create a detailed picture of the changes in patterns of drug use and an understanding of how people are managing with reduced services. This population will have had to face a very distressing situation and threats to their physical and mental health. Our understanding of this will help to ensure that this population receives the attention it needs when preventive measures, such as vaccination programmes, are being put in place to avoid a recurrence of the Covid-19 catastrophe.

Brian Galvin

- 1 The Amsterdam-based Correlation network has compiled accounts from harm reduction services in many parts of Europe, including one provided by the Ana Liffey Drug Project. Available online at: <https://www.correlation-net.org/sharing-experiences/>
- 2 Health Service Executive (2020) *Guidance on contingency planning for people who use drugs and COVID-19*. Dublin: Health Service Executive. <https://www.drugsandalcohol.ie/31804/>

introducing supervised injecting facilities and exploring approaches to the possession of small quantities of drugs.

The ALDP report is specifically focused on this last element – responses to the possession of drugs for personal use. On 2 August 2019, the Government announced the launch of the HDA to the possession of drugs for personal use. This approach offers alternatives to criminal prosecutions for the first two instances in which people are found in possession of drugs for personal use. Essentially, the action taken by An Garda Síochána (AGS) will depend on the number of times an individual has been caught in possession.

- On the first occasion, AGS will refer them, on a mandatory basis, to the Health Service Executive for a health screening and brief intervention.
- On the second occasion, AGS will have the discretion to issue an adult caution.
- On the third or any subsequent occasion, AGS will revert to dealing with the person in line with Section 3 of the Misuse of Drugs Act 1977, under which they could receive a criminal conviction and custodial sentence.

Aim of report

The exact detail of the HDA and how it will be implemented are topics currently under consideration by a governmental working group. The ALDP report aims to inform these considerations and to urge a rethinking of the proposed approach. It reflects on the HDA within the context of Ireland's national and international human rights commitments and related literature.

Human rights of people who use drugs continued

Human rights

The report identifies three areas of human rights which it maintains are compromised by the ongoing criminalisation of possession for personal use:

- 1 The right to health – criminalisation creates barriers to accessing health services, for example.
- 2 The prohibition of discrimination – criminalisation validates and compounds the discrimination experienced by users in the workplace and their communities, for example.
- 3 The right to privacy – the right to privacy should include the right to use a drug in the privacy of one's home, for example.

Under each of these areas, the authors cite international literature that highlights the often contradictory position of drug control laws versus health-based policy positions. For example, the 'inherent conflict between the right to health in the context of the UN human rights treaties on the one hand, and the implementation of the UN drug control regime on the other hand' (p. 8).

Proportionality

Proportionality is a general principle in criminal law which focuses on the idea that the severity of a punishment should reflect the gravity of the crime. In the context of human rights, it is recognised that individual rights may sometimes need to be restricted by policy or law to maintain a 'larger or more important imperative – such as national security' (p. 13). The report argues that in this context the HDA is not a proportionate policy response. First, it will make attendance at a health assessment mandatory – a response described as 'coercive' and in contrast to policy responses to all other health issues. More broadly, the criminalisation of possession itself is seen to lack proportionality. The authors argue that 'there is no reliable "greater good" argument criminalisation of simple possession does not deter people from using drugs in any meaningful or consistent way' (p. 13).

The lack of proportionality is seen to be reinforced when considering the negative impacts of criminalisation for the user. For example, the long-term negative consequences on a person's housing and employment opportunities. The report cites the Global Commission on Drug Policy:

Punitive drug law enforcement is predicated on the idea that criminalization serves as a deterrent. Notwithstanding its popularity, this theory is not supported by evidence. Instead, research indicates that criminalizing drug users actually worsens drug-related problems.³

Irish Human Rights and Equality

Commission Act 2014

In 2014, Ireland became the first European Union member state to introduce legislation that combines equality and human rights as a 'public sector duty'. This public sector duty requires public bodies to take proactive steps to promote equality, protect human rights, and fight discrimination in relation to their functions and powers.⁴ Section 42 of the Irish Human Rights and Equality Commission Act 2014 (IHREC) states:⁵

- (1) *A public body shall, in the performance of its functions, have regard to the need to:*
 - (a) *eliminate discrimination,*
 - (b) *promote equality of opportunity and treatment of its staff and the persons to whom it provides services, and*
 - (c) *protect the human rights of its members, staff and the persons to whom it provides services.*

ALDP concludes that the HDA will not be supportive of the public bodies responsible for executing the policy in also fulfilling their statutory obligations under the above elements of the IHREC Act 2014.

Conclusions

Overall, the report is critical of the HDA and argues that it is not compatible with a human rights-based approach to policy. At its core, the report argues that the proposed HDA will continue to marginalise and stigmatise those experiencing the most harm through their substance use – the most habitual users would be at the most risk of being criminalised for possession on the third or any subsequent occasion. It is therefore seen by ALDP as being contradictory to Ireland's national drugs strategy; while drug use is seen as a health issue in the strategy, the HDA will perpetuate the criminalisation of users. Furthermore, they see it as unsupportive of the public bodies' obligations under Section 42 of the IHREC Act 2014.

Lucy Dillon

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- 1 Scharwey M, Keane M and Duffin T (2019) *Ireland and the human rights of people who use drugs*. Dublin: Ana Liffey Drug Project. <https://www.drugsandalcohol.ie/31427/>
 - 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. <http://www.drugsandalcohol.ie/27603/>
 - 3 Global Commission on Drug Policy (2014) *Taking control: pathways to drug policies that work*. Geneva: Global Commission on Drug Policy. <https://www.drugsandalcohol.ie/22611/>
 - 4 Equality and Rights Alliance (2015) *A new public sector: equality and human rights duty*. Dublin: Equality and Rights Alliance. <http://www.eracampaign.org/uploads/A%20New%20Public%20Sector%20Duty%20March%202015.pdf>
 - 5 Irish Human Rights and Equality Commission Act 2014. Available online at: <http://www.irishstatutebook.ie/eli/2014/act/25/enacted/en/html>

Guidance on human rights for health and social care services in Ireland

On 13 November 2019, the Health Information and Quality Authority (HIQA), in conjunction with Safeguarding Ireland, published *Guidance on a human rights-based approach in health and social care services*.¹ Its overall purpose is to 'promote a human rights-based approach to care and support for adults in health and social care services' (p. 4),¹ including those working in the addiction services. Taking a human rights-based approach to the delivery of care services is a requirement of public body staff and organisations under the Irish Human Rights and Equality Commission Act 2014, where Section 42 of the Act created a 'public sector duty' that requires public bodies to take proactive steps to promote equality, protect human rights, and fight discrimination in relation to their functions and powers.² However, practitioners experienced difficulties with translating the principles of human rights into their day-to-day practice and service delivery. HIQA's guidance aims to bridge that gap.

Guidance structure

The guidance was developed based on a review of national and international best practice and through consultation with stakeholders. It provides an overview of what human rights are and how they apply to those working in health and social care services. The main body of the report is structured around a set of five principles, under each of which is the relevant human rights-related legislation, examples of how service providers can support and promote the principle in their work, and illustrations provided through the use of case studies. While service providers are the primary audience for the guidance, HIQA suggests that it should also be of value to service users by building their understanding of what to expect from any service grounded in a human rights-based approach.

FREDA principles

Based on their review of international best practice, the authors chose to structure the guidance around a set of principles associated with human rights. They use the FREDA principles, which they describe as 'an internationally recognised framework through which human rights can be considered' (p. 11).¹ The five principles as laid out in the guidance are: fairness, respect, equality, dignity, and autonomy (FREDA).

- **Fairness** means ensuring that when a decision is made with a service user about their care and support that the person is at the centre of the decision-making process.
- **Respect** is the objective, unbiased consideration and regard for the rights, values, beliefs, and property of other people. It applies to the person as well as to their value system.

- **Equality** means people having equal opportunities and being treated no less favourably than other people on the grounds set out in legislation. In an Irish context, these grounds are: age; civil status; disability; family status; gender; membership of the Traveller community; race; colour or nationality; religion or sexual orientation.
- **Dignity** means treating people with compassion and in a way that values them as human beings and supports their self-respect, even if their wishes are not known at the time.
- **Autonomy** is the ability of a person to direct how they live on a day-to-day basis according to personal values, beliefs, and preferences. In a health and social care setting, autonomy involves the service user making informed decisions about their care, support, or treatment.

Conclusion

The HIQA guidance sets out to support organisations and staff by translating human rights theory into practice and therefore supporting them in complying with their public sector equality and human rights duty.² While the case studies and illustrations used in the guidance are not specifically in the area of addiction services, the principles should be transferable to any health and social care service.

Lucy Dillon

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- 1 Health Information and Quality Authority (HIQA) (2019) *Guidance on a human rights-based approach in health and social care services*. Dublin: HIQA. <https://www.drugsandalcohol.ie/31418/>
 - 2 Section 42 of the Irish Human Rights and Equality Commission Act 2014 states: '(1) A public body shall, in the performance of its functions, have regard to the need to: (a) eliminate discrimination, (b) promote equality of opportunity and treatment of its staff and the persons to whom it provides services, and (c) protect the human rights of its members, staff and the persons to whom it provides services'. Irish Human Rights and Equality Commission Act 2014. Available online at: <http://www.irishstatutebook.ie/eli/2014/act/25/enacted/en/html>

National LGBTI+ Inclusion Strategy

In November 2019, the Department of Justice and Equality published the *National LGBTI+ Inclusion Strategy 2019–2021*.¹ As with the *National LGBTI+ Youth Strategy 2018–2020*,² the new strategy aims to provide a strategic framework for ‘identifying and addressing issues which may prevent LGBTI+ people from enjoying full equality in practice in Irish society’ (p. 3).¹ The strategy provides a structure in which:

- LGBTI+ groups can identify issues that persist in creating an environment of inequality.
- Government, public agencies, business groups, employer and employee representatives, and civil society can work together to resolve these issues.

It is structured around four thematic pillars, under each of which are a set of outcomes to be achieved and a set of associated actions.

Vision and mission

Vision: A safe, fair and inclusive Ireland where people are supported to flourish and to live inclusive, healthy, and fulfilling lives, whatever their sexual orientation, gender identity or expression, or sex characteristics.

Mission: To promote inclusion, protect rights, and to improve quality of life and wellbeing for LGBTI+ people enabling them to participate fully in Ireland’s social, economic, cultural, and political life.

Thematic pillars

The four thematic pillars are based on stakeholder consultation about what issues LGBTI+ people in Ireland were facing.

Visible and included: This pillar focuses on the need for increased visibility and non-stereotypical representation of LGBTI+ identities, which would support long-term attitudinal change. Among the eight outcomes identified under this pillar were: LGBTI+ people are positively visible across all sectors of society; Irish workplaces are inclusive of LGBTI+ people and support them in bringing their ‘authentic selves’ to work; and better information is available on the population and needs of LGBTI+ people in Ireland to support the development of effective policy.

Treated equally: This pillar has at its core legislative change and awareness raising to ensure that LGBTI+ people are treated equally. Among the five outcomes to be achieved are: LGBTI+ people are aware of the supports and redress mechanisms available to them where discrimination has occurred; same-sex parents are treated equally to opposite-sex parents before the law; supports are provided to those at higher risk of multiple discrimination and marginalisation, including older people, migrants, Travellers, people with disabilities, and prisoners among the LGBTI+ community.

Healthy: The strategy commits to ensuring that LGBTI+ people can fully and equally avail of mainstream health services, while also recognising the need for dedicated services in some circumstances. Among the seven outcomes to be achieved are: healthcare providers and practitioners are trained to understand the identities and needs of their LGBTI+ patients and to avoid making heteronormative assumptions; and people living with HIV in Ireland are supported and not stigmatised. The action in *Reducing harm, supporting recovery: a health-led response to drug and alcohol use 2017–2025*³ aimed at addressing the needs of LGBTI+ people is cited as an action under the following outcome: health policy takes consideration of the needs of all population groups, including the LGBTI+ community.

Safe and supported: The strategy intends to ensure that LGBTI+ people feel safe and secure when living their daily lives. Among the six outcomes linked to this pillar are: Ireland has strong legislation and supports in place to combat hate crime and encourages people to report it; LGBTI+ victims of crime are appropriately supported and included in mainstream service provision underpinned by formalised consultation structures with An Garda Síochána and other relevant agencies; and LGBTI+ people can travel safely and with confidence.

A mid-term report on progress made on implementing the strategy will take place in Q3 of 2020.

Lucy Dillon

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- 1 Department of Justice and Equality (2019) *National LGBTI+ Inclusion Strategy 2019–2021*. Dublin: Government of Ireland. <https://www.drugsandalcohol.ie/31368/>
 - 2 Department of Children and Youth Affairs (2018) *LGBTI+ National Youth Strategy 2018–2020*. Dublin: Department of Children and Youth Affairs. <https://www.drugsandalcohol.ie/29267/>
 - 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/>

PREVALENCE AND CURRENT SITUATION

Health in Ireland – key trends

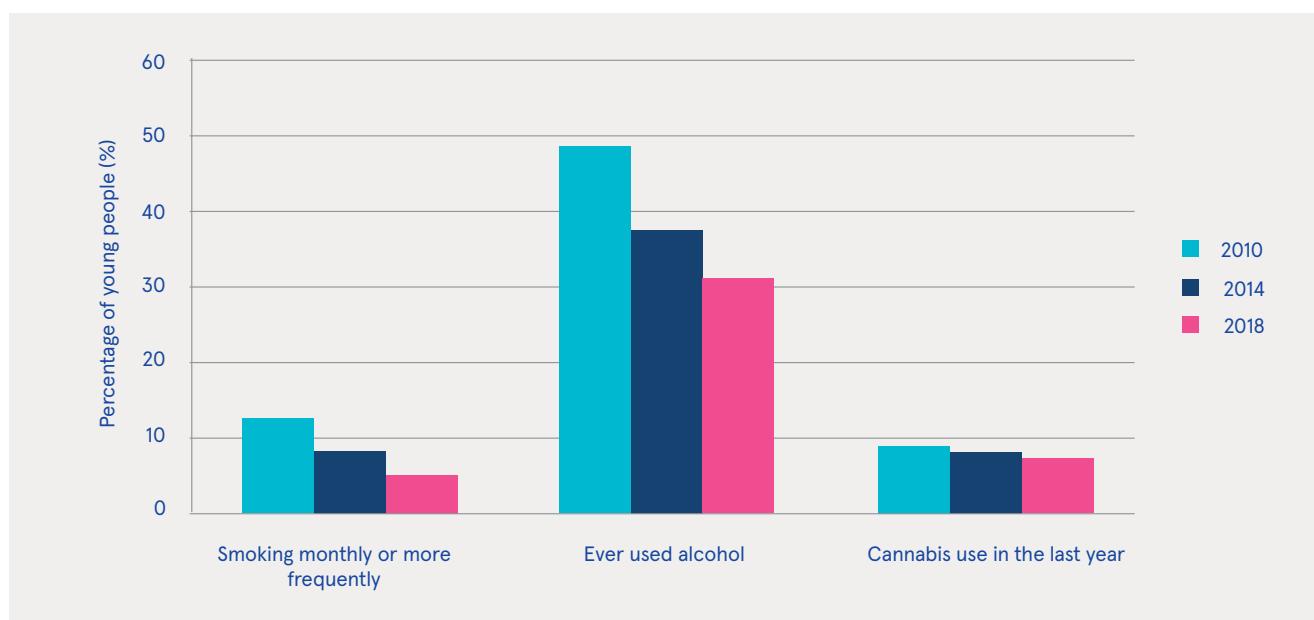
The Department of Health has published the 12th edition of *Health in Ireland: Key trends 2019*.¹ Using data from newly available sources, the report highlights selected trends in drug, alcohol, and tobacco consumption as well as the number of

individuals entering treatment in Ireland for problem drug and alcohol use between 2009 and 2018.

Smoking, alcohol, and cannabis use

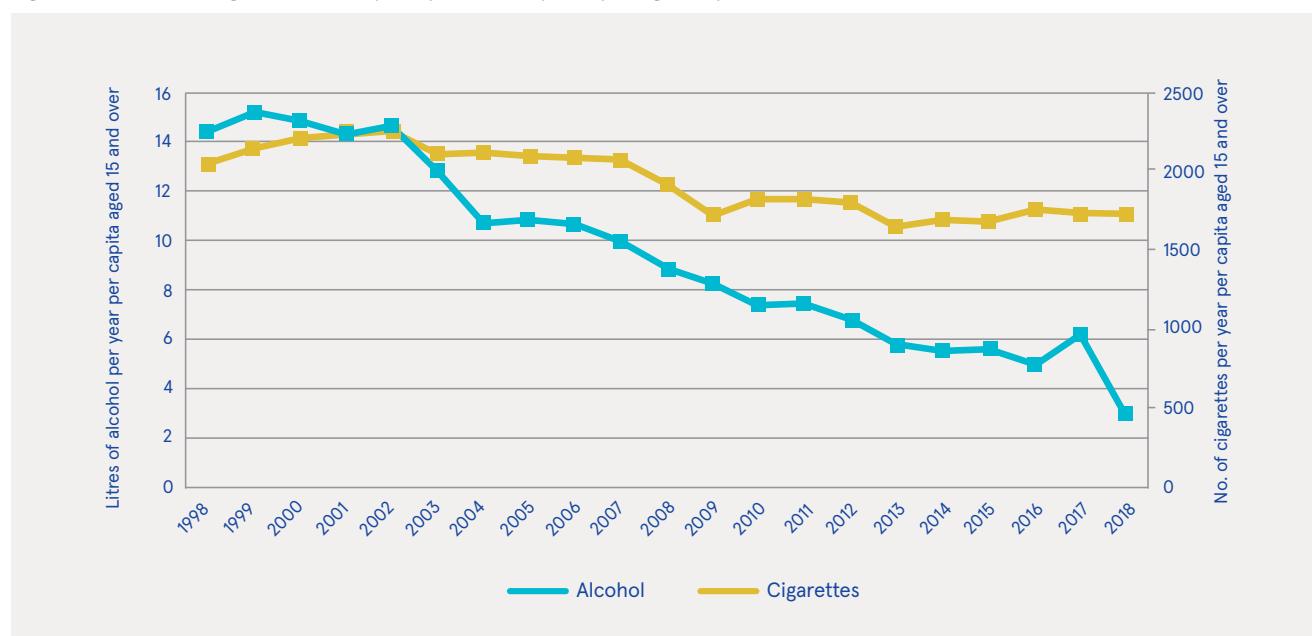
Figure 1 shows the percentage of Irish children, aged 11–17 years, who engaged in risky health behaviours for the years 2010, 2014 and 2018. Findings demonstrate that there has been a constant downward trend in the percentage of children who smoked cigarettes monthly or frequently, who had ever used alcohol, and who had used cannabis in the last year. Similarly, there has been a downward trend in alcohol and cigarette consumption among adults aged 15 years and over between 1998 and 2018 (see Figure 2).

Figure 1: Percentage of children, aged 11–17 years, engaged in risky health behaviours in Ireland, 2010, 2014, and 2018



Source: Department of Health (2019)

Figure 2: Alcohol and cigarette consumption per annum, per capita aged 15 years and over, 1998–2018



Source: Department of Health (2019)

Health in Ireland – key trends

continued

Table 1: Number of cases in treatment for problem drug and alcohol use and rate per 100,000 population aged 15–64 years in Ireland, 2009–2018

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	% Change 2009 -2018	% Change 2017 -2018
Drugs including alcohol												
All cases in treatment	15,092	16,422	16,827	16,126	16,312	17,077	16,933	16,325	15,742	17,093	13.3	8.6
New entries into treatment each year	7,517	7,738	7,719	7,114	6,899	7,237	7,007	6,922	6,482	6,889	-8.4	6.3
Rate per 100,000 (15–64-year-olds)	242.6	250.9	251.7	232.9	226.1	236.5	227.8	223.0	206.7	216.9	-10.6	4.9
Drugs excluding alcohol												
All cases in treatment	7,389	8,699	8,283	7,903	8,894	9,672	9,711	9,097	8,772	10,113	36.9	15.3
New entries into treatment each year	3,359	3,657	3,265	3,191	3,389	3,648	3,651	3,446	3,168	3,859	14.9	21.8
Rate per 100,000 (15–64-year-olds)	108.4	118.6	106.5	104.4	111.1	119.2	118.7	111.0	101.0	121.5	12.1	20.3

Source: Department of Health (2019)

Treatment for problem drug and alcohol use

Table 1 shows the number of individuals entering treatment for problem alcohol or drug use between 2009 and 2018. There were 17,093 cases treated in 2018, representing a rate of 217 people per 100,000 aged 15–64 years. This is an increase of 8.6% compared with 2017, when there were 15,742 individuals in treatment. However, figures show that this rate peaked in 2011 at 251.7 per 100,000 aged 15–64 years and has been slowly decreasing ever since.

Seán Millar

1 Department of Health (2019) *Health in Ireland: Key trends 2019*. Dublin: Government of Ireland.
<https://www.drugsandalcohol.ie/31508/>

Fatality study of drugs taken in intentional overdose in Ireland

Intentional drug overdose (IDO) is the most common method of hospital-presenting, non-fatal self-harm¹ and has been linked with an increase in premature mortality risk due to suicides, accidents, and other causes.² Importantly, the risk of mortality due to suicide is increased among persons who have engaged in IDO and in 2018 intentional overdoses resulted in 7,792 presentations to Irish hospitals.³ Multiple drugs are present in between 26% and 41% of non-fatal IDOs, increasing to 64% in fatal overdoses.^{4,5,6} Nevertheless, despite the involvement of multiple drugs in IDO, the case fatality of drugs taken in multiple drug overdoses remains under-researched and little is known about how case fatality risk varies according to the type of drug(s) taken.

A recent Irish study aimed to examine the incidence of IDO in Ireland, to identify the predictors of fatal IDO, and to establish which drugs are linked with greater risk of a fatal outcome.⁷ In this research, published in the *International Journal of Drug Policy*, data from the National Self-Harm Registry and the National Drug-Related Deaths Index, 2007–2014, were used to calculate incidence, to examine overdose characteristics, and to estimate case fatality risk ratios.

There were 63,831 non-fatal and 364 fatal IDOs during this period (incidence: 148.8 and 1.01 per 100,000, respectively). Compared with non-fatal IDOs, fatal cases were more likely to be male (55.2% vs 42%), were older in age (median 44 vs 35 years), and more frequently involved multiple drugs (78.3% vs 48.5%). The study found that tricyclic antidepressants were associated with a 15-fold increased risk of death, while opioids were associated with a 12-fold increased risk, relative to the

reference category (non-opioid analgesics). While the risk of fatal outcome was higher for males than females, the elevation in risk was greater in females when tricyclic antidepressants or opioids were taken.

As tricyclic antidepressants and opioids were found to be associated with a significantly increased risk of death, the authors concluded that these results add to the current evidence regarding the risk and potential adverse outcomes associated with these drugs. Findings may help inform safe and appropriate prescribing, where clinicians consider the fatality risk of drugs when determining treatment for patients at risk of self-harm, or who have previously harmed themselves.

Seán Millar

- 1 Perry IJ, Corcoran P, Fitzgerald AP, Keeley HS, Reulbach U, et al. (2012) The incidence and repetition of hospital-treated deliberate self harm: findings from the world's first national registry. *PLoS One* 7(2): e31663.
- 2 Finkelstein Y, Macdonald EM, Hollands S, Hutson JR, Sivilotti MLA, Mamdani MM, et al. (2015) Long-term outcomes following self-poisoning in adolescents: a population-based cohort study. *Lancet Psychiatry*, 2(6): 532–539.
- 3 Griffin E, McTernan N, Wrigley C, Nicholson S, Arensman E, Williamson E, et al. (2019) *National Self-Harm Registry Ireland: annual report 2018*. Cork: National Suicide Research Foundation. <https://www.drugsandalcohol.ie/31193/>
- 4 Daly C, Griffin E, Ashcroft DM, Webb RT, Perry IJ and Arensman E (2018) Frequently used drug types and alcohol involvement in intentional drug overdoses in Ireland: a national registry study. *Eur J Public Health*, 28(4): 681–686. <https://www.drugsandalcohol.ie/28709/>
- 5 Finkelstein Y, Macdonald EM, Hollands S, Sivilotti MLA, Hutson JR, Mamdani MM, et al. (2015) Risk of suicide following deliberate self-poisoning. *JAMA Psychiatry*, 72(6): 570–575.
- 6 Health Research Board (HRB) (2015) *National Drug-Related Deaths Index 2004 to 2015 data*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/28086/>
- 7 Daly C, Griffin E, Corcoran P, Webb RT, Ashcroft DM, Perry IJ and Arensman E (2020) A national case fatality study of drugs taken in intentional overdose. *Int J Drug Policy*, 76: 102609.

Blanchardstown Drug and Alcohol Trends Monitoring System

The Blanchardstown Local Drug and Alcohol Task Force (BLDATF) is one of 14 local drug and alcohol task forces (LDATFs) established in 1997 in response to high levels of drug misuse within Irish communities. BLDATF is responsible for implementing the National Substance Misuse Strategy¹ and facilitating a more coordinated response in tackling drug and alcohol use and misuse in Dublin 15. In order to adapt and change services in a thorough and comprehensive manner, the Blanchardstown Drug and Alcohol Trends Monitoring System (DATMS) was established in 2015 to provide a better knowledge of drug-related harms in the area. The specific objective of DATMS is to establish an evidence base for drug use in Dublin 15 and use these data to inform local service provision.

A recent report documents Year 4 of DATMS.² The Year 1 reporting period began in June 2014; Year 2 began in June 2015; Year 3 relates to 2017; and Year 4 to 2018. The DATMS report employs a mixed-method design comprising primary and secondary data sources. Key findings from the report are discussed below.

Treated drug use

Treated cases aged 18 years and under increased from 51 in Year 1 to 97 in Year 4, with 1% of the Dublin 15 population aged 12–17 years having attended treatment for drug and/or alcohol use. From Year 1 to Year 4, the profile of treated cases has remained similar, with a majority being Irish and male. Cannabis herb was found to be the most commonly used drug among this age group, followed by alcohol, with a majority of cases being polydrug users.

Among subjects aged 18 years and over, there was an increase in the number of treated cases from 292 in 2016 to 348 in 2018. The majority of treated cases were Irish, male, and aged 35–44 years. One-third of cases were in treatment for drugs for the first time and the three main problem drugs reported

Blanchardstown DATMS continued

were alcohol, heroin, and cocaine. Changes in the profile of treated drug users included an increase in the use of cannabis herb, alcohol, powder and crack cocaine, benzodiazepines, and Z-drugs. Year 4 also reported an increase in the use of pregabalin, heroin, and cannabis oil.

Untreated drug use

All four years of DATMS reported similar profiles of untreated drug use by young people and adults, with alcohol, cannabis herb, ecstasy, and cocaine powder being the main drugs used and polydrug use being the norm. Changes in the profile of untreated drug users included an increase in the use of alcohol, cannabis herb and oil, powder and crack cocaine, benzodiazepines, and Z-drugs, and that untreated drug users were getting younger.

Normalisation of drug use

The report notes that there are two recurring themes emerging from the different data sources over four years. First, that drug use in Dublin 15 is a community-wide issue that crosses all socioeconomic boundaries, as treated drug users were from every community in Dublin 15, from the affluent to the deprived. Second, that drug use in Dublin 15 has become normalised. The common perception among study participants was that alcohol and drugs are widely used, risk free, and socially acceptable. Alcohol was found to be the most normalised drug in Dublin 15, followed by cannabis, cocaine powder, benzodiazepines, and Z-drugs. Importantly, all four years of DATMS reported the family context as a risk factor for the normalisation of drug and alcohol use and the development of intergenerational drug and alcohol dependence. The majority of treated drug users who participated in Years 3 and 4 reported having family members who also had issues with drugs and/or alcohol.

Recommendations for service provision

The report notes the gaps in service provision identified by study participants and makes a number of recommendations. These include the following:

- Improve drug prevention programmes for people under 18 years of age.
- Increase access to skills-based mental health wellbeing programmes for young people and adults.
- Provide education and information for family members about the latest drug trends.
- Improve treatment programmes for under 18s and young people.
- Improve access to naloxone, the antidote to opioid overdoses.
- Develop a stabilisation programme for non-opioid polydrug users.
- Increase access to mental health services for children, young people, and adults.
- Improve access to aftercare services, training, employment, and housing.

Seán Millar

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- 1 Department of Health (2012) *Steering Group Report on an National Substance Misuse Strategy*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/16908>
 - 2 Blanchardstown Local Drug and Alcohol Task Force (BLDATF) (2019) *Drug and Alcohol Trends Monitoring System (DATMS) 2019: year 4*. Dublin: BLDATF. <https://www.drugsandalcohol.ie/31485/>

RECENT LEGISLATION

Judicial Council Act 2019

The Judicial Council Act 2019 was enacted on 23 July 2019.¹ The Act provides for the establishment of a Judicial Council. The council, which will be an independent body, will promote and maintain excellence and high standards. In addition, it will provide a statutory basis for the training of judges and for the investigation of complaints against judges. Under the provisions of the Act, the Judicial Council will also be responsible for establishing several subcommittees.

Judicial Studies Committee

Under Section 17 of the Act, the Judicial Studies Committee will be responsible for preparing and distributing information relevant to judges. In addition, it will facilitate the continuing education and training of judges regarding their function.

Personal Injuries Guidelines Committee

Under Section 18, the Judicial Council is required to establish a Personal Injuries Guidelines Committee within three months of the council's establishment. This committee will consist of seven judges put forward by the Chief Justice. Each judge will be required to submit draft guidelines and amendments for personal injuries for appropriate general damages for various types of personal injury within six months of its commencement. Following completion of the first review, a follow-up review of the guidelines is required within three years, and once every three years thereafter.

Sentencing Guidelines and Information Committee

Under Section 23, within six months of the first Judicial Council meeting, the council is required to establish a Sentencing Guidelines and Information Committee. Under the provisions of the Act, the committee shall:

- Prepare and submit draft sentencing guidelines and amendments to sentencing guidelines adopted by the council to the board for review.
- Monitor the operation of sentencing guidelines.
- Collate and disseminate sentencing data to judges and other relevant individuals.

Recent legislation continued

Under Section 24, the committee will consist of 13 members: eight judges put forward by the Chief Justice, one of which will act as chairperson, and five lay members, who will be appointed by the Government.

Under Section 29, the Minister for Justice and Equality is required to begin a review of all legislation that provides for the imposition of minimum sentences for offences. The review must consider whether minimum sentences are imposed correctly and at what level of imposition. The findings must be submitted by the Minister to both Houses of the Oireachtas within 12 months of the review starting.

Judicial Support Committees

Under Section 30, five Judicial Support Committees will be established, namely:

- Supreme Court Judicial Support Committee
- Court of Appeal Judicial Support Committee
- High Court Judicial Support Committee
- Circuit Court Judicial Support Committee
- District Court Judicial Support Committee.

These will be available to each of the courts to advise and assist the Judicial Council in the performance of its functions.

Judicial Conduct Committee

Under Section 43, the Judicial Council is required to establish the Judicial Conduct Committee to promote and maintain high standards of conduct among judges relating to principles of judicial conduct requiring judges to uphold and exemplify

judicial independence, impartiality, integrity, propriety (including the appearance of propriety), competence, and diligence, and to ensure equality of treatment to all persons before the courts. This committee will investigate complaints against judges and refer them for resolution by informal means. It is required to prepare and submit a review draft of guidelines for judicial conduct, including guidance on when a judge should recuse him or herself from presiding over legal proceedings.

Under this Act, the Judicial Conduct Committee is considered independent in the performance of its functions and shall have such powers deemed necessary or useful to carry out its functions. It may obtain legal, medical, or other advice in connection with performing its functions and may bring or defend legal proceedings or any other act or thing necessary for the performance of its functions.

Conclusion

Minister for Justice and Equality Charlie Flanagan TD believes that the enactment of this Act is a 'landmark development', which will help to 'shape the way in which our judiciary operates at all levels by promoting consistent standards of excellence, preserving the very valuable confidence that the public has in our judiciary and in the administration of justice in this country'.²

Ciara H Guiney

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- 1 Judicial Council Act 2019. Available online at: <http://www.irishstatutebook.ie/eli/2019/act/33/enacted/en/html>
 - 2 Department of Justice and Equality (2019) Minister Flanagan announces the passage of the landmark Judicial Council Bill. 9 July. Available online at: <http://www.justice.ie/en/JELR/Pages/PR19000187>

Misuse of Drugs (Prescription and Control of Supply of Cannabis for Medical Use) Regulations 2019

A statutory instrument, SI No. 262/2019 – Misuse of Drugs (Prescription and Control of Supply of Cannabis for Medical Use) Regulations 2019, was signed on 26 June 2019. These regulations allow for the use of certain cannabis products for the treatment of persons with certain medical conditions when under the care of a medical consultant.

Prescription and supply under the Cannabis for Medical Use Register

Part 2 of the Regulations provides for the prescription and supply of cannabis under the Cannabis for Medical Use Register (CMUR):

- Under Section 4 of the Regulations, a practitioner prescribing cannabis must be a medical consultant, must include their name and address on the prescription, and must continue to be responsible for and supervise the patient while being treated. In addition, only a person named on the CMUR who has been given a CMUR number from the Health Service Executive (HSE) can be issued a prescription.
- Under Section 4(6), when a prescription is being issued for the first time:
 - It must be intended to treat the person for a specific condition.
 - The HSE must be provided with the person's name, address, date of birth, and the name of the condition being treated; the notifying practitioner's name, registration number, and medical speciality; and any other information required by the HSE.
- Section 5 of the Regulations provides for the establishment and maintenance of the CMUR. The CMUR records the information provided by the practitioner under Section 4(6). The HSE can alter or delete an entry; however, it may need additional information from the medical consultant supervising the treatment. The HSE is also responsible for assigning the CMUR number to each person entered in the register.

Recent legislation continued

- Under Sections 6 and 7, only a pharmacist or a person operating a retail pharmacy business shall supply a specified controlled drug to a practitioner. These suppliers must maintain records of the following:
 - Date of supply
 - Name of drug, quantity, and dosage
 - Name, address, and registration number of the prescriber
 - CMUR number
 - Name and address of the person who is being prescribed the drug
 - Date of prescription.

Commercial supply under licence

Part 3 of the Regulations provides for the commercial supply of cannabis under licence.

- Under Sections 11 and 12, a specified controlled drug should only be supplied to a pharmacist, retail pharmacy business, or hospital. For each consignment supplied, the supplier must maintain a record of each consignment received and supplied for a minimum of five years. The following information should be recorded:
 - Name of the drug, including the brand name
 - Dosage form of the drug
 - Quantity of drug received and supplied
 - Batch number of the drug received
 - Name and address of the producer of that specified controlled drug in the form it was received
 - Name and address of the supplier of each consignment.

This information should be made available to the Minister for Health when requested for review.

- Section 13 prohibits the exportation of imported specified controlled drugs outside of the State.

This legislation provides for the operation of the Medical Cannabis Access Programme on a pilot basis for five years.

Reporting, enforcement, and advertising

Part 4 of the Regulations provides for the reporting, enforcement, and advertising of a specified controlled drug within the scope of Part 2 or Part 3. Under Section 15, a person shall report suspected adverse reactions and quality defects to the Health Products Regulatory Authority (HPRA) within 15 days of being provided with the information. Where there are quality or safety issues relating to a specified controlled drug or batch, HPRA can authorise the withdrawal or recall of the product (Section 16). If notice is received from the Minister for Health or HPRA to stop prescribing, supplying, or importing a specified drug, the specified controlled drug should no longer be supplied or imported (Section 17). Under Section 18, the advertisement or supply of information related to a specified controlled drug to the general public is restricted.

Ciara H Guiney

1 Misuse of Drugs (Prescription and Control of Supply of Cannabis for Medical Use) Regulations 2019. Available online at: <http://www.irishstatutebook.ie/eli/2019/si/262/made/en/print>

Parole Act 2019

The Parole Act 2019 was enacted on 23 July 2019.¹ The purpose of the Act is to confer responsibility for granting parole upon an independent statutory body. It is divided into three parts. Part 1 addresses preliminary and general matters; Part 2 addresses the Parole Board, its powers, and compositions; and Part 3 deals with parole applications, guiding principles, and the parole process.

Part 2 of Act

Section 8 of the Act provides for the establishment of the Parole Board (known as An Bord Parúil). The board will function independently and on a statutory basis. The functions conferred on the board will include:

- Providing information to persons serving sentences of imprisonment, victims, and members of the public in relation to its functions
- Providing information to the Minister for Justice and Equality in relation to the functions of the board
- Making recommendations upon the request of the Minister to help him or her coordinate prisoners released on parole and draw up policy related to prisoners released on parole
- Undertaking or assisting in research projects that may inform how the board operates and assist the Minister in decision-making.

Section 13(1) provides the board with powers that are deemed necessary to carry out its functions. Under this section the board will be able to:

- Authorise written reports from appropriate individuals related to specific individuals.
- Assign a legal representative to the relevant person if they do not already have one during deliberations of parole application or parole order revocations.
- Interview a relevant person and receive oral submissions from him/her or his/her legal representative.
- Receive written arguments from a relevant person or his/her legal representative.
- Assign a legal representative to the relevant victim where he or she wishes to put forward arguments to the board.
- Meet with a relevant victim to receive oral or written arguments from him/her or his/her legal representative.
- Apply to the Courts Service to obtain a transcript of a court hearing that was held in sentencing deliberations of the offender.

For the purpose of considering parole applications, variations to conditions or release dates outlined in a public order or revocations of a parole order, under Section 13(2) the board has the power to request written reports by or on behalf of Irish justice agencies or clinicians working with applicants. When a report is requested under this section, the board will outline all matters that need to be addressed in the report. It

Recent legislation continued

may include one or more of the following: sentence details; conduct of applicant; risk or likelihood of reoffending; ability to comply with conditions outlined in the parole order; level of rehabilitation achieved thus far; ability to reintegrate into society; and risk to the public or victim. Parole will only be granted if the prisoner does not pose an undue risk to the public.

Part 3 of Act

Part 3 of the Act outlines the parole process. For example, under Section 24(1), eligibility for parole for individuals serving life imprisonment sentences has increased from 7 years to 12 years. For individuals who are serving prison sentences that exceed those outlined in the regulations, following engagement with the board, the Minister may impose imprisonment of not less than 8 years, and the portion of imprisonment that needs to be served by a person before eligible for parole.

In some circumstances, individuals may not be eligible for parole. For example, in relation to drug offences, under Section 24(12), where an individual is serving a specified minimum sentence of imprisonment under Section 27(3A) of the Misuse of Drugs Act 1977, pursuant to subsection (3C) or (3F) or that

section, he/she shall not be eligible for parole before the minimum term has expired. Where parole applications have been refused or revoked, applicants will not be eligible to reapply for parole prior to the date specified by the board (Section 24(5) and (6)).

Conclusion

This legislation has been welcomed by Minister for Justice and Equality Charlie Flanagan TD, who views it as a 'ground-breaking piece of legislation' that will ensure that the way decisions are made by the Parole Board are 'open, transparent, fair and fully informed'.² The Irish Penal Reform Trust has long campaigned for the establishment of an independent Parole Board. Its executive director, Fíona Ní Chinnéide, has stated that this legislation will 'provide more clarity and independence in decision-making on the release of eligible prisoners'.²

Ciara H Guiney

1 Parole Act 2019. Available online at: <http://www.irishstatutebook.ie/eli/2019/act/28/en/print#part3>

2 Staines M (2019) People sentenced to life in prison must serve at least 12 years under new law. *Newstalk*. 11 July. Available online at: <https://www.newstalk.com/news/life-sentence-parole-881671>

Provisional review of road collision fatalities

On 3 January 2020, the Road Safety Authority (RSA) published a provisional review of fatal collisions for 2019.^{1,2} The report is the result of analysis of fatality data received from An Garda Síochána. The results in this analysis are provisional and may be subject to change. The report first provides an overview followed by more in-depth analysis by month of year; day of week; time of day; where fatalities occurred; age profile; road user type; and age profile by road user type. Drugs were not mentioned in this analysis.

Overview

Figure 1 shows the trends in fatalities from 1997 to 2019. In 2019, 148 fatalities arose from 137 collisions on Irish roads.

Month of year

The highest number of fatalities were reported in March 2017 (n=20) and September 2019 (n=20). The lowest number of fatalities were reported in May 2018 (n=5). In 2019, the most dangerous month was September (n=20), followed by December (n=16), January (n=14), and February (n=14).

Day of week and time of day

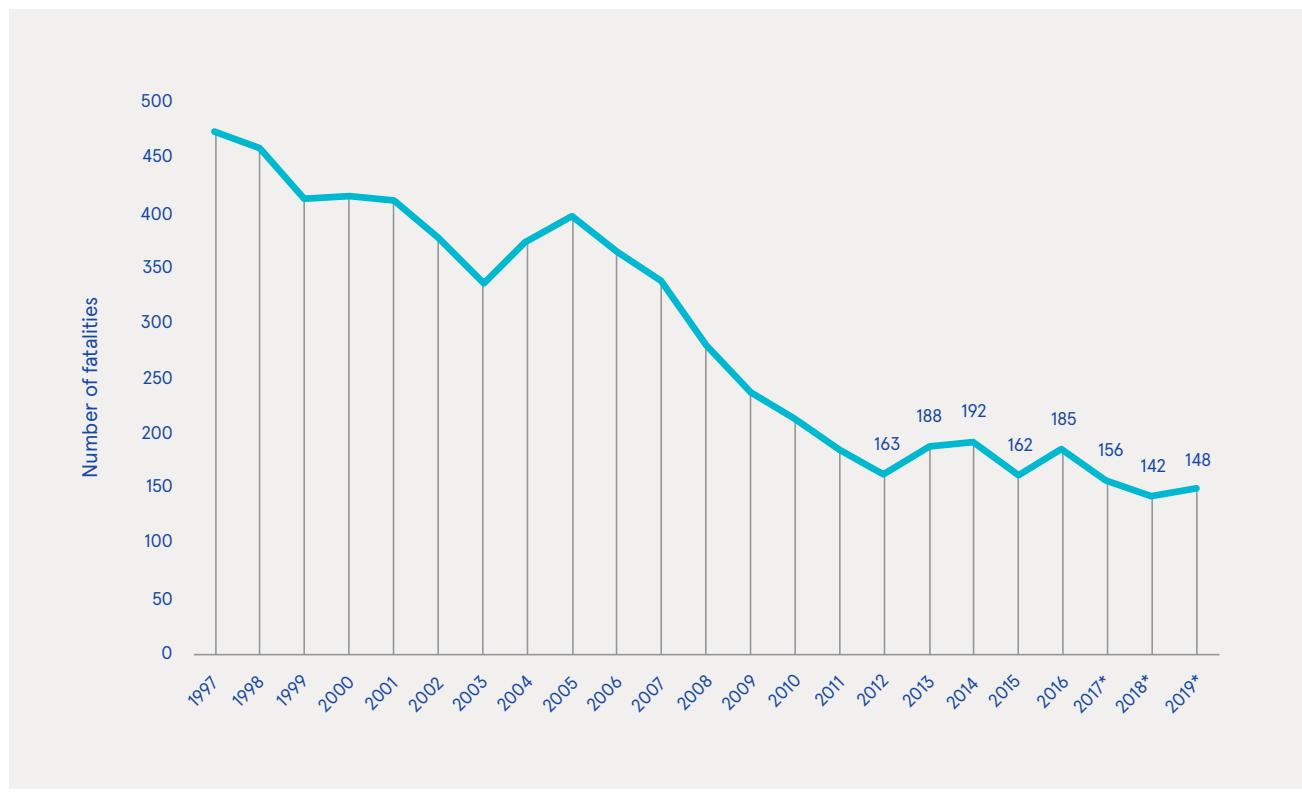
Figures 2 and 3 show what day of the week and what time of day the fatalities occurred. The highest number of fatalities was reported for Sunday in both 2018 and 2019. The data for 2019 were higher for Thursday, Friday, Saturday, and Sunday when compared with 2018. Tuesday and Wednesday were shown to have the lowest number of fatalities in 2019; these figures were lower than those reported in 2018.

Data for 2019 indicated that the worst time for fatalities in Ireland was between 6pm and 8pm followed closely by 2pm–4pm, midnight–2am, and 12pm–2pm (see Figure 3).

Weekdays between 12pm and 8pm showed the highest fatalities, while the lowest fatality was reported at weekends between 8am and 12pm.

Road collision fatalities continued

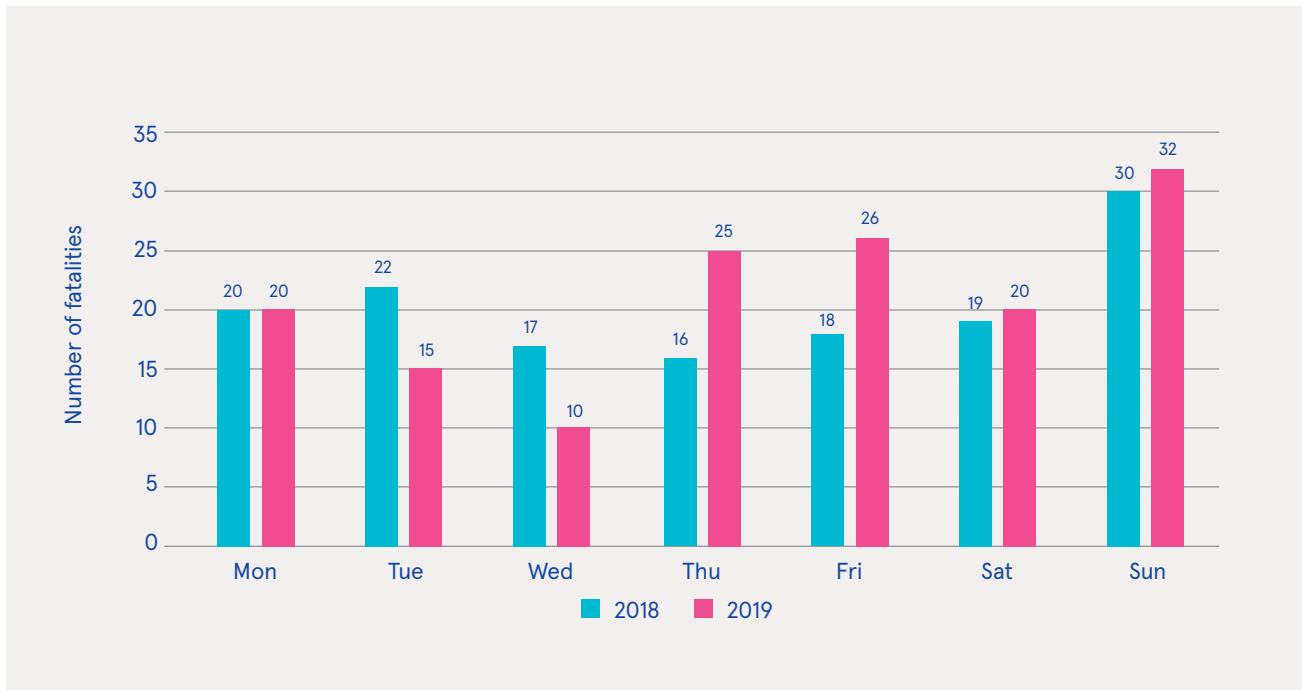
Figure 1: Number of fatalities by year, 1997–2019



Source: RSA (2020), Figure 1, p. 1

* 2017–2019 data are provisional and subject to change.

Figure 2: Number of fatalities by day of week, 2018–2019

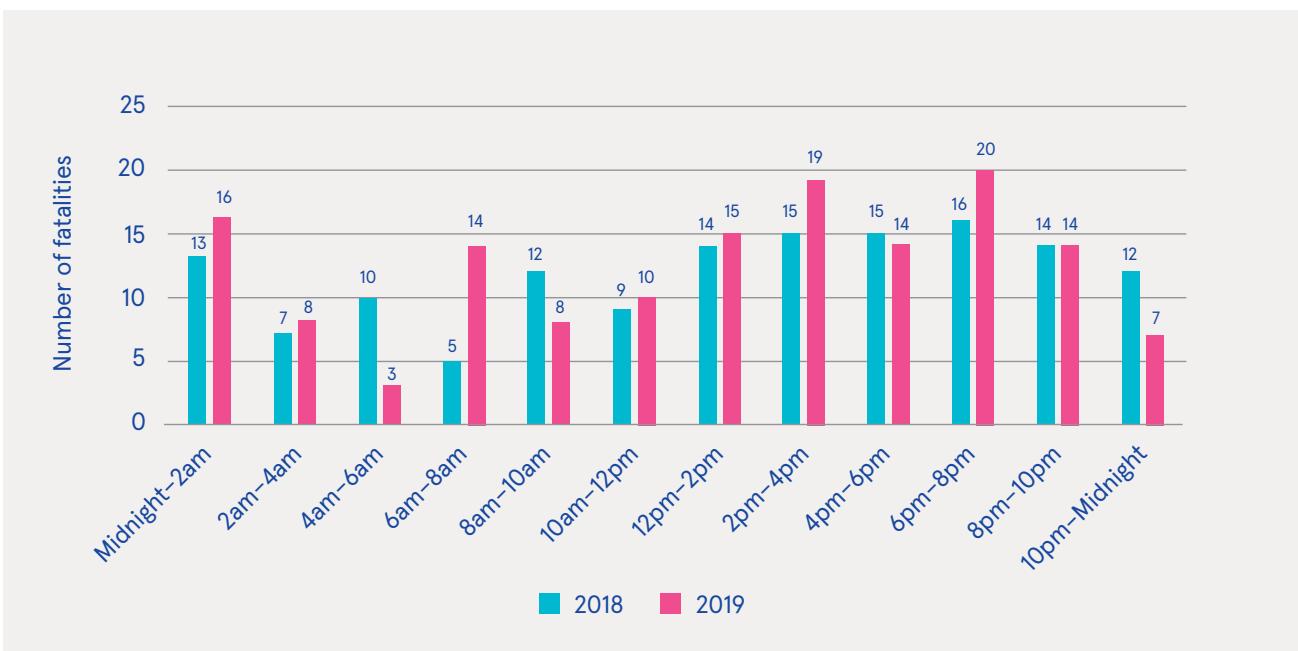


Source: RSA (2020), Figure 4, p. 5

Note: 2018–2019 data are provisional and subject to change.

Road collision fatalities continued

Figure 3: Number of fatalities by time of day, 2018–2019



Source: RSA (2020), Figure 5, p. 6

Note: 2018–2019 data are provisional and subject to change.

Where fatalities occurred

Fatalities in 2018 and 2019 were more likely to occur in rural areas.

Fatalities by speed limit

The highest number of fatalities occurred within an 80 km/h speed limit followed by 100 km/h. A large percentage increase (45%), which occurred within the 80 km speed limit, was evident between 2018 and 2019.

Age profile

Fatalities were reported in all age categories. The majority of individuals who died on Irish roads during this timeframe were aged over 66 years. Between 2018 and 2019, there was a substantial increase (56%) in deaths in individuals aged between 26 and 35 years, while a 21% increase was evident in individuals aged 66 years or over.

Road user type

Across this timeframe the majority of individuals that died were drivers. Between 2018 and 2019, the number of drivers that died increased by 45%. The overall fatality figures in 2019 were slightly higher than 2018 figures; two more fatal collisions were evident, which resulted in a 4% increase in deaths (n=6). Fortunately, the number of pedestrian fatalities decreased by 36% (n=15); however, there was a substantial increase in driver fatalities (45%, n=25).

Age profile by road user type

In 2019, drivers aged 66+ years (n=23), followed by those aged 26–35 years (n=19), and aged 16–25 years (n=12) were more likely to die on Irish roads.

Conclusion

The findings in this report will be used to inform policies and practices with the overall aim of reducing road fatalities. The Minister for Transport, Tourism and Sport, Shane Ross TD, expressed deepest condolences to the families of those who died on Irish roads. He acknowledged that the only response was via ‘action not words’ and emphasised the importance of ‘continuing to implement life saving measures contained in the Road Safety Strategy’.³

The Minister went on to say that:

As ordinary road users ... we need to take greater responsibility for our actions we can do this by slowing down, not driving while impaired through drink, drugs or fatigue, by not driving while using a phone, by wearing a seatbelt and always sharing the road more carefully with pedestrians and cyclists.³

Ciara H Guiney

- Road Safety Authority (RSA) (2020) *Provisional review of fatal collisions: 1 January to 31 December 2019*. Dublin: Road Safety Authority. Available online at: https://www.rsa.ie/Documents/Fatal%20Collision%20Stats/Provisional_Reviews_of_Fatal_Collisions/RRD_Res_20191231_RSAProvisionalReviewFatalities31December2019_03Jan2020.pdf
- Road Safety Authority (RSA) (2020) *Provisional review of fatal collisions: January to 31 December 2019*. Dublin: Road Safety Authority. Available online at: <https://www.drugsandalcohol.ie/31513/>
- Road Safety Authority (2020) *4% rise in road deaths recorded in 2019*. Dublin: Road Safety Authority. Available online at: <https://www.rsa.ie/ga-IE/Utility/Nuacht/2020/4-Rise-in-Road-Deaths-Recorded-in-2019/>

Twenty-First 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 Saturday, 1 February 2020, the NFSN held its 21st Annual Service of Commemoration and Hope in the Church of Our Lady of Lourdes, Sean MacDermott Street, Dublin. This spiritual, multidenominational service is held in remembrance of loved ones lost to substance misuse and related causes and to publicly support and offer hope to families living with the devastation that substance misuse causes. Those in attendance included 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; Mary Lou McDonald TD; Archbishop of Dublin Dr Diarmuid Martin, and other religious representatives; as well as family members, friends, and many people working in the area of substance misuse. Music was provided by soprano Nickola Hendy and Cathal Holland.



Work of the NFSN

In her address to the gathering, Sadie Grace, coordinator of the NFSN, spoke directly to family members in attendance, who are living with the effects of drug abuse on a daily basis. She stated that the NFSN stand in solidarity with them, stressing that they are not alone in their grief.

While acknowledging more work is required to help prevent drug-related deaths and to support families affected by drug use, 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 National Drug-Related Deaths Index (NDRDI) in 2005; development of initiatives to address drug intimidation; setting up the first addiction-specific bereavement support counselling service;

supporting research into the impact of familial addiction and drug-related deaths on the health of family members affected; advocating for the rollout of the naloxone programme, which was set up to help reverse the effects of opioid overdose through training, in recognition and response to overdose due to opioids, 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. Closing her address, Sadie urged family members to look after themselves, to avail of support, and to acknowledge that they deserve to be supported.

Impact of drug misuse and drug-related deaths

In her address, Minister Byrne emphasised the ongoing valuable work of the NFSN. She highlighted the recognition of family members as service users in their own right and the health-led approach and actions on family support included in the current strategy.² She extended her sympathy to the bereaved families present and acknowledged that families need services and support to help copy with drug-related issues, including specialised bereavement support but also in dealing with drug-related intimidation and violence.

A testimony by a family member who has found support from the NFSN, highlighted the need for family members to look after their own health. Through engagement with a family support group as a mother, she learnt the importance of self-care, in a non-judgemental, comfortable environment, and that she was not alone in her struggles.

In his address, Archbishop Martin acknowledged the sadness, hope, courage, and solidarity among the gathering and spoke of the lack of respect for life within the drug trade, with children becoming entrapped in the world of drugs by heartless drug lords.

Art competition

This year the NFSN held an art competition with the theme 'Our Future' for youth groups within the local and regional drug and alcohol task force areas. The theme of hope was very evident in the entries on display. First prize of €500 went to Kilbarrack Coast Community Programme; second prize of €300 went to Kilrush Youthreach; and third prize of €200 went to Dolphin House homework club.

For many families, this service was the first time that they could openly grieve for loved ones lost to drug use and related causes. Of note, the first commemoration service, 21 years ago, included one family support group based outside of the Dublin area. This year support groups from across Ireland were represented, a stark reminder that drug-related deaths affect families throughout the whole of Ireland.

Ena Lynn

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

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/>

Action plan for drug use and higher education institutions

In June 2019, the Minister of State for Higher Education, Mary Mitchell O'Connor TD, convened a meeting of stakeholders to review the issue of drug use in higher education. Part of the outcome from this meeting was the establishment of a Rapid Response Group (RRG) whose brief was to develop an action plan on the issue, consistent with national strategy. In February 2020, the Department of Education published the *Framework for response to the use of illicit substances within higher education*, which is based on the work of the RRG.^{1,2}

RRG membership

Membership of RRG included academics, members of An Garda Síochána, students, and first responders within higher education institutions (HEIs). It was chaired by Dr Andrew Power of the Institute of Art, Design and Technology (IADT) and led by Dr Michael Byrne, head of the Student Health Department at University College Cork (UCC). In her foreword to the report, the Minister described HEIs as having a role in implementing actions that can 'reduce the number of students who decide to use drugs in the first place, or to reduce the harm experienced by those students who have chosen to use drugs' (p. 3).¹

Recommended actions

Central to the RRG's report and subsequent framework is a set of actions that HEIs are recommended to undertake, where relevant to their institution. These are grounded in consideration of the following:

- Existing legislation regarding the use and misuse of drugs
- The National Drugs and Alcohol Strategy 2017–2025³
- The evolving National Healthy Campus Charter and Framework
- Existing activities being carried out in HEIs to address drug and alcohol-related harm, including REACT (Reacting to Excessive Alcohol Consumption in Third-level)
- Input and expertise of RRG members.

The RRG identifies four core actions, with a further set of 12 actions. The core actions recommend that each HEI should:

- Develop a drug and alcohol policy specific to the institution.
- Develop and implement a drug and alcohol action plan specific to the institution and its students.
- Assign to a senior officer of the institution the responsibility for leading the development of the policy and implementation of the action plan.
- Facilitate student engagement with the collection of national-level data on drug use in HEIs.

The additional 12 actions are divided under four themes: institutional leadership; student engagement; community engagement; and service provision.

Institutional leadership

This theme is focused on each HEI's ability to adapt in a complex societal, academic, legislative, and policy environment, while also focusing on the ambitions and welfare of its students. In this context, the actions relate to the evaluation of the effectiveness of individual HEI action plans; the provision of designated substance-free student accommodation and social spaces; and the provision of space for support groups working with those experiencing problematic drug and alcohol use.

Student engagement

The actions under this theme recommend the provision of an online educational, screening, and brief intervention tool; consideration of substance use when planning large-scale student events; and the implementation of a student community support system.

Community engagement

In a context where HEIs consider themselves to have an important role to play in their local communities, the actions are to hold annual meetings with local stakeholders, such as local residents, Gardaí, and local businesses; and to develop partnerships with local community groups such as the local authority and local drug and alcohol task forces.

Service provision

The RRG notes the role of HEIs in providing adequate resources and services to meet the needs of their students. In line with this, the drug-related services identified in the actions are counselling services; visible and accessible referral pathways to treatment; interventions for higher risk groups described as 'vulnerable individuals or individuals from minority groups or communities' (p. 15)²; and the provision of training for staff and students in order to deliver brief interventions and advice.

Drug Use in Higher Education in Ireland survey

In its report, the RRG identified a gap in knowledge about the extent and nature of drug use among students in HEIs. The Drug Use in Higher Education in Ireland (DUHEI) survey has been commissioned and is currently being conducted by a team based in the School of Public Health at UCC. It involves a multidisciplinary team of academics, researchers, and clinicians from Public Health, Business Information Systems, Psychology, and the Student Health Service in UCC, in collaboration with the Higher Education Authority and the RRG.

The survey aims to provide a comprehensive picture of drug use among the higher education population in Ireland. It will cover six areas:

- Demographics – age, gender, year of study, etc.
- Student life – club/society membership
- Drug use – lifetime, recent and current use, frequency of use and drug types, harms, and experiences of consequences
- Cognitive enhancers – use and motivations for use of cognitive enhancers
- Student wellbeing – personal and relationships
- Drug use social norms – student perceptions of drug use.

Fieldwork was due to be carried out in 22 HEIs across the country in March 2020 and a preliminary report presented to the Minister and all participating institutions in mid-2020 (personal correspondence, DUHEI Survey Team, UCC). However, due to the Covid-19 crisis the survey has been suspended.⁴

Higher education institutions

continued

Lucy Dillon

- 1 Rapid Response Group on Use of Illicit Substances within Higher Education (2020) *Framework for response to the use of illicit substances within higher education. Based on the report of the Rapid Response Group (RRG) on Use of Illicit Substances within Higher Education*. Dublin: Department of Education and Skills. <https://www.drugsandalcohol.ie/31649/>

- 2 Rapid Response Group on Use of Illicit Substances within Higher Education (2019) *The report of the Rapid Response Group (RRG) on Use of Illicit Substances within Higher Education*. Dublin: Department of Education and Skills. <https://www.drugsandalcohol.ie/31649/>
- 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 See <https://www.ucc.ie/en/studentsurveys/survey-calendar/>

Know the Score

Know the Score is a new Government resource for Senior Cycle teachers to support their delivery of the substance use module of the Social, Personal and Health Education (SPHE) programme.¹ By supporting teachers, the resource aims to guide and support students (aged 15–18 years) to ‘make conscious and informed decisions about alcohol and drugs’ (p. 4).¹ This complements the Health Service Executive (HSE) guide for parents on how to communicate with their children about alcohol and drugs published in August 2018.² The resource was launched by Minister for Health Simon Harris TD, Minister for Education and Skills Joe McHugh TD, and Minister of State for Health Promotion and the National Drugs Strategy Catherine Byrne TD on 27 November 2019.

Social, Personal and Health Education

SPHE sets out to provide students with dedicated time to ‘further develop knowledge and understanding, values and attitudes and the life skills they need to live healthy lives and to contribute positively to the health and wellbeing of others and their communities’ (p. 7).³ Unlike in primary schools and the Junior Cycle in post-primary schools, SPHE is not a mandatory part of the curriculum for Senior Cycle.

Developing the resource

Know the Score is the outcome of a collaboration between the HSE Alcohol Programme and HSE Addiction Services, which was overseen by a Steering Committee made up of representatives from the HSE, the Professional Development Service for Teachers, and the Drug and Alcohol Task Forces. The resource content was also piloted by teachers and students in 10 schools.

Resource content

The objectives of Know the Score are aligned with those of the Curriculum Framework for the substance misuse module of SPHE (see Box 1). The wide range of objectives is reflected in the resource’s content. It is structured around 14 lesson plans and three short videos, and uses experiential and interactive teaching methodologies.^{1,4} Each lesson plan comes with a set of learning outcomes and resources for the teachers to draw upon in their delivery. Broadly speaking, Know the Score sets out to teach accurate information about drugs and related issues, as well as developing the skills necessary to make healthy choices and minimise the risk associated with substance use. The resource includes relevant factual information, guides for

class discussions, worksheets, and other activities. Based on an examination of the 14 sets of learning outcomes, some of the topics included are:

- Factual information about the range of drugs (both legal and illegal) and their effect on the user’s body and brain, as well as their physical and mental wellbeing
- Prevalence of substance use among young Irish people
- Students’ values, attitudes, and feelings in relation to substance use
- Assertiveness and communication skills in the context of substance use
- Positive strategies for dealing with stress as an alternative to substance use and personal skills to enhance confidence
- Low-risk drinking guidelines and methods for monitoring alcohol intake
- Awareness building of cultural attitudes towards alcohol in Ireland and the influence of alcohol brands and their advertising and sponsorship activities
- Skills development to deal with an emergency situation caused by substance misuse
- An understanding of cannabis, its legal status, and the myths and realities associated with its use.

As mentioned above, Know the Score also includes supporting digital content – three short videos – which aims to facilitate informed discussions about alcohol and drugs in the classroom. The topics covered are: drugs, the brain and dependency; cannabis; and risks of adolescent substance use.

Monitoring delivery

As with all SPHE modules at Senior Cycle, only pupils whose schools choose to deliver the substance misuse module will have the opportunity to benefit from the Know the Score resource. For schools that choose to deliver the module, it will require a teacher with the capacity and ability to deliver on the potentially sensitive content and the experiential and interactive teaching methodologies. A programme of one-day training sessions on Know the Score is underway and open to teachers nationally.⁵ At the time of writing, there are no plans in place to evaluate the resource and its delivery.

Know the Score continued

Objectives of Know the Score

The objectives of the Know the Score resource are the same as those outlined in the substance use area of learning in the Curriculum Framework for SPHE in Senior Cycle (p. 8):¹

- To enhance students' knowledge and understanding about substance use and misuse
- To develop awareness of personal experiences, values, attitudes, and feelings which influence lifestyle choices about substance use
- To develop students' personal and interpersonal skills so that they might have the confidence to act appropriately in the face of social pressures, and to choose how they act with awareness
- To examine life stories associated with the harmful use of substances to develop understanding and empathy with those involved
- To examine the external influences on substance use, including the media, peers, and community
- To remind students that deciding not to drink or use drugs is always a legitimate choice

Lucy Dillon

- 1 HSE Alcohol Programme (2019) *Know the Score: substance use resource materials for Senior Cycle SPHE*. Dublin: Health Service Executive. <https://www.drugsandalcohol.ie/31359/>
- 2 Health Service Executive Alcohol Programme (2018) *Alcohol and drugs: a parent's guide. Practical advice to help you communicate with your child about alcohol and other drugs*. Dublin: Health Service Executive. This guide was published in August 2018 and complements the students' resource. <https://www.drugsandalcohol.ie/29435/>
- 3 National Council for Curriculum and Assessment (NCCA) (2011) *Social, Personal and Health Education: Curriculum Framework. Senior Cycle*. Dublin: NCCA. Available online at: https://www.ncca.ie/media/2688/sphe_framework.pdf
- 4 Links to the videos can be found at: <https://www.drugsandalcohol.ie/31359/>
- 5 A training programme for teachers commenced in January 2020 and the Department of Education and Skills has provided substitution cover for this teacher training. Schools interested in attending the training or viewing a copy of the resource can visit: www.hse.ie/knowthescore

Silent Voices – manifesto on parental alcohol misuse

Silent Voices is an initiative of Alcohol Action Ireland (AAI). As Ireland's national charity for alcohol-related issues, AAI works in the areas of advocacy and policy change, aiming to reduce levels of alcohol harm in Ireland and improve public health, safety, and wellbeing. Silent Voices is focused on the impact of parental alcohol misuse (PAM) on children. It aims to ensure the right supports are available today to children coping with PAM – and those adults dealing with the impact of a childhood trauma in later life.¹

Vision and mission

- **Vision:** Its vision is of a society where no person impacted by PAM will be left unsupported.
- **Mission:** It works to achieve this vision by destigmatising the experience of growing up with PAM in Ireland; by increasing a better understanding of the adverse impact of this experience on emotional and mental health; and by working to enhance supports to those who have lived or are now living with PAM.

Silent Voices activities

There are three broad areas of activities outlined for Silent Voices:

- 1 Raise awareness of the impact of PAM through advocacy, education, and information. Tools used include personal testimony; sharing experiences; and signposting and listing resources.
- 2 Facilitate a better understanding of PAM by providing information and insight to the following groups: health professionals and practitioners; media; parents; policymakers; people who have contact with children; and volunteers.
- 3 Enhance services for children and adult children of PAM by working in partnership to initiate, develop, or contribute to research; fundraising; and development of online information and literature supports.

Manifesto

The *Silent Voices manifesto* was published in advance of General Election 2020.² In addition to outlining the research and policy context for the Silent Voices initiative, it contains a set of 13 recommendations across three areas: a whole-Government approach to the issue; services and supports; and training and awareness raising. The recommendations are aimed at Government and set out to address the harm caused by PAM and its impact across the lifespan. Among the recommendations are:

- A designated senior Government official should be appointed with responsibility for advising, developing, and planning appropriate policies and services to meet

Silent Voices continued

the needs of those who experience harm caused by PAM, and should have the capacity to work across Government Departments.

- Because educators are well placed to identify children experiencing hidden harm, the provision of specific training in relation to adverse childhood experiences should be examined at teacher training level and at all levels of professional development – from teachers to principals to education welfare officers.
- In addition to existing services, properly funded and resourced supports should be developed for children experiencing PAM. Innovative evidence-based programmes should become more widely available in communities around the country. It should also be ensured that children, as an individual right, can access services, even where parents are not in treatment.
- Awareness of PAM and its impact on young and adult children should be raised through information campaigns

and training that target healthcare, social care, early years, child protection, family support, education, and mental health sectors, as well as families and communities. Such campaigns should also reach an adult cohort who perhaps has yet to recognise the underlying cause of its own problems.

- Data should be gathered on the lives of children and adult children who have experienced PAM in Ireland to inform policy development and service provision.
- Public discourse/debate on the right to a childhood free from alcohol harm should take place and children should have their voices heard in relation to the impact of alcohol on their lives.

Lucy Dillon

1 For further information, visit:
<http://alcoholireland.ie/campaigns/silent-voices/>

2 Alcohol Action Ireland (2019) *Silent Voices manifesto*. Dublin: Alcohol Action Ireland. <https://www.drugsandalcohol.ie/31465/>

Oral fluid testing for methadone maintenance patients – accuracy and acceptability

Methadone maintenance treatment is an addiction treatment provided to about 10,000 people in Ireland to improve their health and stability.¹ In a 2019 study published in the *Irish Journal of Medical Science*, O'Callaghan *et al.*² investigated how accurate and acceptable oral fluid testing is to methadone maintenance patients and doctors as a means of substance detection. Importantly, this was the first Irish study capturing patient views on their experience with methadone maintenance.

Background

According to the authors, drug testing during methadone maintenance is crucial as it provides doctors with important insights into patient stability and contributes to decisions about the level, frequency, and supervision of methadone delivery. In Ireland, unsupervised urine testing is commonly used and preferred by general practitioners (GPs). However, unsupervised urine samples can be subject to falsification, and the 2010 external review of the Irish Methadone Maintenance Treatment Protocol³ called for discontinuing supervised urine testing due to its inherent infringement of patient privacy. Testing oral fluid rather than urine is an alternative method for detecting drug metabolites under supervision, without compromising patient privacy. However, its window of detection is shorter than that of urine testing. Hence, the current study examined how accurately oral fluid testing could

detect drug metabolites in comparison with urine testing and self-report. It also investigated patients' and doctors' views on the acceptability of each method and on methadone maintenance generally.

Methods

The study was carried out with seven GPs from four practices within the GP training scheme of Trinity College Dublin and the Health Service Executive from January to April 2016. Of the 65 invited patients, 55 (85%) agreed to participate. The average age of participants was 42.5 years and about two-thirds were male. The authors compared how many patients in the sample (n=55) were identified as having consumed a substance by means of (a) unsupervised urine testing, (b) supervised oral fluid testing, and (c) self-report. Patient views were captured with an eight-item questionnaire administered by GPs.

Key findings

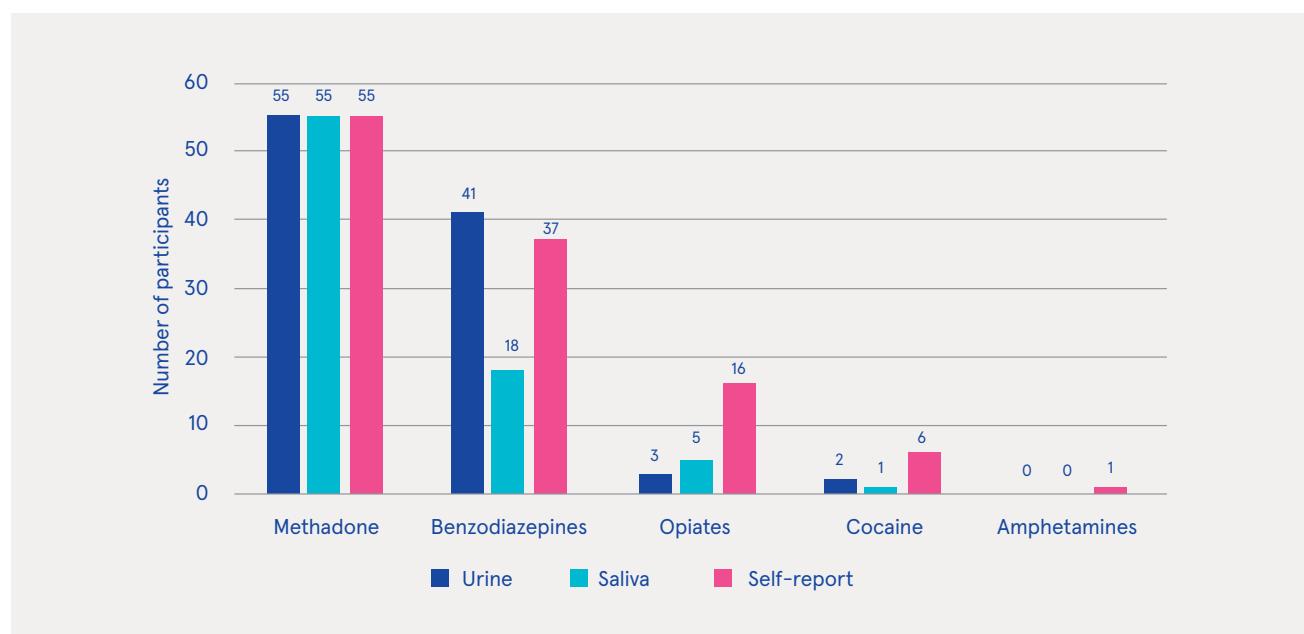
Accuracy

For most drugs, results from oral fluid testing were similar to those from urine testing, with the exception of benzodiazepines (see Figure 1).

- **Methadone:** Consumption of methadone was confirmed through all three methods for all patients (n=55).
- **Benzodiazepines:** Detection of benzodiazepines was superior in urine testing (n=41) and self-report (n=37) compared with oral fluid testing (n=18).
- **Opiates:** Detection of opiates was highest by means of self-report (n=16), and much lower both through urine (n=3) and oral fluid testing (n=5). Additionally, only self-report could identify the type of opiate (heroin n=3; painkillers n=13).
- **Cocaine and amphetamines:** Self-report was superior in capturing cocaine consumption (n=6) compared with both urine (n=2) and oral fluid testing (n=1). Only one patient self-identified as having consumed amphetamines, which was picked up by neither urine nor oral fluid testing.

Oral fluid testing continued

Figure 1: Drug testing results by each of the three methods (n=55)



Acceptability

- Views:** Most patients (95%) and the seven participating GPs evaluated oral fluid testing as acceptable and straightforward, with 60% of patients preferring oral fluid testing, but 13% preferring urine testing.
- Time and reliability:** GPs noted that additional time was necessary to perform both tests; three of them stressed the lack of reliability in the detection of benzodiazepines through oral fluid testing.
- Urine sample supervision:** Contrary to author expectations, only 15% of patients were against supervised urine samples. The authors attributed this to potential reluctance among patients to express negative views to their doctors directly, as well as possible altered levels of self-esteem and expectations for privacy for methadone patients.

Patient experience of methadone maintenance

- Positive vs negative views:** Overall, negative views of methadone maintenance were more frequent than positive ones among the patient sample.
- Detoxification:** More options for detoxing off methadone were desired by 20% of patients.
- Positive perceptions:** Perceived positive aspects included methadone allowing for stabilisation (28%), an alternative to drug use (25%), and better functioning (18%).
- Negative perceptions:** Perceived negative aspects included methadone being addictive (30%), associated with stigma (12%), a long-term treatment (11%), causing dental issues (11%), and causing physical side-effects (10%).

Discussion and conclusions

The current study found that, for most drugs, results from oral fluid testing were similar to those from urine testing but inferior for benzodiazepines. O'Callaghan *et al.* attributed this to the longer window of detection of benzodiazepines in urine compared with oral fluid. However, while many participants reported using benzodiazepines (67%), the authors state that 61% had a prescription for them, drawing into question the importance of their detectability. Hence, the authors conclude that oral fluid testing is an acceptable addition for drug screening in methadone maintenance treatment, and especially advantageous if a urine sample cannot be supplied. Additionally, they found that self-report as a measure of concomitant drug use was as or more worthwhile compared with urine or saliva testing.

However, the authors suggest that studies with larger samples are necessary to further investigate the detectability of drugs through oral fluid testing, especially when considering the low number of patients recorded as having consumed cocaine and amphetamines (through self-report or testing). Overall, given the increasing drug-related mortality observed in Ireland, the authors stress the importance of more research on the substance use but also the perspectives and experiences of methadone maintenance patients.

Britta Thielt

- 1 Delargy I, Crowley D and Van Hout MC (2019) Twenty years of the methadone treatment protocol in Ireland: reflections on the role of general practice. *Harm Reduct J*, 16(1): 5. <https://www.drugsandalcohol.ie/30173/>
- 2 O'Callaghan ME, Regan L, Wilson M, Byrne E, Hollywood B, O'Kelly F, *et al.* (2020) Acceptability and accuracy of oral fluid drug testing for patients on methadone maintenance. *Ir J Med Sci*, 189: 557–561. <https://www.drugsandalcohol.ie/31236/>
- 3 Farrell M and Barry J (2010) *The introduction of the opioid treatment protocol*. Dublin: Health Service Executive. <https://www.drugsandalcohol.ie/14458/>

Appropriate prescribing of pregabalin

In January 2020, the Medicines Management Programme in the Health Service Executive published a document on appropriate prescribing of pregabalin (common brand name Lyrica).¹ It advises that vigilance is required when prescribing pregabalin due to the risk of dependence, illegal diversion, and medical misuse. Currently pregabalin has only three licensed indications in Ireland:

- Treatment of peripheral and central neuropathic pain
- Treatment of generalised anxiety disorder
- Adjunctive therapy in patients with partial seizures with or without secondary generalisation.

This follows on from advice provided by the Irish Medical Council in September 2019 to doctors when prescribing pregabalin to follow best practice guidelines and to only prescribe when absolutely necessary.²

Because of the risk of misuse or dependence, caution is advised when prescribing pregabalin for people with a history of drug or alcohol misuse, particularly as there is a risk of fatal interactions between pregabalin and alcohol in addition to other central nervous system depressant drugs, including opioids. All patients should be monitored for signs of misuse, diversion, or dependence. Withdrawal symptoms include anxiety, convulsions, depression, diarrhoea, dizziness, flu syndrome, headache, excessive sweating, insomnia, nausea, nervousness, and pain. The suggested tapering regime is to reduce the dose gradually by a maximum of 50–100 mg.

Suzi Lyons

- 1 Medicines Management Programme (2020) *Appropriate prescribing of pregabalin*. Dublin: Health Service Executive. Available online at: <https://www.hse.ie/eng/about/who/cspd/ncps/medicines-management/prescribing-tips-and-tools/appropriate-prescribing-of-pregabalin-.pdf>
- 2 Medical Council (2019) Medical Council warns doctors to reduce over-prescribing of benzodiazepines, Z-drugs and pregabalin or face potential investigation (September 2019). Dublin: Medical Council. Available online at: <https://www.medicalcouncil.ie/news-and-publications/press-releases/press-release/items/medical-council-warns-doctors-to-reduce-over-prescribing-of-benzodiazepines.html>

Risk of drug-related poisoning deaths and all-cause mortality among people who use methadone

Methadone is the most commonly prescribed opioid substitution treatment in Ireland. A retrospective cohort study was carried out in all specialist addiction services in Dublin South West and Kildare looking at the risk of death associated with interruptions in methadone maintenance treatment (MMT) for the years 2010–2015.¹

Methods

Using data from the Central Treatment List and the Health Service Executive Methadone Treatment Scheme, start and end dates for patient MMT were identified from methadone dispensing data. This information was then linked to mortality data from the National Drug-Related Deaths Index (NDRDI) and prescription data from the General Medical Services. The researchers were therefore able to categorise the treatment status for every day for each patient (addiction services, primary care, prison, out of treatment). ‘In treatment’ was defined as a continuous daily supply of methadone. If a patient did not receive a new prescription within 7 days after the end of the last prescription, they were considered to be ‘off treatment’. The patient remained off treatment until they received a new prescription.

There were five groups within the study: weeks 1–4 following transfer between treatment providers; weeks 1–4 out of treatment; weeks 5–52 out of treatment; weeks 1–4 of treatment initiation; and weeks 5+ of continuous treatment. A drug-related poisoning (DRP) death was classified as the primary outcome measure, while an all-cause mortality (ACM) death was classified as the secondary outcome.

Findings

The study included 2,899 patients over the six-year study period, equating to 13,300 person-years. The median follow-up period was 5.5 years. The majority were male (63.3%), with a median age of 33.9 years. Forty-nine per cent (48.5%) of patients were found to have transferred, on average, three times between services. Most of the transfers were back and forth between prison and addiction services. Many patients included in the study had evidence of physical ill-health and/or mental health problems, with 66.9% reporting two additional problems, most commonly mental health problems (66%), diseases of the digestive system (34%), and diseases of the respiratory system (24%). The study also recorded the median methadone dose at the last treatment episode, as follows:

- 40.5% median dose <60 mg
- 56.1% median dose 60–120 mg
- 3.4% median dose ≥120 mg.

Of the 2,899 patients included, 154 (5.3%) were known to have died. There were no deaths recorded in weeks 1–4 following transfer between treatment providers. Of those who died, one-third ($n=55$, 36.2%) were a DRP (crude DRP mortality rate of 0.41 per 100 person-years [95% CI: 0.30–0.52]). After adjusting the analysis for other factors, the risk of DRP was highest in weeks 1–4 out of treatment and weeks 1–4 of treatment initiation (see Table 1). The risk was higher for women and increasing age. The crude ACM was higher than DRP, with a rate

Risk of drug-related poisoning

continued

Table 1: DRP and ACM mortality rates per person-years and adjusted relative risk by interruptions to MMT continuity

Interruptions to MMT continuity		Adjusted relative risk	95% CI
DRP mortality rate per 100 person-years			
Weeks 1–4 following transfer between treatment providers	0.00	-	-
Weeks 1–4 out of treatment	1.29	4.04	1.43–11.43
Weeks 5–52 out of treatment	0.27	1.00	0.03–3.34
Weeks 1–4 of treatment initiation	1.11	3.40	1.20–9.64
Weeks 5+ of continuous treatment	0.39	1.00	-
ACM mortality rate per 100 person-years			
Weeks 1–4 following transfer between treatment providers	0.00	-	-
Weeks 1–4 out of treatment	9.32	11.78	7.73–17.94
Weeks 5–52 out of treatment	1.43	2.04	1.20–3.47
Weeks 1–4 of treatment initiation	4.17	5.11	2.95–8.83
Weeks 5+ of continuous treatment	0.82	1.00	-

Source: Durand *et al.* (2020)

of 1.14 per 100 person-years [95% CI: 0.96–1.32]. As with DRP, the risk of ACM was highest in weeks 1–4 out of treatment and weeks 1–4 of treatment initiation (see Table 1). The risk of ACM was higher for those with a recorded disease of the circulatory system and increasing age, while the risk was reduced for those with a history of imprisonment.

The authors noted that the 7-day rule used to categorise treatment status could be a bias in the study, as some patients may not have stopped treatment. Therefore, they conducted the analysis using 14 days instead of 7 days. This did not change the results, with the exception that the risk of ACM for weeks 1–4 in treatment did not remain significant in the multivariate analysis.

The strength of the study is that it included a large number of patients, representing almost one-half of all those in MMT treatment during that time. There was a long follow-up time and the study utilised a number of existing databases to account for interruptions to treatment and mortality.

Limitations

A number of weaknesses and biases were acknowledged. There were other factors and confounders associated with interruption of treatment that could not be accounted or controlled for. One example cited was where a patient may have left treatment, moved into recovery and had stopped

problem opioid use, and had therefore reduced their risk of mortality compared with those who relapsed and returned to treatment. The researchers used a 12-month limit for follow-up after stopping treatment to control for this potential confounder. The study did not include transfers to/from hospital, as hospitals are not required to report to the Central Treatment List. Therefore, given the high proportion of patients who also suffered from physical illnesses, it may be that those off treatment had been admitted to hospital for treatment for those illnesses, which might have influenced the results. Patients on Suboxone were also not included in the study.

Conclusions

This study confirms that the first 4 weeks after treatment initiation and after stopping treatment have the highest risk for mortality among patients in MMT in Ireland. While this trend is similar to findings from United Kingdom studies, mortality rates observed in this study were higher. This may be due to ageing among problem opioid users along with higher levels of comorbidity. The increased risk at initiation could be attributed to continued use of illicit opioids or other respiratory depressant drugs, or could be tolerance related. There were no deaths recorded in the first 4 weeks after transfer between services. Given that many of those transfers were to and from prison, this may reflect the policy of keeping a person's place in community MMT until they are released from prison.

Risk of drug-related poisoning

continued

The authors recommend further investigation into the risks for patients caused by transfer between services. Seeing that the study shows the greatest risk of mortality at treatment initiation or after treatment stops, the authors also recommend closer monitoring of opioid tolerance at these times as well as relapse prevention strategies, which would include provision of take-home naloxone.

Suzi Lyons

- 1 Durand L, O'Driscoll D, Boland F, Keenan E, Ryan B, Barry J, et al. (2020) Do interruptions in the continuity of methadone maintenance treatment in special addiction settings increase the risk of drug-related poisoning deaths? A retrospective-cohort study. *Addiction*, Early online. <https://www.drugsandalcohol.ie/31615/>

Building community resilience: response to criminal networks in Dublin

In December 2019, Four Forum Network (4Fora) and Dublin City Council published a report, *Building community resilience: responding to criminal and anti-social behaviour networks across Dublin South Central*.¹ 4Fora comprises four local policing fora in the Dublin South Central area, and the report was carried out in collaboration with An Garda Síochána.

Research aims

The research aimed to explore five areas:

- 1 Nature and spread of criminal and antisocial behaviour (ASB) networks.
- 2 Impact of these networks on people residing in Dublin South Central.
- 3 Relationships between socioeconomic indicators and the operation and impact of networks, including circumstances that enabled resilience.
- 4 Mapping and evaluation of existing initiatives, structures, and resources.
- 5 Requirements necessary to address impact and causes of these networks.

Methodology

To address the research aims, several approaches were utilised to gather data:

- Social network analysis
- Interviews with Garda members using Twinsight methodology, developed in the Greentown study²
- Socioeconomic analysis of network members
- Mapping of crime and ASB hotspots
- Attending local meetings
- Focus groups, involving community activists
- Research ethics.

Findings

Nature and reach of criminal/ASB networks in Dublin South Central

Approximately 650 people were involved in the overall network, which could be stripped down to two distinct networks: Dublin South Central Network One (SCN1), consisting of 44 people, and Dublin South Central Network Two (SCN2), consisting of 52 people. Some of these network members committed crimes on at least one occasion between 2015 and 2016.

Impact of criminal networks on residents

Perceptions of the impact of criminal networks were provided by Garda respondents and local community activists. Similar to existing research findings in this area, the impact of criminal networks was considered to be hidden. Several themes emerged; for example, issues were identified in schools as a result of being associated with different networks. Drug debt was considered a route to engagement with networks and criminal behaviour, as were fear and easy access to money and material goods for young people. Lack of opportunities for young people also pushed them towards criminal network opportunities.

Community activist perspectives

The link between the frequency of criminal activity and economic deprivation has long been the focus of criminological research. In this study, according to the Pobal HP Deprivation Index map, the majority of members in SCN1 and SCN2 ranged from marginally below average to very disadvantaged, 86% and 88%, respectively.

Building resilience was viewed as a way to help communities provide community-based resolutions to tackle criminal networks and crime. Failure to consistently reinforce pro-social behaviour was cited by Garda respondents as an issue. It was acknowledged that some communities were able to 'take a stand' (p. 62) against ASB, however, other communities were not.

Initiatives, structures, and resources

An overview of current community safety structures, initiatives, and resources was provided. It was acknowledged by 4Fora that structures and functioning could be improved. Reluctance of communities to engage with Gardaí was highlighted. The issues dealt with across the structures were similar, such as lack of Garda resources; difficulties filling Garda vacancies; low Garda visibility; Garda response to calls on serious issues insufficient, in particular ASB in parks; criminal 'hotspots'; intimidation; and gang-related feuding.

Criminal networks in Dublin

continued

Care and control responses

Building a holistic approach to criminal issues in the community emerged as an area of importance. Involvement in community safety groups may have implications for personal safety; hence, residents are unwilling to participate. As a result, it falls to community-based workers to carry out this role. Two problems need to be considered: (a) keeping individuals who are willing to take part safe and (b) making sure that responses to criminal behaviour is not 'enforcement oriented' (p. 12), that is, responses are not about arresting individuals, carrying out surveillance, delivering warnings, and evictions. The authors acknowledged that while this was important, building resilience in communities needed a more subtle and viable approach.

Future guiding principles and action plan

The *Building community resilience* report can be viewed as a starting point for developing a strategy to address ASB and criminal behaviour in the Dublin South Central area. It identifies the main characteristics of the drug trade and ASB networks and elaborates on how it impacts on the community. The 4Fora have provided an outline strategy that identifies the vision, specific actions, and structural reforms necessary to implement it.

Ciara H Guiney

- 1 Connolly J and Mulcahy J (2019) *Building community resilience: responding to criminal and anti-social behaviour networks across Dublin South Central – a research study*. Dublin: Four Forum Network and Dublin City Council.
<https://www.drugsandalcohol.ie/31426/>
- 2 Department of Children and Youth Affairs (2016) *Lifting the lid on Greentown: why we should be concerned about the influence criminal networks have on children's offending behaviour in Ireland*. Dublin: Government Publications.
<https://www.drugsandalcohol.ie/26850/>



UPDATES

Recent publications

PREVALENCE AND CURRENT SITUATION

A national case fatality study of drugs taken in intentional overdose

Daly C, Griffin E, Corcoran P, et al. (2020) *International Journal of Drug Policy*, 76: 102609.
<https://www.drugsandalcohol.ie/31526/>

This study aimed to examine the incidence of intentional drug overdose (IDO), to identify the predictors of fatal IDO and to establish which drugs are linked with greater risk of a fatal outcome.

Male gender, increasing age and multiple drug use were associated with fatal IDO outcome. Tricyclic antidepressants and opioids were associated with a significantly increased risk of death following intentional overdose. Clinicians need to consider the case fatality risk of drugs when determining treatment for patients at risk of or those who have previously harmed themselves.

Counting the toll of smoking-attributable hospitalisations

Sheridan A, Quintyne KI and Kavanagh P (2020) *Irish Medical Journal*, 113(1): 8.
<https://www.drugsandalcohol.ie/31554/>

In Ireland, 20% of adults smoke. Many current and ex-smokers live with ill-health and disability as a result of smoking, and this study aimed to quantify the extent of smoking-related hospitalisations in Irish publicly funded hospitals.

Smoking continues to cause a considerable impact on hospital services in Ireland.

'Bursting the Lyrica bubble': experiences of pregabalin use in individuals accessing opioid agonist treatment in Dublin, Ireland

Brennan R and Van Hout MC (2020) *Heroin Addiction and Related Clinical Problems*, Early online.
<https://www.drugsandalcohol.ie/31533/>

This study aims to add to the evidence based on diverted pregabalin use in the opioid agonist treatment (OAT) cohort in Ireland.

We report here on the first study in Ireland investigating the experiences of individuals who access opioid agonist treatment and reported current or recent pregabalin use. Increased pharmaco-vigilance amongst medical practitioners is warranted when prescribing Lyrica to individuals with vulnerabilities such as a history of problematic drug use. Trauma informed interventions in addition to pragmatic harm reduction information for polydrug users to prevent cross tolerance, dependence and overdose deaths should be part of the healthcare and policy response.

Treatment of adolescent heroin dependence: the end of an era

Smyth BP and McCarney G (2020) *Irish Medical Journal*, 113(1): 2.
<https://www.drugsandalcohol.ie/31553/>

[Editorial] In the 1990s, Ireland had the youngest population of heroin dependent patients in Europe. At that time problems were largely confined to Dublin, and within Dublin use was concentrated in specific areas of very significant deprivation. At the peak of the heroin epidemic in 1996, there were over 180 adolescents (under 18) presenting for addiction treatment in Dublin annually with a heroin use disorder. Given that addiction services had been developed with adults in mind, the National Drug Treatment Centre established the Young Persons Program (YPP) in 2000, in recognition of the very different needs of these young patients. The authors, both child and adolescent psychiatrists, arrived into the service a few years later.

A repeated cross-sectional study of factors associated with pregabalin-positive poisoning deaths in Ireland

Lynn E, Cousins G, Lyons S and Bennett KE (2019) *Drug and Alcohol Dependence*, 206: 107741.
<https://www.drugsandalcohol.ie/31323/>

In this study we examined factors associated with pregabalin-positive poisoning deaths (PPPD) between 2013 and 2016 in Ireland.

Enhanced training to prescribers and treatment providers on the potential risks associated with pregabalin, particularly among people who use drugs, is required.

Recent publications

continued

Low levels of chemsex among men who have sex with men, but high levels of risk among men who engage in chemsex: analysis of a cross-sectional online survey across four countries

Frankis J, Flowers P, McDaid L and Bourne A (2018) *Sexual Health*, 15(2): 144–150.

<https://www.drugsandalcohol.ie/31315/>

This paper establishes the prevalence of chemsex drug use among men who have sex with men (MSM), the extent to which these drugs are used in a sexual context, as well as their associated behaviours and circumstances of use.

Only a small proportion of MSM in Scotland, Wales, Northern Ireland and the Republic of Ireland reported chemsex, and, for the first time, it is demonstrated that not all chemsex drug use was sexualised. Nevertheless, MSM who engage in chemsex (MWEC) reported substantial sexual risk inequalities. These novel findings highlight several opportunities for intervention, particularly around the multiple vulnerabilities of MWEC, opportunities for early identification of those most vulnerable to chemsex-related harm and the potential to develop a specialised responsive patient pathway.

Prevention of suicidal behaviour: results of a controlled community-based intervention study in four European countries

Hegerl U, Maxwell M, Harris F, Koburger N, Mergl R, Székely A, et al. (2019) *PLoS One*, 14(11): e0224602.

<https://www.drugsandalcohol.ie/31340/>

This paper reports on the primary outcome of the intervention (the number of completed and attempted suicides combined as 'suicidal acts') and on results concerning process evaluation analysis. Interventions were implemented in four European cities in Germany, Hungary, Portugal and Ireland, with matched control sites.

Hypothesised mechanisms of action for successful implementation were observed and drivers for 'added-value' were identified: local partnership working and 'in-kind' contributions; an approach which valued existing partnership strengths; and synergies operating across intervention levels. It can be assumed that significant events during the implementation phase had a certain impact on the observed outcomes. However, this impact was, of course, not proven.

Electronic cigarette vapour increases virulence and inflammatory potential of respiratory pathogens

Gilpin DF, McGown KA, Gallagher K, et al. (2019) *Respiratory Research*, 20: 267.

<https://www.drugsandalcohol.ie/31477/>

This study compared the effect of e-cig vapour (ECV) and cigarette smoke (CSE) on the virulence and inflammatory potential of key lung pathogens (*Haemophilus influenzae*, *Streptococcus pneumoniae*, *Staphylococcus aureus* and *Pseudomonas aeruginosa*).

The findings suggest that ECV and CSE can induce changes in phenotype and virulence of key lung pathogens, which may increase bacterial persistence and inflammatory potential.

Sponsorship, advertising and alcohol control in Ireland: the importance of both premises and products in regulating intoxicogenic environments

Houghton F and McInerney D (2019) *Irish Journal of Medical Science*, Early online.

<https://www.drugsandalcohol.ie/31423/>

Ireland's relationship with alcohol is decidedly problematic. Per capita alcohol consumption and binge drinking rates in Ireland are both worryingly high. Such excess results in significant costs in terms of morbidity, mortality, finances and valuable and finite health and hospital resources. Results from both the ESPAD [European Schools Project on Alcohol and Other Drugs] survey and the HBSC [Health Behaviour in School-Aged Children] survey therefore clearly indicate that youth initiation into alcohol use is a significant issue. Further validation of this issue may be seen in results from the National Alcohol Diary Study which indicated that almost two-thirds (63.9%) of males and half (51.4%) of females in Ireland started drinking alcohol before the age of 18 years. These findings are extremely important as evidence examining the impact of alcohol on the developing brain has identified the 'disrupting effects of adolescent binge drinking on the developmental trajectories of both brain and personality'.

Safer injecting facilities: will they work in an Irish context?

Bates C (2019) *Irish Probation Journal*, 16: 184–197.

<https://www.drugsandalcohol.ie/31389/>

This article considers the context and policy development in Ireland around the introduction of safer injecting facilities (SIFs), in addition to exploring the debates about their operation. The findings from a small-scale research study, conducted by the author as part of a master's programme in criminology and criminal justice in University College Dublin in 2018, are outlined. The focus of this research was to gauge the views of members of An Garda Síochána (n = 5) based in the Dublin metropolitan area on the potential for SIFs to operate effectively and efficiently.

Gardaí were identified as appropriate participants as they are often the first point of contact with street drug users and have an awareness of how the introduction of SIFs may impact on policing strategy and operations.

Reducing youth crime: the role of mentoring

O'Dwyer K (2019) *Irish Probation Journal*, 16: 153–167.

<https://www.drugsandalcohol.ie/31390/>

This article discusses the role of mentoring in reducing youth crime, drawing on a 2016 evaluation of Le Chéile mentoring services in the Republic of Ireland. There are many studies of mentoring of 'at risk' children and young people, which show a range of benefits when good practice is followed. There are fewer studies of mentoring of young offenders, and results are less clear-cut – variously described as 'promising', 'mixed', 'indirect', 'modest', 'tantalising' or lacking clear evidence.

The article examines the reasons for the equivocation about mentoring outcomes in other jurisdictions and explores possible reasons for Le Chéile's positive results. It discusses a number of themes, including the importance of volunteer mentors, the building of relationships of trust, the balance between listening and challenging, and the importance of commitment and perseverance.

Recent publications

continued

POLICY

Removing the last billboard for the tobacco industry: tobacco standardized packaging in Ireland

Crosbie E (2019) *Health Policy*, 123(10): 932–935.
<https://www.drugsandalcohol.ie/31537/>

Tobacco Free Ireland set out 60 recommendations and measures to reach the 2025 target, including introducing SP [standardized packaging]. Tobacco companies and trademark and intellectual property organizations opposed the SP proposal claiming it would: (1) not work to reduce smoking levels, (2) increase illicit tobacco trade, (3) create unnecessary problems for retailers, and (4) violate domestic and international laws governing trademarks. However leading health groups in Ireland presented evidence on how SP would communicate the harms of tobacco to smokers and discourage young people from beginning to smoke. These efforts combined with strong political will helped Ireland to become the second country in the world to enact standardized packaging for all tobacco products.

Reducing harm, supporting recovery: a partnership and evidence-informed approach to developing the new Irish health led, National Drug Strategy

Comiskey C (2020) *Harm Reduction Journal*, 17(1): 3.
<https://www.drugsandalcohol.ie/31534/>

Policy development by partnership is difficult, however, 'Reducing Harm, Supporting Recovery: A health led response to drug and alcohol use in Ireland 2017–2025' hailed a new era. This policy was based on an agreed philosophy and core values across a 21-member partnership and has stated a common commitment to a health-led response.

A key recommendation from the process was to ensure that all voices had an equal opportunity to be heard and to ensure that priority actions identified from the wider sources of evidence were not lost during the extended process. The breadth of the partnership aided this. While we have succeeded in developing a sound strategy, success will depend on continuing support from the partnership and appropriate resourcing from the ministries.

A senior management perspective on the policy debate of needle and syringe exchange program provision in Irish prisons

Rosalim JP (2020) *Journal of Correctional Health Care*, 26(1): 27–35.
<https://www.drugsandalcohol.ie/31593/>

This study examined from an Irish perspective the contentious policy debate about providing clean needles to injecting drug users within prison systems; specifically, it examined the views of six senior managers who were prison health staff and security management.

Research participants were generally opposed to the introduction of prison-based needle and syringe exchange programs (PNSP) in Ireland. They argued that (1) PNSP were unnecessary since injecting drug use within Irish prisons has declined significantly, (2) PNSP, by making needles freely available to prisoners, would make prisons riskier since these needles might be used as weapons against prison staff or other prisoners, and (3) PNSP might be seen as condoning illicit drug use and sending the 'wrong message'. It is concluded that, for the moment at least, there is little likelihood of PNSP becoming a reality in the Irish Prison Service.

RESPONSES

Hepatitis C virus infection in Irish drug users and prisoners – a scoping review

Crowley D, Murtagh R, Cullen W, Lambert JS, McHugh T and Van Hout MC (2019) *BMC Infectious Diseases*, 19(1): 702.
<https://www.drugsandalcohol.ie/31395/>

The aim of this review was to map key findings and identify gaps in the literature (published and unpublished) on HCV [hepatitis C virus] infection in Irish PWUD [people who use drugs] and prisoners.

Ireland like other European countries has high levels of undiagnosed and untreated HCV infection. Collecting, synthesising and identifying gaps in the available literature is timely and will inform national HCV screening, treatment and prevention strategies.

Brief interventions targeting long-term benzodiazepine and Z-drug use in primary care: a systematic review and meta-analysis

Lynch T, Ryan C, Hughes CM, et al. (2020) *Addiction*, Early online.
<https://www.drugsandalcohol.ie/31589/>

The aim of the study is to assess the effectiveness of brief interventions in primary care aimed at reducing or discontinuing long-term benzodiazepine/Z-drug (BZRA) use.

Brief interventions delivered in primary care are more effective than usual care in reducing and discontinuing long-term benzodiazepine/Z-drug use.