The newsletter of Ireland's focal point to the EMCDDA

drugnet IRELAND

Issue 74 | Summer 2020

In this issue

Covid-19 evidence brief
See page **5–9**

19 Reducing youth crime

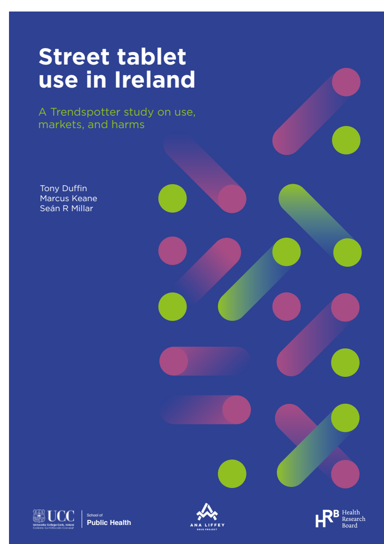
11 New youth services plan

23 Teenagers' experience of cannabis treatment

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

Street tablet use in Ireland – results from a Trendspotter study on use, markets, and harms

The non-medical use of prescription drugs has become a global health concern. Non-medical usage is defined as the taking of prescription drugs, whether obtained by prescription or otherwise, except in the manner or for the reasons or time period prescribed, or by a person for whom the drug was not prescribed.[1] The non-medical use of pharmaceuticals is a unique category of substance misuse in a number of ways, as the scale of the problem is largely unknown owing to lack of data. This is partly due to the existence of many gaps in the monitoring of their legal use for medical purposes. In addition, most studies on, and monitoring instruments for, substance abuse pertain to the use of illegal drugs or alcohol and tobacco.



Health Research Board

Research. Evidence. Action.

Contents

COVER STORY

Street tablet use in Ireland – results from a Trendspotter study on use, markets, and harms 01

POLICY AND LEGISLATION

HRB evidence brief on the response of drug services to Covid-19 05

Gender and drug policy 09

Launch of UBU Your Place Your Space 11

PREVALENCE AND CURRENT SITUATION

Qualitative insights into pregabalin use among individuals in opioid agonist treatment 12

Inspector of Prisons annual report, 2018 14

GYDP young people: response to Covid-19 public health measures 16

Fostering understanding, empowering change: practice responses to adverse childhood experiences and intergenerational patterns of domestic violence 17

Reducing youth crime: role of mentoring 19

RESPONSES

Strategy and intervention framework for Planet Youth 21

Experiences of teenagers in treatment for cannabis use 23

Hepatitis C screening and care for opioid substitution patients in Ireland 24

DOVE Service, Rotunda Maternity Hospital annual report, 2018 26

Trends in alcohol and drug admissions to psychiatric facilities 28

National Self-Harm Registry annual report, 2018 29

New clinical guidelines for management of opioid substitution in hospital setting 30

UPDATES

Recent publications 33

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

In brief

The Covid-19 pandemic has underlined the importance of effective responses to rapidly developing dangers to public health. Accurate data are the basis on which effective monitoring systems are built and trends derived to inform policy and to plan services. In recent years, new tools have been developed to gather and report drug-related information faster than the traditional routine systems. These tools have proved particularly useful in recent months, as innovative approaches have been needed to record and analyse the impact of the crisis on people who use drugs and on services.

Shortly before the introduction of restrictions to deal with the pandemic, Ana Liffey Drug Project published a Trendspotter study on street tablet use in Ireland. Trendspotting is a technique for assessing information using multiple research methods to rapidly expand knowledge on an area of interest. It has been developed by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The report is summarised in this issue of *Drugnet Ireland* and is a fine example of collaborative working between non-governmental organisations and scientists to make valuable information on a pressing topic available quickly.

EMCDDA applied its trendspotting methodology to analyse the impact of Covid-19 and also produced reports on changes to the illicit drugs market. In a very different setting, the Evidence Centre of the Health Research Board (HRB) has refined its approach to research synthesis in the area of health services and policies and have several different products available for use in different situations. We were able to respond quickly to a request from the Department of Health to contribute to its rapid assessment of effects of the pandemic on the drugs situation. Our evidence brief is also summarised in this issue and uses the tools developed by the HRB to provide descriptive accounts of topics of immediate concern.

The response to the threat that Covid-19 presented to the vulnerable homeless population at the beginning of the pandemic was exemplary. The statutory and community and voluntary sectors worked in a highly efficient and coordinated way to ensure the safety of homeless people and people who use drugs. A number of those directly involved in this work have recorded this experience so that the lessons learned can inform future interventions.[1] This is an excellent example of an innovative and responsive approach to research, using the knowledge gained from routine monitoring and other information resources to present a compelling narrative and provide a guide for the future.

There are lessons here for the broader research and monitoring environment. If we make full use of the information that is available, in excellent monitoring systems and the knowledge of practitioners and service providers, then the benefits for those who use these services will be immense. We've seen how the State can respond to a crisis when the evidence is clearly presented and there is the confidence and the capacity to use this evidence.

1 O'Carroll A, Duffin T and Collins J (2020) *Saving lives in the time of COVID-19: case study of harm reduction, homelessness and drug use in Dublin, Ireland.* London: London School of Economics and Political Science. https://www.drugsandalcohol.ie/32291/

New Minister of State with responsibility for the National Drugs Strategy

On 2 July 2020 Frank Feighan TD for Sligo-Leitrim was appointed the Minister of State for Public Health, Well Being and National Drugs Strategy.

Trendspotter study continued

In the Republic of Ireland, converging signals of the ongoing non-medical use of pharmaceuticals ('street tablets') among clients of community-based, drug harm-reduction service agencies in Dublin were noted in 2018. These included significant levels of street tablet use among service clients, an increase in the prevalence of pregabalin in drug-related deaths data since 2015, and reports of online purchasing of tablets for the Irish market. In order to better understand these converging signals, the Ana Liffey Drug Project (ALDP), the School of Public Health at University College Cork, and the Health Research Board, with the support of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), conducted a Trendspotter study to examine patterns of use, markets, and harms related to street tablets in Ireland.[2]

Trendspotter study

A Trendspotter study is a rapid information assessment that uses multiple social research methods to explore a topic of interest or concern. The approach was developed and has been used by the EMCDDA since 2011 as a tool to complement other routine drug-monitoring methodologies.[3] It has generally been utilised to explore emerging phenomena and new trends that are in their infancy and/or not covered by existing datasets. Undertaken between May and September 2019, the study commenced with a phase of data collection and a literature review, culminating in a 1.5-day expert presentation and facilitated groups meeting. The meeting consisted of a group of 11 experts from ALDP, the University of Limerick, Forensic Science Ireland, the Health Products Regulatory Authority, the Health Service Executive Addiction Services, Merchants Quay Ireland, An Garda Síochána, and addiction/homelessness specialist general practitioners. Key findings from the report are discussed below.

Street tablet use

Experts provided data on use, changing consumption patterns, and availability, with a majority indicating that there has been an increase in the use and availability of street tablets in Ireland between 2016 and 2019. Drugs which are commonly misused in tablet or capsule form include benzodiazepines, Z-drugs, and gabapentinoids. The user groups identified included high-risk opioid users, prison populations, people with complex and multiple needs, and young people. Among these groups, the motivations for using street tablets included their intoxicating effects, to enhance desired effects from illicit substances, to help withdrawal symptoms, to improve sleep, and to reduce stress. Other potential reasons for use are that tablets are cheap to purchase and are easily available. Feedback from recent research as well as experts in this study highlighted the importance that culture plays in the availability and use of street tablets among communities. On a cultural level, there is an acceptance of the misuse of street tablets as part of normal life and behaviour. Doctors have the legal ability to prescribe these medications on a wide scale, which strengthens the idea that they are safe to use for long periods of time. Also, in addition to affecting local cultures, street tablet supply, trade, and distribution have become embedded in local economies, as people are selling, sharing, and swapping street tablets as a form of currency.

Street tablet markets

In terms of the importation of ready tableted products, the main sources appear to originate from the Indian subcontinent. However, as Ireland is not a transit country, identifying the origin of drugs being transported to Ireland can be difficult. Another possible avenue of availability cited was the healthcare system, with overprescribing resulting in the ability for individuals to sell unused tablets on the street. Online sources were also identified as a source of street tablet availability and that, through the internet and social media, distribution of benzodiazepines, Z-drugs, and pregabalin is much easier and wider-reaching. Insofar as routes to markets for tablets in Ireland are concerned, all of these sources are likely to play a part.

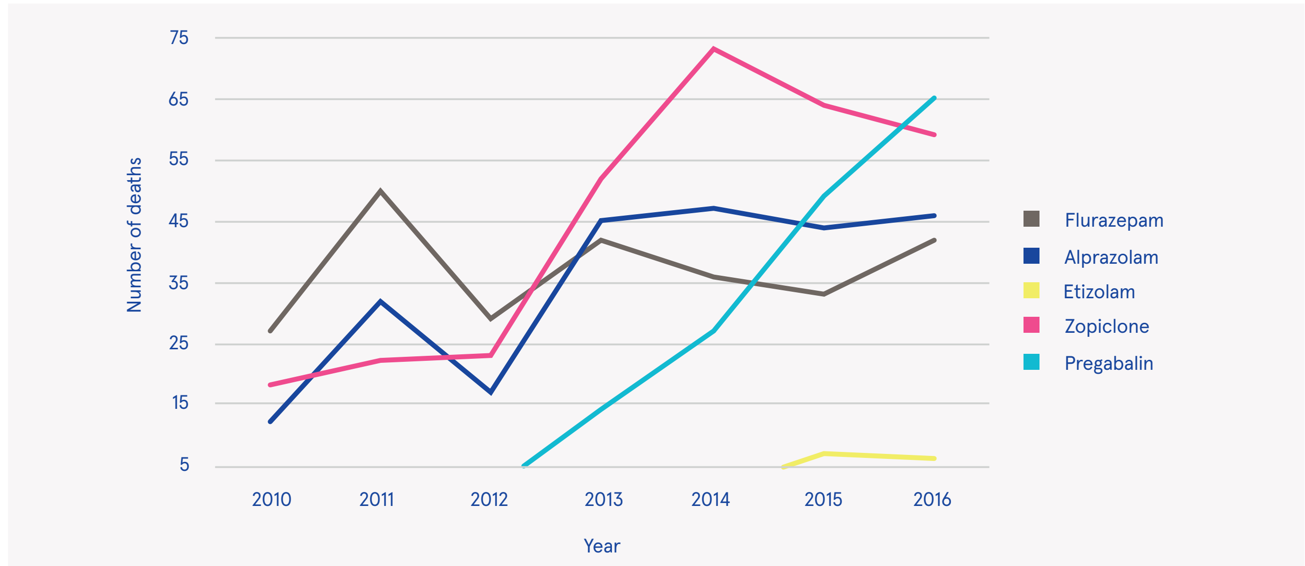
It is interesting to note that in terms of online purchasing, as far as prescription medications are concerned, the study noted that there are adequate sources available on the surface web to suggest that purchasers do not have to be sophisticated web users capable of operating on the dark web in order to purchase tablets online. There are many 'online pharmacies' where medications may be purchased without a prescription. As these sites do not have to be registered in Ireland, or store their stock here, it can be difficult for Irish regulators to assert authority over such enterprises. Concerningly, the study noted that the laboratory analysis of detained products demonstrated that medicines purchased online often contain too little or too much of the active ingredient. They have also been found to contain harmful or undeclared substances.

Street tablet harms

Data from the Irish Healthcare Pricing Office demonstrate an increase in the number of non-fatal self-poisoning cases involving benzodiazepines and antiepileptic and sedative-hypnotic drugs between 2015 and 2018. Statistics from the National Drug-Related Deaths Index (NDRDI) also indicate an overall increase in the number of deaths involving alprazolam, zopiclone, and pregabalin. In particular, pregabalin-related deaths have risen year on year between 2012 and 2016, with an increase of 33% between 2015 and 2016 and an overall increase of 364% between 2013 and 2016 (see Figure 1). Concurrent with an increase in the number of drug-related deaths in Ireland involving benzodiazepines and antiepileptic and sedative-hypnotic drugs, data from the NDRDI also show an increase in the number of poisoning deaths involving a combination of substances between 2004 and 2016 (see Figure 2). Experts who took part in the study indicated that polydrug use remains a consistent factor in the harms related to street tablet use and that the combined use of controlled substances and street tablets has contributed to an increase in drug-related deaths. In addition, the study found that from reports by Irish drug

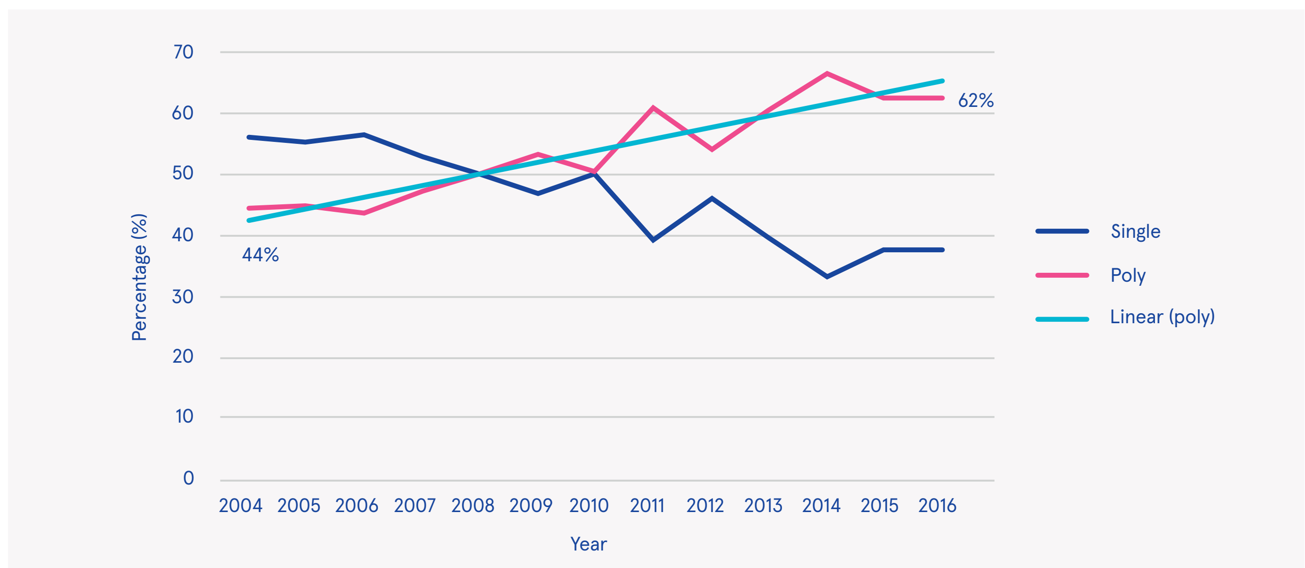
Trendspotter study continued

Figure 1: Poisoning deaths in Ireland involving benzodiazepines and antiepileptic and sedative-hypnotic drugs: main specific drugs implicated, 2010–2016



Source: Duffin, Keane and Millar (2020)

Figure 2: Poisoning deaths in Ireland, by single/poly drugs involved, 2004–2016



Source: Duffin, Keane and Millar (2020)

harm reduction services and external studies indicate that individuals who misuse pharmaceuticals are taking (often much) higher than recommended doses and that a vast majority have a history of misuse or dependence on other drugs.

Conclusions

The study identified a number of issues which could help to manage the street tablet market. In terms of preventing leakage from the legitimate sources, a robust electronic prescribing system could help better control access, and might help prevent 'doctor shopping'. However, it was also noted that care is needed not to inadvertently divert people to the street market to seek access to tablets. There is also a need to understand and be effective in addressing why individuals are using tablets in the first place, and therefore able to address the reasons why people have to access the tablet market. In this context, supporting medical professionals to better understand and be equipped to address the demand encountered is important, as is the need to get existing public health and harm reduction messaging into novel market spaces, such as the online environment.

Seán Millar

1 United Nations Office on Drugs and Crime (UNODC) (2011) *The non-medical use of prescription drugs: policy direction issues*. New York: United Nations.

2 Duffin T, Keane M and Millar SR (2020) *Street tablet use in Ireland: a Trendspotter study on use, markets, and harms*. Dublin: Ana Liffey Drug Project. https://www.drugsandalcohol.ie/31872/

3 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2018) *Trendspotter manual: a handbook for the rapid assessment of emerging drug-related trends*. Luxembourg: Publications Office of the European Union. https://www.drugsandalcohol.ie/30080/

HRB evidence brief on the response of drug services to Covid-19

Policy context

The Covid-19 pandemic presents particular challenges for people who are using drugs and for those providing services to vulnerable populations. In April 2020, the Drug Policy Unit at the Department of Health (DOH) established a rapid assessment group to look at the impact of the pandemic in Ireland. As part of this rapid assessment, DOH asked the Health Research Board (HRB) to prepare an evidence brief examining the situation in a number of comparable jurisdictions. This rapid evidence brief will help DOH put the Irish response to the Covid-19 crisis in an international context. The findings will enable a comparison with the situation in other countries and assist in identifying initiatives that may be relevant to the drugs situation in Ireland.

Research questions

The primary research question for the evidence brief is what approaches have been taken in Scotland; New South Wales (NSW), Australia; New York State (NYS); and British Columbia (BC), Canada to deal with the impact of the Covid-19 pandemic on people who use drug treatment and harm reduction services and other people who use drugs.

There are four sub-questions:

1. How has Covid-19 impacted on people who use drugs?
2. How has Covid-19 impacted on the demand for drug and alcohol services?
3. What guidelines and supports have been provided for drug and alcohol services in light of Covid-19?
4. How are drugs and alcohol services being restructured to meet clients' needs in light of Covid-19, especially clients with complex needs and who are most vulnerable?

The evidence brief applied the four research questions to the situation in Scotland, NSW, NYS, and BC. These were chosen because they are developed economies and have been disrupted by the Covid-19 pandemic and because official documentation is available in English. They also have patterns of problem drug use similar to Ireland and provide a comparable range of treatment and harm reduction responses. The evidence brief also presents a summary of information available in Ireland and in other European Union (EU) countries to provide a context beside which findings from the four research jurisdictions can be read.

Question 1: How has Covid-19 impacted on people who use drugs?

When this research was being carried out, there was very little evidence available regarding the impact of the Covid-19 pandemic. In early March 2020, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) began an investigative rapid assessment to monitor the impact of Covid-19 on the drugs situation in Europe and the responses to it. This assessment included a mini-web survey of people who use drugs but might not be accessing services. The first report from the EMCDDA study was published in May 2020[1] and some report findings from that and from an EMCDDA report on drug markets are presented in the evidence brief. Information on the situation in the four research jurisdictions was mainly anecdotal, apart from one survey undertaken in Scotland.

Ireland and European context

Data from the EMCDDA mini-web survey indicate that respondents in Ireland who used cannabis or cocaine more frequently (daily or almost daily) in the 30 days prior to the introduction of restrictions were much more likely to use drugs more frequently or to use greater amounts in one session than they had before. In answer to the question 'In general, would you say you have used more or less illicit drugs, since the start of the Covid-19 epidemic in your country?', 209 (33%) respondents replied less, 142 (22%) replied more, and 90 (14%) replied the same amount.

An EMCDDA study on drug markets[2] found that disruptions to the supply chain were most evident at the distribution level, resulting in increased violence in some jurisdictions. Bulk movement of drugs through shipping has not been interrupted. Domestic production of cannabis has been disrupted and prices have increased. Alternative means of both acquisition, for instance, through online sources, and distribution, through the postal service and drops, have been reported.

New York State

The Drug Enforcement Administration (DEA), a federal body and lead agency for domestic enforcement of the Controlled Substances Act, reports that the price of street drugs has increased as distribution costs have risen. Since March, cannabis prices increased by 55%, cocaine prices by 12%, and heroin prices by 7%.

Scotland

The Scottish Drug Deaths Taskforce has received feedback from services and communities which suggests that service-level provision of harm reduction services is being scaled back in some areas. Responses to the Crew survey[3] in April suggest that there have been product shortages, less variety, poorer quality, and some price increases. Some respondents report an increase in unintended withdrawal symptoms as a result of reduced availability.

Question 2: How has Covid-19 impacted on the demand for drug and alcohol services?

There was little concrete information available to answer this question when the research was being conducted. The European context is described below with information from one of the research jurisdictions.

Ireland and European context

Many EU jurisdictions saw an initial decline in treatment demand attributed to restrictions on movements, reduced capacity in treatment services, and fewer referrals from the criminal justice system. Harm reduction services have reported an increase in demand for social support and increases in alcohol and benzodiazepine use as a result of higher levels of anxiety among service users. Generally, much of the increased demand for treatment services has come from people's inability to access heroin.

Covid-19 evidence brief continued

Scotland

There is anecdotal evidence that more stimulant users are coming into contact with services due to a reduced ability to source these drugs or due to changes to daily routine enforced by lockdown, leading to the realisation that their substance use is problematic. This includes more vulnerable stimulant users who may not have been previously visible to services.

Question 3: What guidelines and supports have been provided for drug and alcohol services in light of Covid-19?

This was the research question for which there was most evidence available. All of the health services in the areas covered responded very quickly to the situation with clear recommendations and generally a high degree of flexibility. The need to maintain access to opioid substitution treatment (OST) or opioid agonist therapy (OAT) for existing clients is a common theme and ensuring this has required a great deal of coordination and the development of innovative service and policy approaches. Variations in responses are somewhat determined by historical factors, the degree of autonomy accorded to local administrators of health services, and the degree to which a harm reduction ethos has been embedded. For instance, NYS followed guidelines issued by DEA, and the degree of independence, or willingness to innovate, at the state and city level seems to be less than in Vancouver or BC. Separate but compatible guidelines for OAT have been published by Vancouver Coastal Health,[4] a regional health authority, and the British Columbia Centre on Substance Use (BCCSU)[5] addiction. Health Canada provides the overarching direction for policy and health service delivery at the federal level.

Ireland and European context

In Ireland, guidelines on contingency planning from the Health Service Executive (HSE)[6] recommend several actions, in particular for people who are unable to access services either through their own isolation or because services are not currently available. The process by which a clinical review for OST clients can be undertaken remotely (with video link or smartphone) is spelled out in detail in guidance documents. A number of options are available for a person in treatment who is isolating at home, including provision of sufficient doses for the duration of the self-isolation and provision of medication to family members or a driver or key worker. The guidelines provide advice regarding the secure storage of doses, general safety, medicines management policy, remote consultation, and record keeping.

OST treatment services in Ireland have continued. The use of eConsultation software and the delivery of medication have ensured people in isolation can continue their treatment. Clinics have implemented social distancing measures and provided people with letters stating the date and time of their appointment to ensure permission to travel during the period of restricted movement. Recovery groups are now provided online in several areas.

The wait for methadone treatment has been reduced from 12 weeks to three days. Benzodiazepine prescriptions have increased to enable easier stabilisation of drug use during isolation. Resources have been provided to support cocooning and isolation of vulnerable homeless people. Outreach services have been active in providing information on Covid-19 to clients when delivering needle and syringe exchange services.

Temporary amendments to the Medicinal Products and Misuse of Drugs legislation are designed to ensure that patients can continue to access their ongoing treatment and 'regular' medicines during the ongoing emergency and to assist in easing the additional burdens on prescribers and pharmacists arising from the pandemic. The amendments allow for the electronic transfer of prescriptions between doctors and pharmacies and remove the need for a paper equivalent. The legislation also extends the validity of prescriptions from six to nine months and enables pharmacists to make additional supplies of prescription-only medicines to patients from an existing prescription. This additional authority to pharmacists must only be used where, in the pharmacist's professional judgement, continued treatment is required, and it is safe and appropriate to make an additional supply.

Several international organisations have produced guidelines for drug services and these have been adapted or added to by services in many countries. Most guidelines include advice on take-home doses, moving from supervised consumption of substitution medication, prescription delivery, remote counselling, and initiation of treatment. German guidelines[7] point out that OST patient must be visited by a doctor when a prescription for self-administration is being delivered.

While these guidelines are welcome, many jurisdictions have reported challenges in starting treatment for new clients. Detoxification has been discontinued or significantly curtailed in most jurisdictions. The need to maintain access to OST for existing clients is a common theme and ensuring this has required a great deal of coordination and the development of innovative service and policy approaches. There is concern around the greater danger of overdose as some services prescribe larger take-home packs of OST. The effort to accommodate those entering or seeking to maintain OST may have the effect of making less resources available for those who use other drugs. Telemedicine, by phone or video, has largely replaced face-to-face contacts. There are obvious benefits to using these technologies as contacts with clients can be maintained and counselling sessions continued. However, there have been difficulties in persuading clients to engage with remote technologies and the inability of service users to access the devices needed to use them.

New York State

At the federal level, DEA has partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to ensure authorised practitioners may admit and treat new patients with opioid use disorder. DEA states that practitioners may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation during this public health emergency. Patients presenting with respiratory symptoms should be evaluated by a medical provider who will decide on a safe number of take-home doses, up to 28 days of medication, taking into consideration the patient's stability in treatment and ability to safely store and protect the medication.

Federal law requires a complete physical evaluation before admission to an opioid treatment programme (OTP). Under exemptions to the Controlled Substances Act, practitioners may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation. New patients treated with buprenorphine can be assessed using telehealth

Covid-19 evidence brief continued

systems, but this exemption does not apply to methadone patients, who are not permitted to receive escalating doses for induction as take-home medication.

Patients who only have access to one take-home medication or do not use this service should be considered for a staggered take-home schedule. Patients can still be evaluated frequently and do not receive more than two days of take-home medication at any one time. Based on the more favourable safety profile of buprenorphine, programmes should seek to maximise the ability of patients to take their buprenorphine at home during the Covid-19 crisis.

As there are no time-in-treatment take-home regulatory requirements for patients being dispensed buprenorphine, patients should be evaluated for flexible take-home doses as clinically warranted. An OTP can provide delivery of medication to an individual patient's home or to another controlled treatment environment. A responsible adult can serve as a designated other or surrogate to pick up an OTP patient's medication.

SAMHSA urges providers to consider utilising benzodiazepines for individuals with alcohol use disorder where they believe there would not be a benefit from administration of anticonvulsant medications. Medications such as gabapentin, topiramate, or carbamazepine are useful in preventing seizures related to alcohol or benzodiazepine withdrawal. These medications also possess a much lower abuse potential. Limited doses of benzodiazepines might be considered for specific symptom relief for a short duration (several days).

British Columbia

Specialised substance use services, including withdrawal management services, are delivered primarily through five regional health authorities, the First Nations Health Authority, and the Provincial Health Services Authority. Canada's Controlled Drugs and Substances Act 1996 has been amended to permit pharmacists to extend, renew, and transfer prescriptions and verbally prescribe controlled substances, which can be delivered by pharmacy technicians to a private address, not necessarily that of the patient receiving the prescription. Changes of pharmacy regulation allow emergency supplies to patients with expired prescriptions and the provision of carries to reduce exposure to Covid-19.

BCCSU general prescribing guidance advises general practitioners to send OAT prescriptions to pharmacies with the capacity to deliver, or deliver medications directly to patients, weekly if necessary, with advice on storage. In order to reduce the risk of withdrawal, exposure to Covid-19, and exposure to a limited and toxic drug supply, BCCSU recommended replacing illicit and licit products with prescribed or regulated substances. For patients who use opioids, BCCSU recommended offering OAT or increasing doses or providing carries for existing current patients. Co-prescription of oral morphine will help to reduce withdrawal symptoms.

For patients using street opioids in addition to their OAT or who decline OAT, prescriptions should be made according to current use and patient preference as well as clinical judgement to select appropriate medications and dosage. Dose and medication will depend on whether or not patients are being co-prescribed OAT and patterns of substance use. The dose can be adjusted over time, with the goal of the person being comfortable and not needing to access the illicit drug market. Witness ingestion is not required and the prescription of up to seven days' supply of carries, preferably in blister packages, can be considered where clinically appropriate. Similar guidelines apply to the prescription of buprenorphine/naloxone and patients can receive longer duration carries because of the reduced risk of overdose. Micro-induction may be considered for individuals transitioning from another OAT medication to buprenorphine/naloxone, to avoid the need for a washout period and moderate withdrawal to be reached prior to induction.

Similar guidelines are provided for prescribing sustained-release oral morphine and methadone, and guidance on injectable OAT (hydromorphone and diacetylmorphine) is forthcoming. As with other OAT medication, prescribing will depend on patient stability and their capacity to store. In all cases, clear communication with pharmacies is essential. Risk of overdose, diversion, or risks to household members must be carefully considered when deliveries or extended carries are being considered. Telehealth is especially recommended for use when dealing with patients accessing OAT.

For those at risk of severe withdrawal from alcohol, BCCSU recommended inpatient withdrawal management, which may include prescribing benzodiazepines. For those declining this treatment, advice on withdrawal, including safely reducing alcohol and accessing alcohol, should be given. If the patient is at low risk of complicated withdrawal, prescribers should consider gabapentin and/or clonidine and/or carbamazepine. BCCSU recommended psychostimulants, such as Dexedrine and methylphenidate, as part of replacement therapy for those with stimulant use disorder. The prescription must come with advice regarding possible worsening of symptoms and side-effects of medication. For users of illicit benzodiazepines, BCCSU recommended relatively low doses of clonazepam or diazepam with up-titration as needed.

A Health Canada class exemption enables a flexible approach to supervised consumption services that may include drug checking and virtual supervision of drug consumption. The British Columbia Centre for Disease Control (BCCDC) has published an overdose prevention protocol in the context of Covid-19, taking account of the change in regulations and making recommendations on safer injecting, take-home naloxone kits, and observation of consumption in any health or social service sector environment.

Scotland

Responsibility for the National Health Service (NHS) in Scotland is a devolved matter and rests with the Scottish Government. The Scottish Drugs Forum works with policymakers, service planners and commissioners, service managers and staff as well as people who use or have used services to ensure service quality and evidence-based policy and practice. The forum has published comprehensive guidance to help treatment services plan, manage, and deliver services for people who use drugs during the Covid-19 pandemic.

Supervision of self-isolating OST patients can be relaxed, and 14 days of take-home medication can be provided where needed, and arrangements made for home delivery. The patient can nominate a representative to collect and deliver medication, including controlled drugs. Provision should be made to ensure medication is still available should a pharmacy be closed.

Covid-19 evidence brief continued

Take-home supplies of safe injecting equipment for up to 14 days should be encouraged. Take-home supplies have largely replaced daily supervised dispensing and there is guidance around managing home delivery. Priority should be given to those seeking treatment as a result of the supply reduction of heroin. Doorstep titrations – of methadone or buprenorphine, depending on the patient's circumstances – using existing protocols are used by some services, and guidelines on this approach are provided.

Serious shortage protocols legislation may be enacted to allow pharmacists to supply branded products and different preparation strengths, and methadone tables not currently licensed may be used if an oral solution is not available. Conversion to various formulations of buprenorphine is possible with caution of the risk of precipitated withdrawal and micro-dosing to support a slower transition. Injectable buprenorphine and modified-release preparations may be considered.

For those with alcohol use disorders, the priority should be to avoid the abrupt changes in alcohol consumption patterns that might trigger serious withdrawal symptoms. Relapse prevention medications, such as acamprosate, disulfiram (Antabuse), naltrexone, and baclofen, can be crucial to recovery, and prescriptions should be maintained. It has been reported that more vulnerable stimulant users are seeking treatment. While psychosocial interventions are typical for problematic stimulant use, the guidelines note the harm reduction approach being pursued in Canada. Scotland has decided to allow the prescribing of benzodiazepines to those at risk of harm, while acknowledging the absence of peer-reviewed and established evidence-based guidance on benzodiazepine prescribing. While it is not possible to estimate tolerance when illicitly produced benzodiazepines are being used, estimated equivalents of prescribed drugs serve as a guideline.

New South Wales

The federal minister for health administers Australia's national health policy, and state and territory governments administer elements of healthcare within their jurisdictions. State governments have responsibility for funding and managing community and mental health services, which include drug and alcohol services. A national guidance document suggests sublingual buprenorphine, with transfer to depot buprenorphine, as it requires less clinical monitoring and a shorter period of supervised dosing. Patients should be categorised into high, moderate, or low risk groups, which will determine the dosing regimen. Guidance is provided on collection and delivery of medication for those in isolation, including the selection of the agent responsible. Prescribers should advise all OAT patients to obtain take-home naloxone as a safety precaution.

Question 4: How are drugs and alcohol services being restructured to meet clients' needs in light of Covid-19, especially clients with complex needs and who are most vulnerable?

New York State

The Office of Addiction Services and Supports (OASAS) states that an inability to keep take-home doses of medication safe due to a chaotic living situation (e.g. certain types of homelessness) would be grounds for patients being deemed ineligible for an emergency, take-home exemption. For these patients who, for safety reasons, need to continue daily dosing, every precaution should be made to limit exposure to patients possibly symptomatic for Covid-19, as well as to older and/or medically fragile patients. However, OASAS do not provide any further guidance in relation to this.

British Columbia

Vancouver Coastal Health published comprehensive guidance for implementing and operating Covid-19 facilities for homeless and under-housed residents who are unable to self-isolate. They identify that long-term substance users are at high risk from complications of Covid-19 and that their needs should be addressed.

Scotland

In February 2020, some 26% of the prison population were receiving a daily OST, which is difficult to sustain under Covid-19 due to efforts to comply with social distancing and elevated rates of staff absence. The Scottish Government guidance recommended transferring appropriate patients receiving daily OST via oral methadone or solid dose buprenorphine to monthly injections of slow-release buprenorphine (Buvidal). It is essential that those leaving prison at risk of overdose are provided with naloxone on release. In addition to the existing intramuscular products already provided, work is underway to pilot the provision of intranasal naloxone to increase the numbers of people with naloxone in their possession on release. It was anticipated that 350–400 people under the scheme would be released from prison by the end of May 2020.

Guidance from Pathway, the leading homeless healthcare charity in the United Kingdom (UK), has been developed in a UK/English legal context, but is of use to those planning and delivering services in Scotland. The guidance states that patients with alcohol, drug, or nicotine addiction should be able to access a variety of approaches to prevent withdrawal, with input from specialist addiction services to minimise their need to leave isolation.

New South Wales

The NSW Department of Communities and Justice has developed guidance for providers that are delivering services for people experiencing homelessness during Covid-19. It advises that consideration should be made in relation to assisting clients in accessing 'take-away' supplies of replacement drug therapies (i.e. methadone and buprenorphine) in consultation with the local health network/ methadone clinic.

Discussion

There was limited information on the impact of the Covid-19 pandemic on people who use drugs or on the demand for treatment services. The guidance for treating new patients entering OTPs differed by region. NYS recommended treating with buprenorphine where possible, as it can be prescribed by telemedicine without first conducting an in-person evaluation. However, this does not apply to patients starting methadone. Buprenorphine was also recommended by NSW, followed by transfer to depot buprenorphine after one week. Scotland stated that either buprenorphine or methadone may be used but titration onto methadone is often safer when the medication can be provided on a daily supervised dispensing regime from a pharmacy. BC recommended considering buprenorphine but also provided comprehensive guidance for all other potentially suitable medications. The reasons cited

Covid-19 evidence brief continued

for using buprenorphine include its superior safety profile and reduced risk of overdose and diversion.

In response to the Covid-19 pandemic, each region has introduced changes to their protocols on providing take-away doses (TADs) to patients and on delivering medications. This has led to patients being allowed to receive an increased number of TADs. While NYS and NSW are prescriptive in their guidance around TADs, provision of TADs in BC and Scotland appear to be at the discretion of the prescriber and based on the individual patient. In circumstances where patients cannot access their medications, in each region it is now permissible for pharmacies and treatment programmes to deliver medication, or, alternatively, nominated persons are allowed to collect medication on the patient's behalf. Given the relaxation of the rules around prescribing controlled medications, the risk of overdose was cited, with BC, Scotland, and NSW all recommending that patients be provided with take-home naloxone. Scotland recommended offering naloxone with injecting equipment provision transactions, while BC has allowed the establishment of temporary spaces that comply with physical distancing within supervised consumption services.

Regarding other substance use, BC has published the most comprehensive guidance. It recommends replacing illicit and licit products with prescribed or regulated substances. It has also published a detailed pharmacotherapy protocol for opiates, alcohol, benzodiazepines, and stimulants. In relation to alcohol use, NYS, BC, and Scotland provide guidance on managing outpatient withdrawal and on the use of medication to do this. BC is the only area that has guidance on how to provide a managed alcohol programme and on how to ensure that patients have access to an adequate alcohol supply to prevent severe withdrawal complications. For benzodiazepine use, NYS, BC, and Scotland recommend prescribing benzodiazepines, with BC providing more detailed guidance on how to manage these clients. Just BC and Scotland provide guidance for stimulant use, which in fact differs: BC recommends prescribing Dexedrine or methylphenidate for stimulant users, while the Scottish guidance does not recommend the use of these off-licence drugs.
There was some guidance in BC, Scotland, and NSW in relation to vulnerable people or those with complex needs. BC and NSW provided guidance for services dealing with people who are homeless; this guidance mainly related to ensuring they could access and store medications. Scotland was the only region to provide guidance in relation to prisons. It recommended transitioning those receiving daily supervised OST to Buvidal, which is a long-acting buprenorphine depot injection, for people serving six months or longer. This was to achieve a rapid reduction in the need for daily contact with NHS front-line and prison staff. It also recommended that those leaving prison be provided with naloxone.

Brian Galvin and Deirdre Mongan

1 European Monitoring Centre for Drugs and Drug Addiction (2020) *European Trendspotter series. Impact of COVID-19 on drug services and help-seeking in Europe.* Lisbon: EMCDDA. https://www.drugsandalcohol.ie/31967/

2 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol (2020) *EU drug markets: impact of COVID-19.* Luxembourg: Publications Office of the European Union. https://www.drugsandalcohol.ie/32100/

3 Crew (2020) *Covid-19 drug markets survey summary: month 2 – May 2020.* Edinburgh: Crew. https://www.drugsandalcohol.ie/31949/

4 Vancouver Coastal Health (2020) *Prescriber guidelines for risk mitigation in the context of dual public health emergencies.* Vancouver: Vancouver Coastal Health.

5 British Columbia Centre on Substance Use (2020) *COVID-19: information for opioid agonist treatment prescribers and pharmacists*. Vancouver: British Columbia Centre on Substance Use.

6 HSE National Social Inclusion Office (2020) *Guidance on contingency planning for people who use drugs and COVID-19.* Dublin: Health Service Executive. https://www.drugsandalcohol.ie/31804/

7 Conference of the Chairmen of Quality Assurance Commissions of the Associations of Statutory Health Insurance Physicians in Germany (2020) *Information on opioid substitution and Sars-CoV-2/Covid-19: advice for physicians.* Gernsheim/Hamburg: Forum Substitutionspraxis.

Gender and drug policy

The mission of the Pompidou Group of the Council of Europe is to contribute to the development of multidisciplinary, innovative, effective and evidence-based drug policies in its member states.[1] Since the late 1980s, it has worked to support the integration of a gender dimension into drug policies and has delivered on a number of activities in this area of policy.[2] The group is currently running a project on implementing a gender approach in different drug policy areas: from prevention, care, and treatment services to law enforcement and the criminal justice system. It is based on an understanding that the gender dimension includes women, men, transgender, and intersex people. The Irish team taking part in this project is made up of representatives from academia, the Department of Health, and drug services.[3] As part of their work, they published a paper on gender and Irish drug policy in April 2020.[4]

Aims of Pompidou project

The overall aims of the Pompidou Group's project are to:

- Carry out an analysis of needs and draw up proposals for feasible actions and interventions to be undertaken by different stakeholders (including government and non-governmental agencies) to effectively integrate different gender perspectives of persons who use drugs in planning, service delivery, and professional practice.

Gender and drug policy continued

- Identify obstacles and barriers for accessing care and treatment and for introducing a gender dimension in drug policy, as well as ways to overcome them.
- Identify obstacles and barriers for the integration of gender approaches in drug law enforcement and the criminal justice system, as well as ways to overcome them.
- Provide a better understanding of when best to apply gender-neutral approaches, and when applying gender-specific responses would be more appropriate.

Irish contribution

Morton *et al.*'s paper outlines the Irish situation in relation to five topics linked to these aims: gender in current drug policy; transgender and/or intersex persons within service delivery; stakeholders at national level; obstacles to the integration of a gender-sensitive approach; and benefits to society and health and wellbeing of target groups of adapting and implementing a gender-sensitive approach. Some of the findings are outlined below.

Gender and drug policy

Ireland's current national drugs strategy, *Reducing harm, supporting recovery* (2017–2025),[5] is described in the paper as marking a shift in Irish drug policy away from previous strategies that were 'relatively gender-neutral' (p. 3)[4] to one which 'attends extensively to the issue of women and substance use' (p. 3).[4] Morton *et al.* outline the elements of the strategy that deal with gender, specifically noting four of the 50 strategic actions contained in the document – three relate to women specifically, while a fourth refers to the needs of the LGBTQI community.

1. There is a strategic action to 'respond to the needs of women who are using drugs and/or alcohol in a harmful manner', by increasing the range of wraparound community and residential services equipped to meet their needs and by developing interventions to address gender and cultural-specific risk factors for not taking up treatment (p. 42).[5]
2. There is a commitment to 'expand addiction services for pregnant and postnatal women' through seven developments, including strengthening links between addiction and maternity services (p. 43).[5]
3. Under the strategic action 'to improve the range of problem substance use services and rehabilitation supports for people with high support needs who are homeless', mention is made specifically of developing the provision of gender-specific stepdown services for women and their children progressing from residential rehabilitation treatment who are at risk of discharge into homelessness (p. 48).[5]
4. There is a strategic action that sets out to improve the capacity of services to accommodate the needs of people who use drugs and alcohol from specific communities. (p. 49).[5]

The authors note that there are neither gender-specific actions within the current drugs strategy in regard to prevention nor any specific considerations of transgender or intersex populations or risks for these populations. They describe any consideration of the needs and specialist supports for those who are transgender and/or intersex in Ireland as being in 'relative infancy' (p. 5).

Gender and treatment

Drug treatment and intervention in Ireland is described as having evolved over the previous 15 years to a more gender role focus. The authors identify some changes made: including women in substance use treatment and intervention; developing gender-specific services and interventions for women; and developing resources and responses within relevant ancillary services to meet the needs of women who use drugs. Table 1 outlines the gender-specific treatment and interventions for women in Ireland identified in the paper.

Table 1: Gender-specific treatment and interventions for women in Ireland

Service	Intervention	Host organisation
Ashleigh House	Residential treatment for women and women with children up to preschool age	Coolmine Therapeutic Community
Saol Project	Gender-specific harm reduction, education, day programme, childcare provided up to preschool age	Saol Project
Aiséirí Céim Eile	Residential secondary treatment programme, gender specific	Aiséirí
Farnanes	Residential treatment for women, gender specific	Cuan Mhuire
Ocean View	Residential treatment for women, gender specific	Tiglin
Tabor Renewal & Fellowship House	Residential secondary treatment programme, gender specific	Tabor Group
Helping Women Recover Programme	This Limerick-based project works with women over the age of 23 who are clients of the Probation Service	PALLS
Specialist drug liaison midwives	The three maternity hospitals in Dublin have specialist midwives who work with pregnant women who use drugs	Health Service Executive

Source: Morton *et al.* (2020)

Gender and drug policy continued

Gender and the criminal justice system

The Pompidou Group is also interested in how gender is addressed within the criminal justice system. While this does not feature in Ireland's national drugs strategy, Morton *et al.* note that the needs of women are identified in other related policy documents.[6,7] They also identify issues arising within the courts and the prison system for women. For example, there are 'specific risks for women involved within the criminal justice system, including a lack of housing supports on exit from prison, substance misuse within the prison itself, separation from children, and lack of integration supports on exit from prison' (p. 5).

Obstacles to gender-sensitive approach

The authors outline a series of obstacles facing the adoption of a gender-sensitive approach to drug policy and interventions in Ireland. These exist at societal, policy, community, organisational, practitioner, and individual levels. For example:

- At a community level, women who use drugs experience stigma within their communities, which presents a major barrier to accessing supports.
- At an organisational level, funding streams can prevent the integration of a gender-sensitive approach either by not providing funding for gender-specific services or the services of the broader range of agencies that would be needed to meet the complex needs of women who use drugs.
- At the practitioner level, practitioners may not have been trained in 'specialist responses that take account of gender within substance use patterns or trajectories, or in responding to women where there are complex issues and trauma histories' (p. 10).

Gender mainstreaming

The authors offer support for the adoption of a gender-mainstreaming approach to policy development in Ireland. This approach would mean each 'drug policy proposal is assessed for its potential (unintended) positive and negative impacts across genders' (p. 10), as well as a critical examination of the gendered norms and assumptions that underpin the proposals. The authors also report there is evidence in Ireland of an increasing focus on inclusion health and a patient and public involvement (PPI) approach to health issues. These along with other factors suggest an environment that might be more conducive to a fully gender-sensitive approach to policy and service development evolving in Ireland. The authors conclude:

> Key within the Irish context will be the leveraging off the current developments within social inclusion based health, PPI, participative [national drugs strategy] structures and existing innovation in gender responsive intervention and treatments in order to further advance gender mainstreaming within drug policy, which may ultimately address some of the key individual issues such as stigma and shame in regard to gender and substance use. (p. 10)

Project output

Morton *et al.*'s paper is an output of the first phase of this broader project by the Pompidou Group. The final output of the project is expected to be a handbook for practitioners and decision-makers. It will contain a set of principles and practical examples that provide concrete guidance for implementing a gender approach in planning and delivering prevention, care, and treatment services for people who use drugs. It will also provide guidance for law enforcement agencies on the practical integration of gender approaches in their work. The project is in its early stages and due for completion in October 2021.

Lucy Dillon

1 For more information on the activities of the Pompidou Group, visit: https://www.coe.int/en/web/pompidou/about

2 For more information on the gender-related activities of the Pompidou Group, visit: https://www.coe.int/en/web/pompidou/activities/gender

3 The team members are: Sarah Morton, director of the Community Drugs Programme, University College Dublin; Eva Devaney, National Voluntary Drug and Alcohol Sector; Karen O'Connor, Drugs Policy and Social Inclusion Unit, Department of Health; Pauline McKeown, chief executive officer, Coolmine Therapeutic Community; and Anita Harris, residential services manager, Coolmine Therapeutic Community.

4 Morton S, Devaney E, O'Connor K, McKeown P and Harris A (2020) Gender and Irish drug policy: report submitted to the working group as part of the 'Implementing a gender approach in different drug policy areas: from prevention, care and treatment service to law enforcement' project. Dublin: University College Dublin and Department of Health. https://www.drugsandalcohol.ie/31888/

5 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/

6 Department of Justice and Equality (2017) *National Strategy for Women and Girls 2017–2020: creating a better society for all.* Dublin: Department of Justice and Equality.

7 Department of Justice and Equality (2018) *Irish Prison Service and Probation Service: strategic plan 2018–2020*. Dublin: Department of Justice and Equality. https://www.drugsandalcohol.ie/29241/

Launch of UBU Your Place Your Space

UBU Your Place Your Space is a new, targeted youth-funding scheme launched by the then Minister for Children and Youth Affairs, Dr Katherine Zappone TD, in December 2019.[1] It targets young people who are marginalised, disadvantaged, or vulnerable, and aims to provide services that support them. These include services that cover health, education, employment, and social connectedness. It combines four pre-existing overlapping schemes, including the Young People's Facilities and Services Fund and the local drug task force projects. The scheme explicitly supports the delivery of action 1.2.8 in the National Drugs Strategy: to improve services for young people at risk of substance misuse in socially and economically disadvantaged communities.[2]

Launch of UBU Your Place Your Space continued

Background

In 2014, the Department of Children and Youth Affairs (DCYA) published *Value for money and policy review of youth programmes*.[2] It reviewed programmes targeting at-risk youth that share similar objectives and target similar groups of young people – including a focus on those living in areas characterised by problem drug use, educational disadvantage, criminal activity, unemployment, and homelessness. Preventing the onset of or reducing drug taking is a common focus of the programmes. While recognising the value of the programmes, the review called for their 'significant reform' (p. 10) and made a set of recommendations to this end.[3] Since the review, work has been ongoing at DCYA to implement its recommendations. It undertook an extensive programme of work, including reviewing evidence and engaging stakeholders to inform the development of this single funding scheme: UBU Your Place Your Space.

UBU Your Place Your Space

Mission and vision

Mission: To provide out-of-school supports to young people in their local communities to enable them to overcome adverse circumstances and achieve their full potential by improving their personal and social development outcomes.

Vision: All young people are enabled to realise their maximum potential, by respecting their rights and hearing their voices, while protecting and supporting them as they transition from childhood to adulthood.

Values

- Young people are free to participate in a wide range of quality activities.
- Provision is rights based and young person-centred.
- Young people are empowered to reach their full potential.
- Relationship building is key.
- There is clarity of purpose.
- Projects are maximised by promoting efficiency and effectiveness.

Funding strands

- Strand A provides funding for the direct provision of youth services.
- Strand B provides funding to support the access of young people to existing youth facilities.
- Strand C provides funding for capacity building.

Lucy Dillon

1 For more information on the scheme, visit the designated website: https://ubu.gov.ie/home

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/

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

PREVALENCE AND CURRENT SITUATION

Qualitative insights into pregabalin use among individuals in opioid agonist treatment

Recent research and reports have highlighted the drug pregabalin due to its potential for dependence and abuse, and an increase in pregabalin-related overdose deaths in several European countries. As a prescription-only central nervous system (CNS) depressant analogue to gamma-aminobutyric acid (GABA), it is used for an array of conditions, including neuropathic pain, epilepsy, generalised anxiety disorder, and fibromyalgia.[1] In a 2020 study published in *Heroin Addiction and Related Clinical Problems*, Brennan and Van Hout present qualitative insights into the experiences of patients in opioid agonist treatment (OAT) with pregabalin.[2] The authors selected OAT patients as their study population because of their increased risk for problematic use of pregabalin and overdose.[3] Though related research in Ireland is sparse, international evidence has demonstrated that using pregabalin leads to the development of tolerance and withdrawal symptoms when ceased. The combined use of both opiates and pregabalin as two CNS depressants, while highly prevalent, has been shown to increase the risk of overdose and death.[4] The current study was the first in Ireland to capture the experiences of OAT patients using pregabalin.

Methods

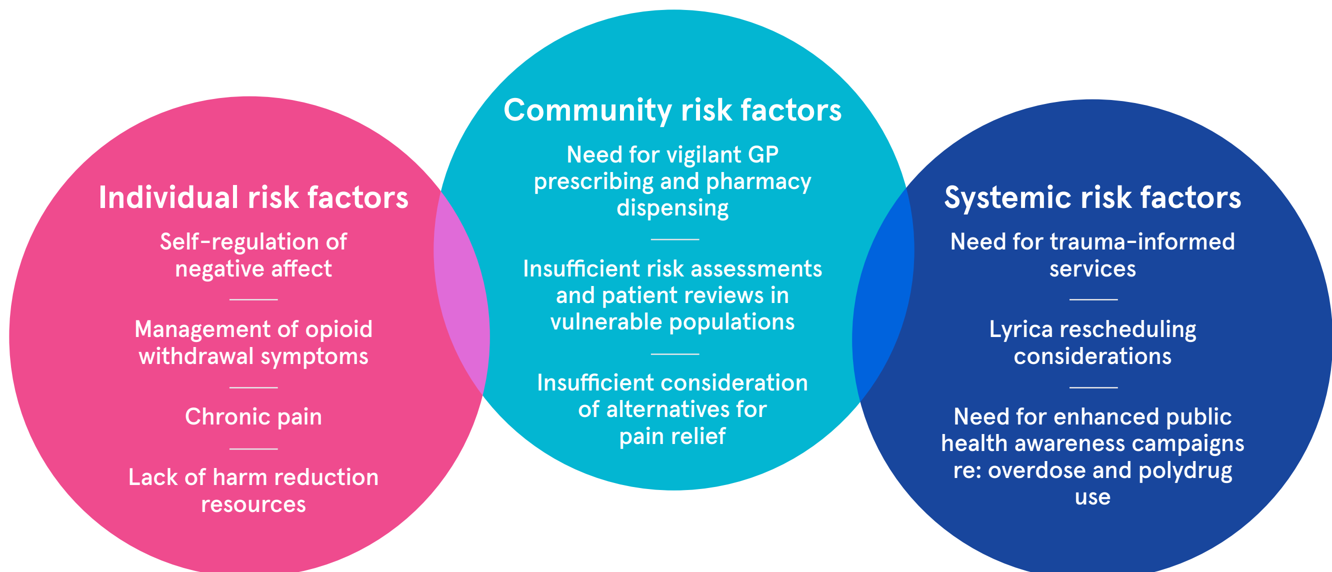
The qualitative descriptive study utilised one-on-one semi-structured interviews. Participants were recruited from a service offering OAT and harm reduction in Dublin. To be eligible, participants had to be both current or former OAT patients and current or recent users of pregabalin. Of 15 participants, nine were male and six female, ranging in age from 25 to 45 years. Data were analysed using thematic analysis assisted by NVivo 12 software. Having finalised the thematic framework, one researcher performed a participant check to ensure the accurate reflection of participants' views.

Pregabalin use continued

Key findings

- **Use patterns:** One-half of participants were initially prescribed pregabalin, predominantly for pain. The others first consumed pregabalin after receiving it from peers. For many participants, being part of a polydrug use/'tablet taking' culture and a history of using benzodiazepines or Z-drugs often preceded pregabalin use. Participants recounted combining pregabalin with substances such as methadone, benzodiazepines, and Z-drugs, and with stimulants such as crack cocaine to 'come down'. Many stated consuming more than 1000 mg daily, with doses ranging from 800 mg to 6000 mg. Most took pregabalin orally, but none reported injecting, given its connotation with past heroin use.
- **Motivators:** The reasons for consuming pregabalin included the self-regulation of negative emotions and enhancement of sociability and confidence. Participants specifically stated using pregabalin to numb distress and underlying psychological issues such as trauma.
- **Side-effects:** Examples of undesirable side-effects mentioned were losing consciousness or control and behaviours such as shoplifting or aggression due to feeling 'invincible'.
- **Sourcing routes:** Strategies included approaching multiple doctors, exaggerating symptoms while seeking prescriptions, buying street pregabalin (also through social media), or diverting legitimate prescriptions from their network.
- **Role of medical professionals:** While some described doctors as gatekeepers to sourcing pregabalin, multiple participants received it from doctors or pharmacists illegitimately, filling prescriptions early or selling prescriptions.
- **Detoxification and withdrawal symptoms:** One participant recounted experiencing very severe physical and psychological withdrawal symptoms while detoxing from pregabalin at home. Another reported undergoing a medically supervised detox. Several other participants described psychotic symptoms and suicidal ideation during pregabalin withdrawal consistent with previous descriptions in the literature.
- **Combination with opioids:** The data provided some insights into the popularity of combining opioids with pregabalin. Participants reported using it to manage withdrawal symptoms from opioids and finding it superior to other substances. Use of pregabalin was also explained with its similarity in effect to opioids, specifically heroin. Additionally, pregabalin was described as strong in its effect, and therefore attractive to those with built-up tolerance.
- **Harm perception and reduction:** Participants were alert to the risk of overdose, often due to personal experiences, and reported using indigenous harm reduction strategies, such as decreasing consumption and not buying counterfeit Lyrica.

Figure 1: Risk factors for problematic pregabalin use in an OAT patient sample in Dublin



Pregabalin use continued

Discussion

Based on the participant responses, Brennan and Van Hout conceptualise the consumption of pregabalin among service users receiving OAT within a socio-ecological model, reflecting interacting risk factors on the individual, community, and systemic levels (see Figure 1). They extrapolate several recommendations for policy and healthcare service delivery from participants' accounts.

Given the participants' worrying descriptions of malpractice, Brennan and Van Hout emphasise the need for monitoring pregabalin prescriptions and for doctors and pharmacists to carry out risk assessments considering OAT patients' vulnerability to pregabalin dependence, reduce off-label prescribing, and choose alternatives to pregabalin for pain relief.

The authors also call for increased healthcare support for OAT patients using pregabalin, such as trauma-informed interventions, medical supervision, and vigilance to psychiatric symptoms during pregabalin detox, harm reduction measures, and information campaigns.

The study's findings should be viewed in light of several methodological limitations, including the small sample, single study location, and potential recall bias. Considering the prevalence of polydrug use, statements about the effects of pregabalin should be interpreted with caution.

The study nonetheless provides important first insights into the risk factors for pregabalin use among OAT patients as an at-risk group, and features recommendations for policy and health service responses grounded in qualitative data.

Britta Thiemt

1 Lyons S (2018) Overview on pregabalin and gabapentin. *Drugnet Ireland*, 65(1): 11–12. https://www.drugsandalcohol.ie/29105/

2 Brennan R and Van Hout MC (2020) 'Bursting the Lyrica bubble': experiences of pregabalin use in individuals accessing opioid agonist treatment in Dublin, Ireland. *Heroin Addiction and Related Clinical Problems*, 22. Early online. https://www.drugsandalcohol.ie/31533/

3 McNamara S, Stokes S, Kilduff R and Shine A (2015) Pregabalin abuse amongst opioid substitution treatment patients. *Irish Medical Journal*, 108(10): 309–310. https://www.drugsandalcohol.ie/24965/

4 Al-Husseini A, Van Hout MC and Wazaify M (2018) Pregabalin misuse and abuse: a scoping review of extant literature. *Journal of Drug Issues*, 48(3): 356–376.

Inspector of Prisons annual report, 2018

In December 2019, the Minister for Justice and Equality published the eight annual report of the Office of the Inspector of Prisons.[1] Under section 32 of the Prisons Act 2007, the Inspector of Prisons is required to submit a report to the Department of Justice and Equality outlining how the inspector's functions were carried out during the preceding 12 months. This was the first annual report prepared by Ms Patricia Gilheaney who was appointed inspector in May 2018.

Office of the Inspector of Prisons

The Office of the Inspector of Prisons (OIOP) is a statutory body launched under the Prisons Act 2007 to carry out regular inspections of Irish prisons.[2] The main mission of the OIOP is 'supporting excellence in both delivery and outcomes in Ireland's prisons through an independent programme of inspections and investigations'.[3] The work is centred on several values, such as 'independence and impartial; human rights focused; transparent and collaborative; capable and systematic'.[3]

While the frequency of prison inspections is not specified in the legislation,[2] according to international best practice inspections are carried out every three years.[1] The main activities to be carried out by the Inspector of Prisons include:

- Regular inspection of all Irish prisons (n=13)
- Investigations of deaths arising in custody and on temporary release from prison
- Investigations requested by the Minister for Justice and Equality into how a prison is managed or functions
- Receive and respond to prisoners' letters
- In accordance with Rule 57B of the Prison Rules,[4] the OIOP should receive:
  - Notifications within seven days of a complaint being received by the prison governor
  - Copies of decisions for not carrying out investigations into complaints that have no foundation or do not meet criteria outlined in the Prison Rules
  - Copies of investigation team reports and interim reports
  - Letters from complainants who are dissatisfied with the outcome.

The OIOP role does not include investigating or adjudicating over individual prisoner complaints but may examine reasons for complaints when performing this role.

Review of operational structure and resources

An external review of OIOP operational structure and resources was submitted to the Minister of Justice and Equality in December 2018. It acknowledged the ongoing growth, progress of operating models and business processes, and the hard work and dedication of staff within the OIOP. Nonetheless, several identified areas illustrated that the OIOP was not meeting its statutory role in accordance with international best practice. For example:

- Only three prisons were inspected in the previous five years.
- 50% of prison estates were not 'formally' inspected since the OIOP was initiated 10 years ago.

Inspector of Prisons annual report continued

- Due to insufficient resources, no programme of announced or unannounced inspections was made.
- Processes were not aligned to international 'good practice' (p. 6).
- The legal framework of the Prisons Act 2007 was deemed to lack clarity and comprehensiveness.
- There was insufficient funding of the OIOP.

While the report concluded that the OIOP was not 'fit for purpose' (p. 7), it acknowledged the intentions of the OIOP to develop:

- A comprehensive and ongoing programme of inspections
- Strong and reliable business processes based on international best practice
- A network of expert delivery partners and advisors
- A properly resourced inspectorate.

Due to the level of work that had been anticipated in 2019, the first inspection was not expected to take place until 2020. The intention was to conduct the inspection in such a way that supported collaborative learning, whereby other prison estates would learn how the new inspection regime was to be carried out. This first inspection was deemed vital to embedding a new quality standard and tone in the work of a revamped prisons inspectorate (p. 7).

Overview of 2018

Since the appointment of Ms Gilheaney in May 2018, the OIOP has been involved in several activities. For example: prison visits; the prisoner complaints system; letters from prisoners; investigations; and the Inspection of Places of Detention Bill Draft Scheme 2014.

Prison visits

Between May and July 2018, prison familiarisation visits were carried out with the aim of seeing the prisons and meeting prisoners and prison staff. While these visits were not formal inspections, several areas of concern were identified. These involved safety (protection, solitary confinement/restricted regimes, overcrowding, broken windows, and contraband); prisoner health and provision of appropriate services; rehabilitation; equity and women prisoners; professionalism of staff; and chaplaincy.

Prisoner complaints system

In 2018, some 79 category A complaints relating to nine prisons were reported to the OIOP. Analysis of all complaints was unachievable due to issues around submission of incomplete returns.

Letters from prisoners

Overall, the OIOP received 71 letters from prisoners in 2018. The highest number of complaints was received from the Midlands Prison (n=13) and Mountjoy Prison (n=13). The lowest number was received from Cork Prison (n=1) and the Dóchas Centre (n=1).

Investigations

In total, 21 death-in-custody investigations were completed and submitted to the Minister in 2018. The Minister published 15 death-in-custody reports from a three-year timeframe: 2016 (n=1), 2017 (n=10), and 2018 (n=4). In addition, a further preliminary investigation was requested by the Minister in response to allegations of misconduct by the Irish Prison Service reported in the *Irish Examiner*.

Inspection of Places of Detention Bill Draft Scheme 2014

Following an invitation by the Department of Justice and Equality, views on the Inspection of Places of Detention Bill Draft Scheme 2014 were submitted by the inspector to the department in September 2018.

Conclusion

The Irish Penal Reform Trust welcomed this report and looks forward to the OIOP publication of the Inspection Framework and Strategic Plan.[5] It believes that these documents are essential to establishing the standards that will enable the OIOP to move towards meeting the inspector's vision of a 'world class'[1,5] Inspectorate of Prisons.

Ciara H Guiney

1 Office of the Inspector of Prisons (2019) *Office of the Inspector of Prisons annual report 2018.* Dublin: Office of the Inspector of Prisons. https://www.drugsandalcohol.ie/31468/

2 Prisons Act 2007 Revised (2018). Available online at: http://revisedacts.lawreform.ie/eli/2007/act/10/front/revised/en/html

3 Office of the Inspector of Prisons (2020) Office of the Inspector of Prisons. Available online at: https://www.oip.ie/

4 SI No. 252/2007 – Prison Rules 2007. Available online at: http://www.irishstatutebook.ie/eli/2007/si/252/made/en/print

5 Irish Penal Reform Trust (2019) Inspector of Prisons Annual Report 2018 published. Dublin: Irish Penal Reform Trust. Available online at: https://www.iprt.ie/latest-news/inspector-of-prisons-annual-report-2018-published/

GYDP young people: response to Covid-19 public health measures

On May 2020, the then Minister of State with responsibility for Youth Justice, David Stanton TD, launched a report that examined the response of young people participating in Garda Youth Diversion Projects (GYDPs) to the Covid-19 public health measures.[1] The report was a collaboration between the Research Evidence into Policy, Programmes and Practice (REPPP) project based in the School of Law at the University of Limerick and the Department of Justice and Equality.[1,2] The design of the report allows for rapid assessment by policymakers.[1]

Method

Participants

Youth justice workers (YJWs) (n=113) based in GYDPs across Ireland (n=104) were invited to complete an online qualitative survey. Data were collected between 23 April and 28 April 2020. Survey questions were centred on four areas (p. ii):

1. Young people in their GYDP and compliance with Covid-19 public health measures.
2. Observed impacts for young people's behaviours since measures were introduced.
3. How Covid-19 and restrictions affected GYDP work practices.
4. Requirements for front-line work with young people in GYDPs arising from Covid-19.

Where feasible, YJWs liaised with colleagues, local Gardaí, other community services, young people, and parents/caregivers. There was a 97% response rate.

Survey focus

The characteristics of the survey participants included:

- Participating in GYDPs and having previous involvement in youth offending
- Being cautioned mainly with a criminal offence
- Representing a small cohort of Irish young people (approx. 1 per 1000).

However, this population is consistent across Irish communities. In 2019, some 3,604 Irish youth were involved in GYDPs. YJWs were given autonomy on the prescribed population. The youth fell into three categories:

- Young people engaged with their GYDP (95%)
- Young people known in some capacity to the GYDP (64%)
- Young people in the locality covered by the GYDP (18%).

Findings

Compliance with Covid-19 public health measures

YJWs reported that most young people participating in GYDPs have been to 'varying degrees' in compliance with Covid-19 public health measures.[1] However, a minority of current and former participants were non-compliant.

Lifestyle changes and coping behaviours

Covid-19 health measures have resulted in greater reliance on social media and gaming to keep in touch with friends, mainly at night-time. YJWs acknowledged that due to changes in routine that engaging with young people has become more challenging. They report that in some cases family bonds have become stronger. However, for others, the measures have resulted in greater stress, giving rise to staying away from home. In some instances, adults have influenced non-compliant behaviour. YJWs have also reported that changes have negatively impacted on the young person's mental health.

Prosocial behaviour

More than 50% of YJWs acknowledged that the majority of young people have engaged with prosocial behaviour and altruistic behaviour. Prosocial activities included:

- Self-care (education, physical, and mental health)
- Altruistic behaviour within family (e.g. caring for younger siblings)
- Altruistic behaviour external to family (e.g. checking-in on and doing jobs for the elderly, picking up litter, and fundraising) (p. iv).

Challenges for GYDP engagement with young people

GYDP engagement with young people is centred on a 'relationship-based' intervention (p. v). While imaginative approaches were used to sustain engagement, several practical challenges emerged in attempts to do so (p. v). For example:

- **Antisocial behaviour:** Challenging antisocial behaviour and promotion of prosocial behaviour required the physical presence of the YJW and the young person. While YJWs overcame this problem using remote and online social media, this area is not addressed in policy and guidance.
- **Technical IT support:** Access to IT equipment and communication tools were needed by GYDP and by young people and their families.
- **Financial pressures:** Increased household costs were experienced by some families (e.g. food, cleaning products).
- **Recreation/health:** Recreation/health items were required (e.g. games for families and sanitisation equipment).
- **Tools, training, and guidance:** These were required remotely in areas of education, mental health, and parent and family support.
- **Funder support:** Funder support was required (e.g. budget security and return to work guidance).
- **Targeted re-engagement:** Limitations of remote working were acknowledged, particularly with vulnerable young people, and targeted re-engagement was required.

Study limitations

The main limitations acknowledged by the authors included:

1. Observations of behaviour were only reported by YJWs participating in the survey.
2. The survey population represented a small cohort of young people in Ireland and in individual communities.

Garda Youth Diversion Projects

continued

Conclusion

Minister Stanton commented that he was proud that young people were involved in prosocial behaviours and activities during Covid-19. He believes that these actions illustrate that these young offenders are engaging with their communities and are attempting to turn corners, and it is vital that they continue to be supported. The Minister acknowledged the importance of this research and thanked the REPPP project and the Department of Justice and Equality for their collaboration.[2] On 1 May 2020, a draft of the new Youth Justice Strategy was published online for consultation.[3] The Minister called on all young people to contribute to this online consultation so that their voices can be heard.[2,4]

Ciara H Guiney

1 Research Evidence into Policy, Programmes and Practice (REPPP), University of Limerick (2020) *How are young people participating in Garda Youth Diversion Projects responding to the Covid-19 public health measures? A local to national qualitative profile: report 1.* Dublin: Department of Justice and Equality and Department of Children and Youth Affairs. https://www.drugsandalcohol.ie/32053/

2 Department of Justice and Equality (2020) *Report finds majority of youth offenders are compliant with Covid-19 restrictions.* Dublin: Department of Justice and Equality. Available online at: http://www.justice.ie/en/JELR/Pages/PR20000090

3 Department of Justice (2020) *Draft Youth Justice Strategy 2020–2026.* Dublin: Department of Justice and Equality. Available online at: http://www.justice.ie/en/JELR/Draft_Youth_Justice_Strategy_2020_(Public_Consultation).pdf/Files/Draft_Youth_Justice_Strategy_2020_(Public_Consultation).pdf

4 Department of Justice (2020) *Public consultation on the Youth Justice Strategy*. Survey available online at: https://www.surveymonkey.com/r/RJW2H9H

Fostering understanding, empowering change: practice responses to adverse childhood experiences and intergenerational patterns of domestic violence

In November 2019, Dr Sarah Morton and Dr Megan Curran of University College Dublin published the results of a Tusla-funded study, *Fostering understanding, empowering change: practice responses to adverse childhood experiences (ACEs) and intergenerational patterns of domestic violence.*[1]

The aim of this study was to examine the experiences of women at the Cuan Saor Women's Refuge, a domestic violence service in Co Tipperary. The focus was to identify the level of ACEs experienced by the women who accessed the service. Based on the ACEs routine enquiry process, trauma-informed responses (TIRs) to women's childhood experiences and the intergenerational transmission of trauma were examined as well as the role of ACEs routine enquiry and intervention in relation to infant mental health (IMH), a key area of work for childcare workers within domestic violence (p. 10).

Adverse childhood experiences

The term initially appeared in an American study that examined childhood experiences, such as neglect and abuse, along with challenges at home and health and wellbeing.[2] Seven types of ACEs were identified in the initial study: psychological, physical, or sexual abuse; domestic violence; or living with household members who abused substances, were mentally ill or suicidal, or had been incarcerated.[2] As research in this area has grown, the list has expanded to include, for example, parental separation (p. 11).[1] Even so, how specific ACEs have been operationally defined has not been consistent across the various studies.

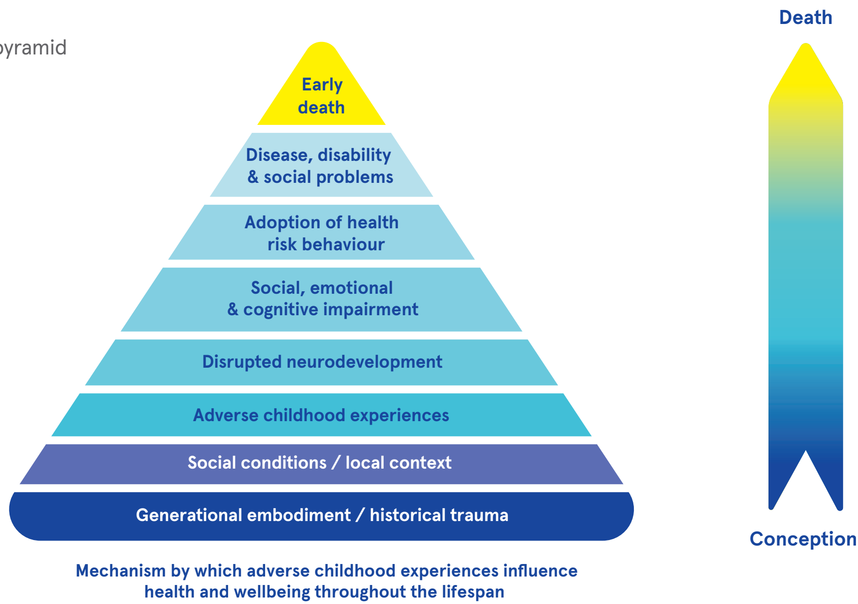
A strong relationship has been demonstrated between the seven ACEs and chronic illness and death. Moreover, those reporting four ACEs or more were likely to experience several health risk factors when they were older.[2] Figure 1 identifies areas that can be influenced by ACEs.

Intergenerational effects are also associated with ACEs. This means that when children with an ACE become adults, they are inclined to engage in behaviour that develops possible ACEs for their children. In children, ACEs are viewed as a form of trauma that result in a chronic state of stress. When this stress occurs during critical phases of their development, it can result in physiological changes, impacting brain development, immunity, and hormones. In addition, it prevents them from forming secure attachment bonds, which in turn impacts on their ability to explore their social world and develop relationships.

Adverse childhood experiences

continued

Figure 1: The ACE pyramid



Source: US Centers for Disease Control and Prevention

Methodology

The study carried out at Cuan Saor Women's Refuge was an action-research approach and involved a mixed-methods design using quantitative and qualitative data. It was carried out over nine months and broken down into three phases:

1. **ACEs routine enquiry:** Women who accessed the refuge over a three-month period anonymously completed a 10-question ACEs questionnaire (n=60).
2. **Qualitative data:** These were collected via practitioner inquiry groups consisting of Cuan Saor staff (n=10). Three inquiry groups which lasted 90 minutes approximately were run every 4–6 weeks.
3. **Interagency cooperative inquiry group (n=7):** This examined the possibility of integrating ACEs into wider interagency work, particularly in the areas of IMH. This consisted of two inquiry groups that lasted 90 minutes approximately. They were run four weeks apart.

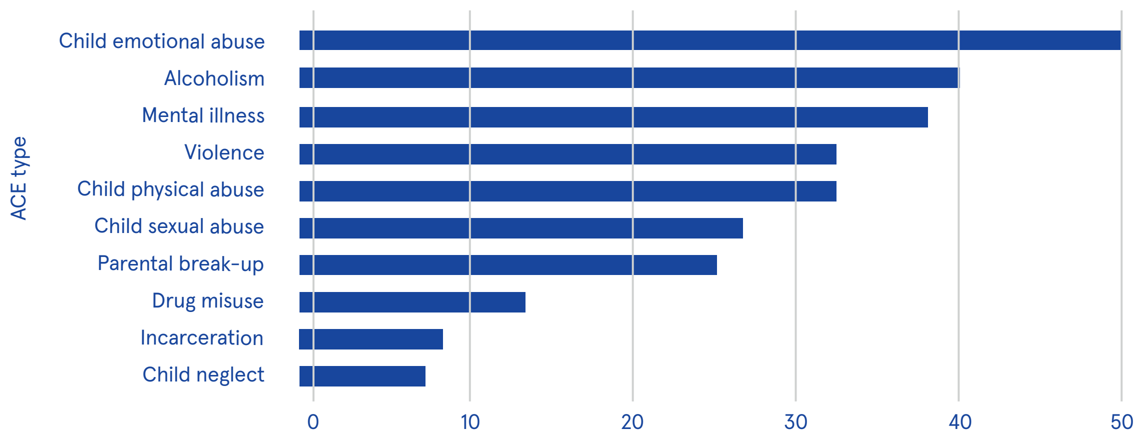
Results

Quantitative

- The mean ACEs score for service users was 2.7.
- 18% of service users reported having no ACEs in childhood.
- 58% experienced at least two ACEs.
- 33% experienced four or more ACE events in childhood.
- 40% experienced alcoholism in childhood.
- 13% experienced drug misuse.

Figure 2 identifies the most common types of ACEs by percentage experienced by Cuan Saor service users from highest to lowest.

Figure 2: Most common types of ACEs experienced by Cuan Saor service users (n=60)



	Child neglect	Incarceration	Drug misuse	Parental break-up	Child sexual abuse	Child physical abuse	Violence	Mental illness	Alcoholism	Child emotional abuse
%	7	8	13	25	27	32	32	38	40	50

Adverse childhood experiences

continued

Qualitative

Several qualitative themes emerged:

- Implementing ACEs routine enquiry:
  - Training
  - Implementation
- Lessons from ACEs routine enquiry:
  - Relevance of the ACEs tool
  - Responding to disclosures of trauma
  - Timing ACEs routine enquiry within the helping process
  - Understanding and empowerment of users
  - Interagency work.

Implications

Several implications were put forward by the authors. These were based on the results of this study and the wider ACE literature. Four areas were identified: service users, practitioners, organisations, and funders.

Service users

Practitioners found that the completion of the ACEs routine enquiry by services users resulted in the identification of practice issues and responses. This information was deemed helpful to others implementing the ACEs routine enquiry. Practitioners also found that using the ACEs routine enquiry helped service users to come to terms with past experiences, leaving them in a better position to address the impact of the ACEs on themselves and their children. However, the appropriateness of the ACEs routine enquiry for older women was questioned.

Practitioners

ACE is one of several TIRs that has been reviewed and put into practice across services. However, practitioners raised some concerns:

- Time and resources for appropriate training and support around the implementation of ACEs to deal with disclosures that may change the service user emotionally
- The importance of boundaries and limitations when dealing with these issues
- The impact of dealing with ACEs on the practitioner.

Organisations

Organisations need to independently consider the best way to implement a TIR, the instrument to be used, training and support for practitioners, follow-up and referral services, and the evaluation process. From an interagency perspective, it would be important to determine whether non-governmental agencies and community organisations would be in a better position to pilot this approach in light not having the same constraints as larger organisations, for example, Tusla.

Funders

How to develop and fund TIRs particularly ACEs in health and social care was deemed to be challenging. To implement change, several factors need to be considered: the evidence; development and implementation of the intervention; practitioner training; getting the organisation on board; and resources. This study used a limited budget, existing supervision, and support structures within Cuan Saor and strong interagency relationships between IMH practitioners. This infrastructure may not always be available, which can further impact on funding.

Limitations and further research

As acknowledged by the authors, the questionnaire used in this study provided insight into the level and types of ACEs experienced by domestic violence users, thus enabling the implementation of a more responsive service. However, this approach was not intended to determine whether a causal link existed between ACEs in childhood and later outcomes. In addition, only practitioners took part in the enquiry groups. Also, in terms of future research, the views and impact of ACEs on female service users should also be assessed.

Ciara H Guiney

1 Morton S and Curran M (2019) *Fostering understanding, empowering change: practice responses to adverse childhood experiences (ACEs) and intergenerational patterns of domestic violence.* Tipperary: Cuan Saor Women's Refuge. https://www.drugsandalcohol.ie/31507/

2 Felitti VJ, Anda RF, Nordenberg D, *et al.* (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of deaths in adults: the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*, 14(4): 245–258. Available online at: https://www.ajpmonline.org/article/S0749-3797(98)00017-8/pdf

Reducing youth crime: role of mentoring

In October 2019, Kieran O'Dwyer, a consultant and trainer within the field of criminal justice and restorative practices, published an article, entitled *Reducing youth crime: the role of mentoring*.[1] The article discussed the results of an evaluation of a La Chéile mentoring programme, which is delivered to young people aged 12–21 years who come before the criminal courts in Ireland.[2]

Mentoring programmes

Mentoring programmes are based on the idea that a relationship developed between a mentor (older person) and a mentee (younger person) may assist the young person to cope with adversity and may help them to cultivate a positive sense of themselves and their future.[3] Programmes that target youths involved with the criminal justice system are mainly designed to provide support and guidance, thus enabling the young person to become a responsible adult. The presence of a mentor is also considered to offset the absence of a responsible adult in the life of that young person.[4]

Reducing youth crime continued

Effectiveness of mentoring in reducing offending

The author acknowledged that evidence on the impact of mentoring on reoffending is a relatively new area of research and lacking in clarity. For example, a report by the Ministry of Justice in the United Kingdom (UK) argued that analysis of reviews and meta-analyses was 'promising'.[5] However, the authors advised that results should be interpreted with caution due to programme variation and insufficient information on the mentoring context and how it was implemented.[5] An earlier report nonetheless indicated that only some programmes resulted in positive outcomes.[6] In contrast, a review of programmes supported and funded by the Youth Justice Board in the UK found that after one year in a mentoring programme, evidence to suggest offending or severity in offending had reduced was unconvincing.[7] In fact, when reoffending rates were compared between mentees and corresponding national cohorts (n=359), rates for mentoring programmes fared worse.[8]

Factors critical to success in mentoring

Drawing on the research evidence base, the author identified several factors[1] that were necessary for mentoring to be effective:

- Frequent contact and emotional closeness should be developed over a minimum period of 6–12 months.
- There should be weekly meetings of five hours or more.
- Volunteer mentors should be screened, matched, trained, supported and supervised.
- Attitudes and attributes of mentors should be considered.
- The advocacy role on behalf of the mentee was vital.
- The nature of the mentoring relationship should be considered.
- Interventions should combine mentoring and leisure-time programmes with a focus on psychological and sociological development.
- There should be an emphasis on emotional support.
- Mentoring should involve intensive training and structured activities.
- The organisation and administration of schemes should be considered.[1]

La Chéile mentoring

In Ireland, Le Chéile mentoring service collaborates with the Probation Service in Dublin, Cork, Meath, the Midlands, the South-East, and the South-West. Referrals are mainly made by the Probation Service and mentoring is carried out as part of probation supervision. Each area is overseen by a coordinator responsible for recruiting, training, supervising, and supporting volunteer mentors. Mentors are mainly mature persons (aged 20 plus) who come from all walks of life and are non-judgemental, unbiased, and enjoy working with youth. Their main role is to assist, provide stability and advice, and help mentees make decisions and achieve goals. When a mentor and mentee are matched, the mentoring relationship is prioritised and built on via participation in social and fun activities, which is followed by setting attainable goals and tasks. Sessions are of two hours' duration each week for approximately 6–12 months and occasionally longer.

Le Chéile mentoring evaluation

Methodology

Information was collected from several sources, for example, young people, parents, mentors, coordinators, and the Probation Service, via interviews and surveys. Areas examined via self-report included:

- Participants' perceptions of mentoring at start and end
- Coordinators and Probation Service staff perceptions' of mentees at start and end
- The extent that mentoring brought about change.

Phases of relationship building and challenging

Mentoring consisted of two phases:

1. **Relationship-building phase:** This lasted 6–8 weeks but sometimes longer and was tailored to the needs of the individual. The aim at this stage is for mentors and mentees to get to know each other and build trust via fun activities. If this phase is rushed, it can result in failure.
2. **Challenging, target-focused phase:** This prioritised goal setting using a 'softly, softly' approach, where behaviour and attitudes are challenged in 'subtle, progressive, encouraging and supportive ways' (p. 163).[1]

Results

A reduction in reoffending was reported by approximately 28% of participants along with several other outcomes. These include:

- Improved family and peer relationships
- Involvement in activities outside the home
- Reduction in misuse of alcohol and drugs
- Involvement in education, work, and training
- Increased self-confidence and wellbeing (p. 10).[2]

In addition, several programme strengths emerged in the evaluation:

- Space, time, and exclusive focus on the mentee
- Patience and persistence of mentors and coordinators
- Unpaid volunteer mentors
- Personality of mentors
- Close relationships of mentees with their mentors
- Mentoring values, non-judgemental and attentive
- Provision of structure and routine
- Flexibility of mentoring
- Mentoring tailored to individual needs.

Limitations

The author acknowledged several limitations in the Le Chéile evaluation. No control group was utilised and the offending data provided was based on self-reports, not on independent offending data. In addition, the design of the study was not longitudinal. Further information on these limitations can be found in the evaluation report.[2]

Reducing youth crime continued

Conclusion

As acknowledged by the author, evidence from the international literature was mixed. Disparities between mentoring programmes made comparison difficult. However, specific aspects – such as emotional connection and relationship between mentor and mentee, regular contact, length of programme (six months or longer), structured activities, and parental support – have emerged as areas that are likely to result in positive outcomes when included. Evaluation of the Le Chéile mentoring programme indicated that offending reported by participants was negatively related to mentoring, that is, as mentoring increased, self-reported offending reduced. The author concluded that the Le Chéile programme provides strong evidence that mentoring results in participating less in criminal activities, while at the same time increases 'life chances' for those involved in the programme (p. 165).[1]

Ciara H Guiney

1 O'Dwyer K (2019) Reducing youth crime: the role of mentoring. *Irish Probation Journal*, 16 (10): 153–167. Available online at: https://www.pbni.org.uk/wp-content/uploads/2019/12/Reducing-Youth-Crime.pdf

2 O'Dwyer K (2017) *Reducing youth crime in Ireland: an evaluation of Le Chéile mentoring.* Dublin: Le Chéile. https://www.drugsandalcohol.ie/27105

3 Dolan P, Brady B, O'Regan C, Canavan J, Russell D and Forkan C (2011) *Big Brothers Big Sisters (BBBS) of Ireland: evaluation study. Report 3: summary report.* Galway: UNESCO Child and Family Research Centre on behalf of Foróige. Available online at: https://aran.library.nuigalway.ie/bitstream/handle/10379/4498/BBBS_Report_3.pdf

4 Danish Crime Prevention Council (DKR) (2012) *The effectiveness of mentoring and leisure-time activities for youth at risk: a systematic review.* Glosrup: Danish Crime Prevention Council. Available online at: https://www.researchgate.net/publication/326508283_The_Effectiveness_of_Mentoring_and_Leisure-Time_Activities_A_Systematic_Review_for_Youth_at_Risk

5 Adler JR, Edwards SK, Scally M, *et al.* (2016) *What works in managing young people who offend? A summary of the international evidence.* London: Ministry of Justice. Available online at: https://www.gov.uk/government/publications/what-works-in-managing-young-people-who-offend

6 Ministry of Justice (2014) *Transforming rehabilitation: a summary of evidence on reducing reoffending.* 2nd edn. London: Ministry of Justice. Available online at: https://www.gov.uk/government/publications/transforming-rehabilitation-a-summary-of-evidence-on-reducing-reoffending

7 St James-Roberts I, Greenlaw G, Simon A and Hurry J (2005) *National evaluation of Youth Justice Board mentoring schemes 2001 to 2004.* London: Thomas Coram Research Unit, University of London. Available online at: https://core.ac.uk/download/pdf/4157305.pdf

8 Tarling R, Davison T and Clarke A (2004) *The national evaluation of the Youth Justice Board' s mentoring projects*, London: Youth Justice Board. Available online at: https://scottishmentoringnetwork.co.uk/assets/downloads/resources/youthjusticeboardevaluation.pdf

RESPONSES

Strategy and intervention framework for Planet Youth

In February 2020, President Michael D Higgins launched the *Planet Youth strategy and implementation framework: Galway, Mayo and Roscommon*.[1] Planet Youth was established in Ireland in 2018 by the Western Region Drug and Alcohol Task Force (WRDATF). In May 2019, the first tranche of survey data was published from pupils in schools across the three participating areas in the region (Galway, Mayo, and Roscommon).[2,3,4]

Planet Youth

Planet Youth is an evidence-based approach to preventing drug use aimed at young people. A core principle of Planet Youth is that prevention activities should engage the whole population of young people, rather than targeting particular individuals or groups. Developed in Iceland, the prevention model is predicated on three pillars of success: using evidence-based practice; using a community-based approach; and creating and maintaining a dialogue among research, policy, and practice.[5] There are three key components to the programme: data collection and analysis that maps out the nature of the risk and protective factors facing young people; implementing prevention activities through a wide range of stakeholders to increase protective factors and reduce the risk factors; and reflection and learning. For more detail on the background to the programme, see previous issues of *Drugnet Ireland*.[6,7]

Strategy framework

Planet Youth is a programme that involves a wide range of stakeholders from national and local government to public bodies, schools, and community-based organisations. The authors argue that 'prevention activities are more likely to succeed when they are systematic, evidence-based and collaborative. While the need for prevention is increasingly recognised, it often occurs in an ad hoc manner' (p. 19). It is within this context that the strategic framework has been developed – to encourage stakeholders to prioritise prevention 'in an integrated and holistic way' (p. 19) and to support them in adhering to the Planet Youth model. The document outlines the vision, mission, guiding principles, and objectives of the programme in the Western Region (pp. 18–20).

Vision and mission

Vision: All young people are active, healthy and happy, connected to their families and communities, and achieving their full potential.

Planet Youth continued

Mission: To lead a process of transformative change by embedding primary prevention approaches which enhance young people's health, relationships, environment, and wellbeing.

Guiding principles

1. Apply a primary prevention approach that is designed to enhance the social environment.
2. Emphasise community action and embrace schools as the natural hub of community efforts to support the wellbeing and development of young people.
3. Engage and empower stakeholders to make practical decisions using local, high-quality accessible data and findings.
4. Integrate researchers, policymakers, practitioners, and stakeholders into a unified team dedicated to solving complex, real-world problems.
5. Match ambition to the scale of the problem, including emphasising long-term actions, systems changes, and investment.

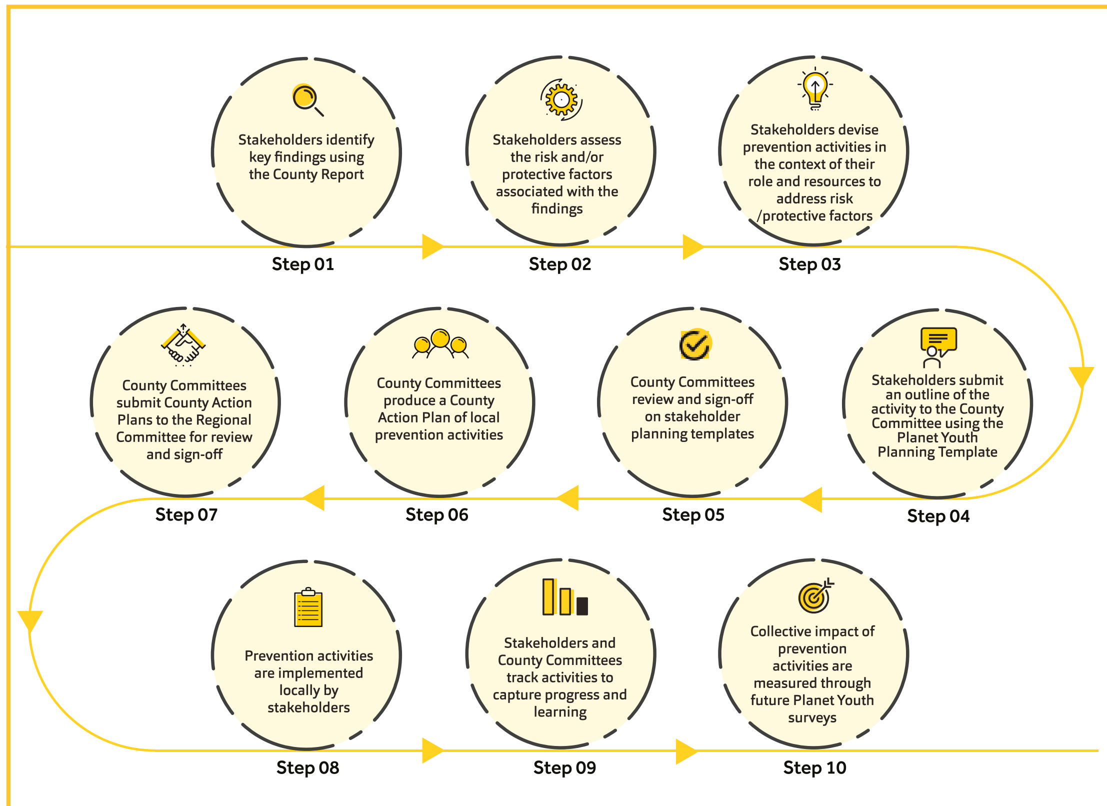
Objectives

1. Improve outcomes and opportunities for young people across the programme's four domains: parents and family; leisure time and local community; school; and peer group.
2. Deliver a wide range of evidenced-informed prevention activities which address risk and protective factors.
3. At county, regional, and national level, build and maintain a strong, collaborative, well-informed partnership of community, agency, and political stakeholders.
4. Build strong brand recognition and stakeholder involvement throughout the Western Region.
5. Secure sustainable investment for development and coordination of Planet Youth in the Western Region.
6. Capture learning and track activities in order to inform the future development of Planet Youth.
7. Develop a strategy for sustaining Planet Youth linked to relevant national policies, including *Better outcomes, brighter futures,* the national policy framework for children and young people, and *Reducing harm, supporting recovery,* a health-led response to drug and alcohol use in Ireland, 2017–2025.[8,9]

Implementation framework

The authors emphasise the importance of stakeholders maintaining fidelity to the Planet Youth model if the best outcomes for young people are to be achieved. To support them in doing so, section 3 of the report provides guidance on how best to implement the model by embedding primary prevention approaches into their day-to-day activities. They identify 10 steps that aim to guide the stakeholders through identifying risk and protective factors within their remit or scope and to make changes to their policy, practice, or resources in order to positively impact young people's lives. These steps are outlined in Figure 1.

Figure 1: Steps for implementing prevention activities



Planet Youth continued

Next steps and Covid-19

In collaboration with stakeholders, WRDATF is supporting the delivery of a range of prevention activities within the region. In line with the design of the Planet Youth programme, a second schools survey was due to take place in October 2020. However, at time of print it is unclear how this will be implemented given the Covid-19 situation, although it is still hoped that it will be undertaken in some form. Covid-19 is recognised by Planet Youth as presenting challenges for young people. WRDATF is working in collaboration with the Icelandic Centre for Social Research and Analysis, who developed the programme, to include questions on the impact of Covid-19 on young people in any future versions of the standardised questionnaire.

The North Dublin Regional Drug and Alcohol Task Force was similarly planning to implement the programme in their region, carrying out their initial surveys in schools in October 2020. This also faces delays given the Covid-19 situation.

Lucy Dillon

1 Western Region Drug and Alcohol Task Force (2020) *Planet Youth strategy and implementation framework: Galway, Mayo & Roscommon.* Galway: Western Region Drug and Alcohol Task Force. https://www.drugsandalcohol.ie/31961/

2 Western Region Drug and Alcohol Task Force (WRDATF) (2019) *Growing up in the west: county report Mayo*. Galway: WRDATF. https://www.drugsandalcohol.ie/30531/

3 WRDATF (2019) *Growing up in the west: county report Roscommon.* Galway: WRDATF. https://www.drugsandalcohol.ie/30532/

4 WRDATF (2019) *Growing up in the west: county report Galway.* Galway: WRDATF. https://www.drugsandalcohol.ie/30528/

5 Sigfúsdóttir ID, Thorlindsson T, Kristjánsson AL, Roe KM and Allegrante JP (2009) Substance use prevention for adolescents: the Icelandic Model. *Health Promot Int*, 24(1): 16–25. http://www.drugsandalcohol.ie/28656/

6 Dillon L (2018) Planet Youth. *Drugnet Ireland*, 66: 24. https://www.drugsandalcohol.ie/29607/

7 Dillon L (2019) Planet Youth in WRDATF. *Drugnet Ireland*, 71: 9–11. https://www.drugsandalcohol.ie/31448/

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

9 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/

Experiences of teenagers in treatment for cannabis use

Cannabis continues to be the most common 'main problem drug' for new cases accessing treatment in Ireland. In 2018, it was reported as the main problem drug for 38% of new cases, followed by cocaine (31.1%) and opioids (18.1%).[1] A new Irish study explores the experiences of a sample of teenagers (n=8) attending treatment for their cannabis use, entitled *'Debt on me head': a qualitative study of the experience of teenage cannabis users in treatment.*[2]

Sample profile and method

The paper reports on a qualitative study based on interviews with eight young people in Dublin who were in treatment for their cannabis use. They were aged between 15 and 18 years, with a mean age of 16.75 years. Age at initiation of cannabis use ranged from 11 to 15 years, with the mean age for first use at 13 years. On average, 3.5 years had passed since their first use. Interviews were recorded and transcribed verbatim. They were analysed thematically and six core themes were identified. Key findings under each theme are outlined below.

The findings of this study should be considered within the context of two main limitations. First, interviews were carried out by a member of staff from one of the treatment centres. This may have impacted on young people's willingness to disclose certain types of information, in particular when discussing their views and experiences of treatment. Second, the sample was drawn from two Dublin-based centres and these young people's experiences may therefore not reflect those of teenagers living in other parts of the city or the country.

Early initiation and heavy use

Initial cannabis use began with friends in relaxed social situations. However, usage became more regular and seven of the eight respondents progressed to daily use. This more regular use became less associated with feeling 'giggly and high' and more linked with 'feeling normal'. They described feeling psychologically addicted and some experienced cravings and withdrawals when they did not use cannabis. Effects included sleep problems, appetite disturbance, and agitation.

Cannabis ambivalence

Respondents were found to be largely ambivalent about their cannabis use. On the one hand, they valued the high experienced and the opportunities to meet new people that it presented. However, on the other hand, they described in negative terms the costs and other effects such as anxiety and low mood, which they associated with heavy use. Overall, the negative effects were not associated with cannabis as such, rather with the frequency with which it was used. This ambivalence led to a situation whereby respondents continued to want to use cannabis albeit at a reduced level. 'All but one were still using cannabis and had no strong desire for abstinence' (p. 214).

Experiences of teenagers in treatment for cannabis use

continued

Stealing and dealing

Selling cannabis, stealing money and mobile phones, and armed robbery were all identified as ways in which these young people had raised money to buy cannabis. There were also reports of young people getting into debt with dealers and threats being made to them and their families over payment of these debts.

Treatment

Overall, respondents were reported to have spoken favourably about treatment. They valued the opportunity to talk with well-informed, non-judgemental professionals about their situation. However, as noted above, these findings may have been impacted by the interviews having been carried out by a member of staff from one of the treatment centres.

Damage to relationships

In some cases, cannabis use was perceived to have caused problems for users in their personal relationships with friends and family members. There were tensions within families over drug debts and the associated threats, as well as some parents' concerns about their young person's drug use progressing to 'more harmful' or 'harder' drugs.

Parental cannabis use

The final recurring theme discussed in the paper is that of parental cannabis use – that of either the respondent's own parents or those of their friends. While the study found that some of the young people knew adults who smoked cannabis, it was not found that parents either provided or condoned its use.

Conclusion

Despite the limitations of this study, *Debt on me head* provides insights into the experiences of this cohort of service users in an Irish context. The early onset of use and subsequent problems experienced, alongside their ambivalence to cannabis and resistance to aim for abstinence as a result of treatment, are shown by the authors to reflect findings elsewhere in the literature. Among the authors' conclusions is that despite this ambivalence to the effects of cannabis 'the financial cost of cannabis use and the ensuing debts appear to act as a catalyst to change' (p. 217). They argue that the study emphasises 'the reality that young people attending treatment for their cannabis use have experienced significant problems because of their cannabis use and cannabis dependency appears common' (p. 217). They highlight the need for other professionals working with young people to understand the negative effects that cannabis use may be having on these young people.

Lucy Dillon

1 Health Research Board (2019) *National Drug Treatment Reporting System 2012–2018 drug data*. Dublin: Health Research Board. https://www.drugsandalcohol.ie/30969/

2 James PD, Comiskey C and Smyth BP (2019) 'Debt on me head': a qualitative study of the experience of teenage cannabis users in treatment, *J Addict Nurs*, 30(3): 211–218. https://www.drugsandalcohol.ie/31042/

Hepatitis C screening and care for opioid substitution patients in Ireland

Hepatitis C virus (HCV) is now among the most common causes of cirrhosis and primary liver cancer in Europe.[1] As HCV is a blood-borne virus, people who inject drugs are the primary risk group for contracting HCV, making up 80% of new infections.[2] With opioid substitution increasingly being provided in primary care settings, they have an important role in HCV screening and treatment. In a 2018 study published in the *Interactive Journal of Medical Research*, Murtagh *et al.* investigated compliance in Irish primary care practices with guidelines on screening for HCV, other blood-borne viruses, and alcohol use disorder.[3]

About 74% of patients contracting HCV will become chronically infected, which is associated with considerable morbidity and mortality.[4] As symptom onset can be delayed by decades and result in considerable damage to the liver, screening for HCV is vital among opioid substitution patients, who are often at increased risk of HCV infection due to a history of drug injection. Additionally, opioid substitution patients often present with problem alcohol use, which can exacerbate the risk of liver disease. Hence, guidelines from the World Health Organization and Health Service Executive advise on addressing alcohol use with HCV patients.

Effective diagnostic technology (e.g. FibroScan) and treatment for HCV (direct-acting antiviral (DAA) treatment) are now available, but due to the high cost of treatment, guidelines prescribe prioritising patients with the highest clinical need.[5] Additionally, scarce time and resources can complicate treatment within primary care. Given new options and plans to expand HCV interventions, the study's aim was to investigate whether opioid substitution patients were receiving HCV screening and care in line with best practice guidelines.

Methods

The study used baseline data from the larger HepLink study on developing community-based HCV treatment interventions. Participants were opioid substitution patients recruited through non-probability sampling, which was deemed an acceptable method for the HepLink feasibility study. Of 63 general practices in the selected study area (Mater Misericordiae University Hospital catchment area in Dublin), 14 practices participated, each recruiting 10 participants. In total, 134 patients participated, 71.6% of whom were male. Their mean age was 43 years. Data were collected from patient records and

Hepatitis C screening continued

included information on screening, treatment, and vaccination for blood-borne viruses (HCV, hepatitis B virus (HBV), and HIV), and drug and alcohol use.[6]

Key findings

HCV

- **HCV screening:** In their lifetime, 94.8% of participants had been screened for HCV (23.9% in the past year); 77.9% of whom tested positive for HCV at least once (72% of patients tested in the past year; see Figure 1).
- **Interventions:** Only 17% of HCV-positive participants had had a FibroScan and only 20% had started HCV DAA treatment (3% in the past year; see Figure 2).

HIV and HBV

- **HIV screening:** 83.6% of participants had been screened for HIV in their lifetime (25.4% in the past year), 6.3% of whom tested positive (3% of patients tested in the past year).
- **HBV screening:** 66.4% of participants had been screened for HBV in their lifetime (22.4% in the past year), 8% of whom tested positive (3% of patients tested in the past year).
- **Vaccination:** 48.5% of patients had previously been vaccinated against HBV (8% in the past year).

Drug and alcohol use

- **Alcohol screening:** Clinical records showed that 30.6% of participating patients had been asked about their alcohol consumption by their general practitioners (GPs) in the past year.
- **Interventions:** Only 6% had received a brief intervention and 2.2% had a referral to specialist addiction services.
- **Drug screening:** 37.3% of participants' last urine sample showed metabolites of non-prescribed drugs.

Discussion

Murtagh *et al.* welcome the high rate of HCV screening of 94.8% in this study, noting that this is a considerable increase from 69% in a 2003 study.[7] In contrast, the low proportion of HCV-positive participants receiving treatment is concerning. The authors attribute this to the high cost of DAA treatment, necessitating the triaging of patients. They envisage that as antiviral medication becomes cheaper, its availability will increase for Irish HCV patients.

Less than one-third of patients had been screened for problem alcohol use, and brief interventions and referrals were only scarcely provided. While this represents an improvement from previous studies,[8,9] the authors note that this is still insufficient given the risks to liver health of both HCV and alcohol use. Also considering the high proportion of opioid substitution patients with substance use in the study, Murtagh *et al*. conclude that GPs should be trained to provide more brief interventions and harm reduction education for their opioid substitution patients.

Figure 1: Percentage of participants ever screened for HCV (n=134) and results for those screened (n=127)

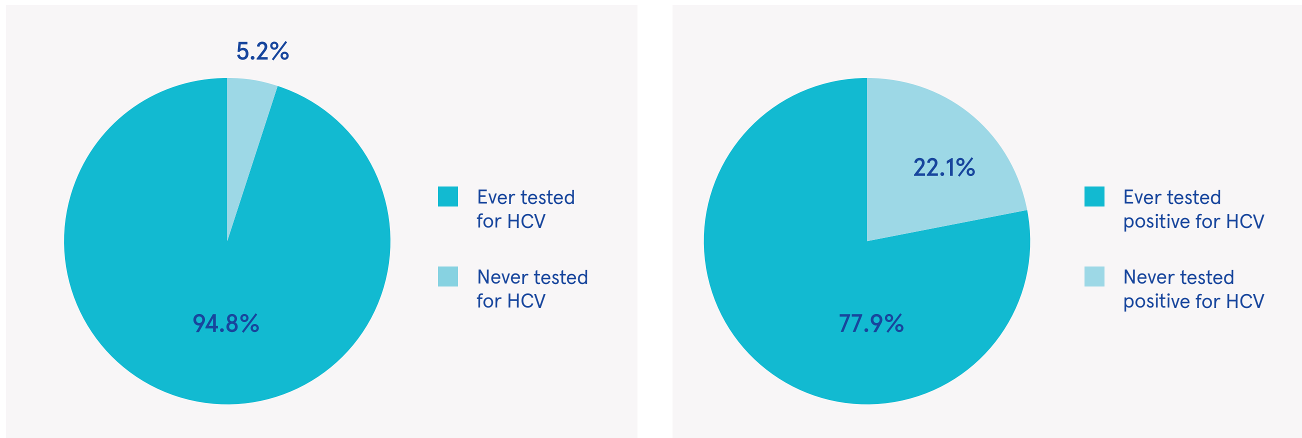
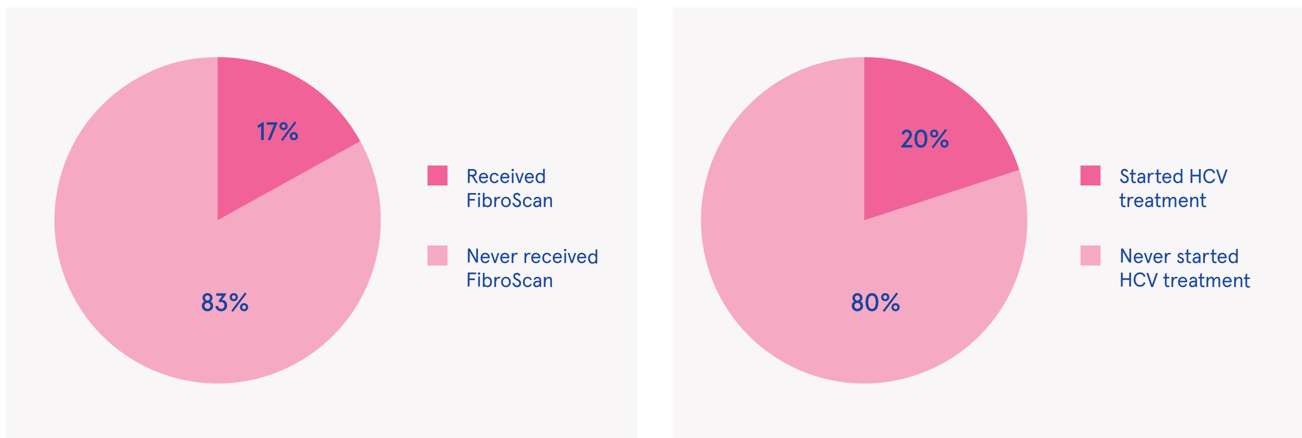


Figure 2: FibroScan assessment and intervention rate for HCV-positive participants (n=99)



Hepatitis C screening continued

Compared with previous findings in Ireland, the rates of patients in this study testing positive for HCV (77.9%) and for HBV (8%) are higher, whereas the rates for HIV (6.3%) are lower or similar.[7,8] However, these differences should be interpreted with caution due to the variation in sample sizes and source of comparison data.

The study's findings must be viewed in light of further limitations, including limited generalisability due to the non-randomised sampling technique and potential self-selection bias among participating GPs. Murtagh *et al.* also note the imperfections of clinical records as a data source on viral screening, as they do not capture care provided to patients in other practices. Nevertheless, the study provides important insights into the status quo of screening and care for informing the expansion of HCV treatment.

Britta Thiemt

1 Blachier M, Leleu H, Peck-Radosavljevic M, Valla DC and Roudot-Thoraval F (2013) The burden of liver disease in Europe: a review of available epidemiological data. *J Hepatol*, 58(3): 593–608.

2 Lazarus JV, Sperle I, Matičič M and Wiessing L (2014) A systematic review of hepatitis C virus treatment uptake among people who inject drugs in the European region. *BMC Infect Dis*, 14, (Suppl 6): s16.

3 Murtagh R, Swan D, O'Connor E, *et al.* (2018) Hepatitis C prevalence and management among patients receiving opioid substitution treatment in general practice in Ireland: baseline data from a feasibility study. *Interact J Med Res*, 7(2): e10313.

4 Micallef JM, Kaldor JM and Dore GJ (2006) Spontaneous viral clearance following acute hepatitis C infection: a systematic review of longitudinal studies. *J Viral Hepat*, 13(1): 34–41.

5 Matičič M, Videčnik Zorman J, Gregorčič S, Schatz E and Lazarus JV (2014) Are there national strategies, plans and guidelines for the treatment of hepatitis C in people who inject drugs? A survey of 33 European countries. *BMC Infect Dis*, 14 (Suppl 6): s14.

6 Further measures not reported here included information on alternative HCV tests, hepatitis A virus (HAV), chronic illness, and healthcare use; see Murtagh *et al.* (2018) study.

7 Cullen W, Stanley J, Langton D, Kelly Y and Bury G (2007) Management of hepatitis C among drug users attending general practice in Ireland: baseline data from the Dublin area hepatitis C in general practice initiative. *Eur J Gen Pract*, 13(1): 5–12.

8 Klimas J, Anderson R, Bourke M, *et al.* (2013) Psychosocial interventions for alcohol use among problem drug users: protocol for a feasibility study in primary care. *JMIR Res Protoc*, 2(2): e26.

9 Klimas J, Henihan AM, McCombe G, *et al.* (2015) Psychosocial Interventions for Problem Alcohol Use in Primary Care Settings (PINTA): baseline feasibility data. *J Dual Diagn*, 11(2): 97–106.

DOVE Service, Rotunda Maternity Hospital annual report, 2018

The Danger of Viral Exposure (DOVE) Service in the Rotunda Hospital, Dublin was established to meet the specific needs of pregnant women who have, or are at risk of, blood-borne or sexually transmitted bacterial or viral infections in pregnancy. Exposure may also occur through illicit drug use. Figures from the service for 2018 were published in the hospital's annual report in 2019.[1]

Figure 1 shows the number of women who booked into the DOVE Service for antenatal care each year during the period 2008–2018. It also shows the diagnosis for these women.

During 2018, some 128 women booked into the DOVE Service for antenatal care. Of these:

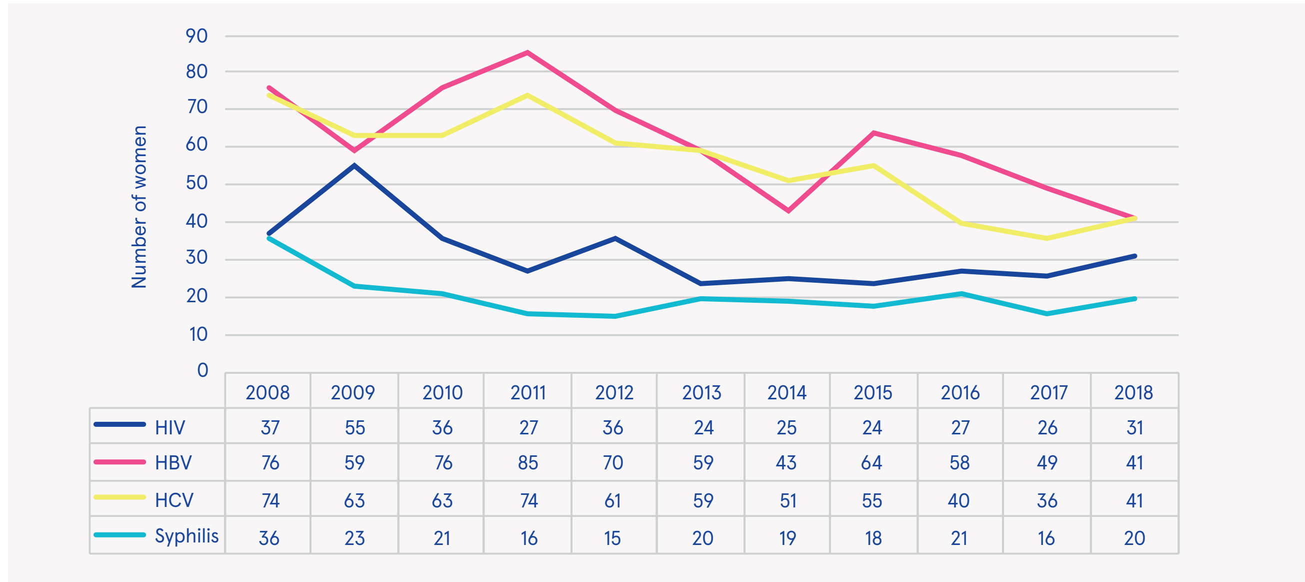
- 31 (24%) women were positive for HIV infection.
- 41 (32%) women were positive for hepatitis B (HBV) surface antigen.
- 41 (32%) women were positive for hepatitis C (HCV) antibody.
- 20 (16%) women had positive treponemal serology (syphilis).

In addition to the figures presented above, a number of women attended the service for diagnosis and treatment of human papillomavirus, herpes simplex virus, chlamydia, and gonorrhoea.

It should be noted that these numbers refer to patients who booked for care during 2018. Table 1 summarises the outcome of patients who actually delivered during 2018. Of these patients, 30 were HIV-positive, 48 were HBV-positive, and 42 were HCV-positive. During 2018, some 106 women were referred to the Drug Liaison Midwife (DLM) service, including 39 women who had a history of opiate addiction and were engaged in a Methadone Maintenance Programme. There was a total of 61 deliveries to mothers under the DLM service in 2018.

DOVE report, 2018 continued

Figure 1: DOVE Service bookings by year, 2008–2018



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
HIV	37	55	36	27	36	24	25	24	27	26	31
HBV	76	59	76	85	70	59	43	64	58	49	41
HCV	74	63	63	74	61	59	51	55	40	36	41
Syphilis	36	23	21	16	15	20	19	18	21	16	20

Source: The Rotunda Hospital (2019)

Table 1: Deliveries to mothers attending the DOVE Service who were positive for HIV, HBV, HCV or syphilis, or who were attending the drug liaison midwife, 2018

Mother's status	HIV-positive	HBV-positive	HCV-positive	Syphilis-positive	DLM
Total mothers delivered	30	48	42	16	61
Total mothers delivered <500 g (incl. miscarriage)	0	0	1	0	0
Total mothers delivered >500 g	30	48	41	16	61
Live infants	31*	48	43***	16	63***
Miscarriage	0	0	1	0	0
Stillbirth	0	0	0	0	0
Infants <37 weeks' gestation	8	1	10	1	7
Infants ≥37 weeks' gestation	23	47	33	15	56
Caesarean section	15	17	15	5	15
HIV, HBV, HCV or syphilis-positive infants	0	0**	0**	0	-
Maternal median age	34	31	32	34	-

Source: The Rotunda Hospital (2019)

* One set of twins.
** Final serology test not yet available for all infants.
*** Two sets of twins.
DLM = drug liaison midwife.

Seán Millar

1 The Rotunda Hospital (2019) *The Rotunda Hospital Dublin annual report 2018.* Dublin: The Rotunda Hospital.

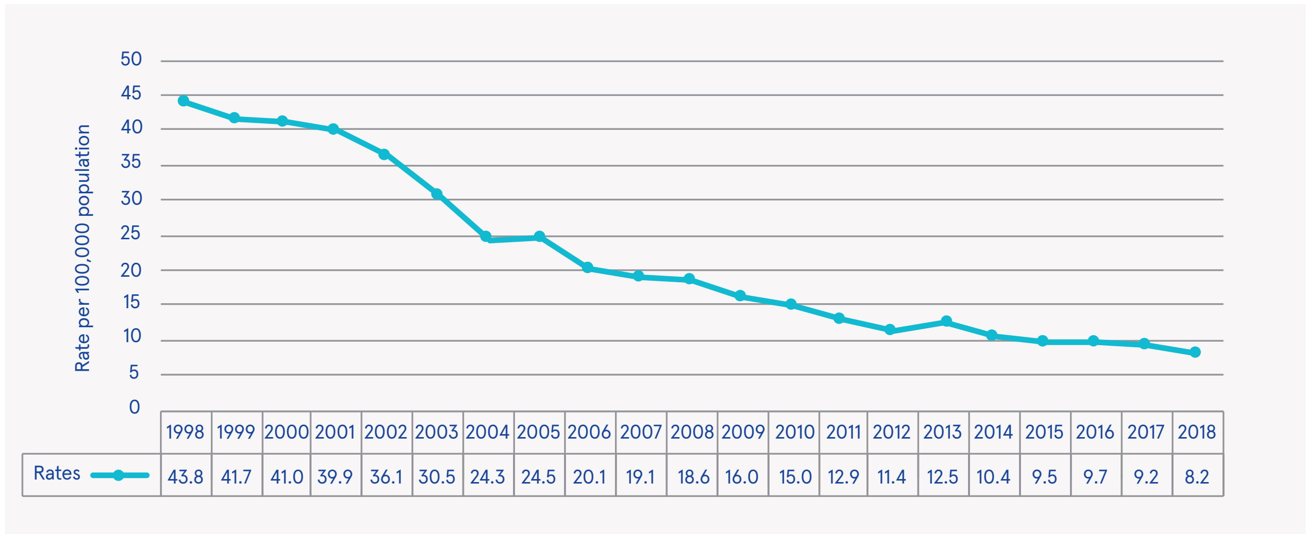
Trends in alcohol and drug admissions to psychiatric facilities

The annual report published by the Mental Health Information Systems Unit of the Health Research Board, *Activities of Irish psychiatric units and hospitals 2018*,[1] shows that the rate of new admissions to inpatient care for alcohol disorders has decreased.

In 2018, some 1,086 cases were admitted to psychiatric facilities with an alcohol disorder, of which 389 were treated for the first time. Figure 1 presents the rates of first admission between 1998 and 2018 for cases with a diagnosis of an alcohol disorder. The admission rate in 2018 was lower than the previous year, and trends over time indicate an overall decline in first admissions. One-third of cases hospitalised for an alcohol disorder in 2018 stayed just under one week, while 33% of cases were hospitalised for between one and three months, similar to previous years.

In 2018, some 995 cases were admitted to psychiatric facilities with a drug disorder. Of these cases, 408 were treated for the first time. Figure 2 presents the rates of first admission between 1998 and 2018 of cases with a diagnosis of a drug disorder. Although the rate decreased slightly in 2018, there has been an overall increase in the rate of first admission with a drug disorder since 2011. It should be noted that the report does not present data on drug use and psychiatric comorbidity; therefore, it is not possible to determine whether or not these admissions were appropriate.

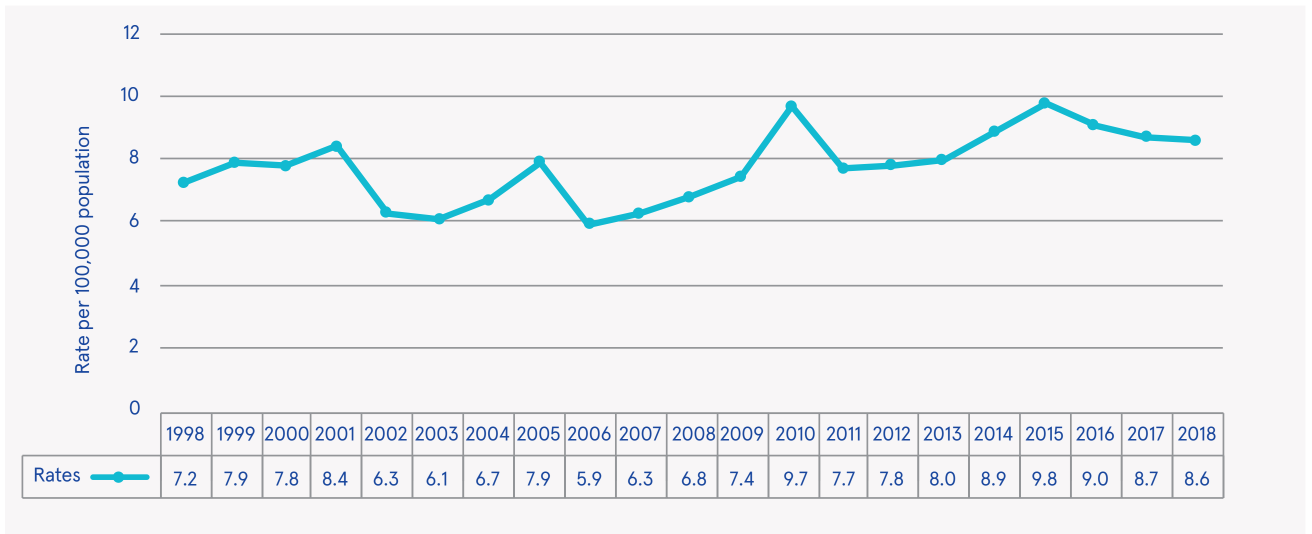
Figure 1: Rates of psychiatric first admission of cases with a diagnosis of an alcohol disorder per 100,000 of population in Ireland, 1998–2018



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Rates	43.8	41.7	41.0	39.9	36.1	30.5	24.3	24.5	20.1	19.1	18.6	16.0	15.0	12.9	11.4	12.5	10.4	9.5	9.7	9.2	8.2

Source: Daly and Craig (2019)

Figure 2: Rates of psychiatric first admission of cases with a diagnosis of a drug disorder per 100,000 of population in Ireland, 1998–2018



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Rates	7.2	7.9	7.8	8.4	6.3	6.1	6.7	7.9	5.9	6.3	6.8	7.4	9.7	7.7	7.8	8.0	8.9	9.8	9.0	8.7	8.6

Source: Daly and Craig (2019)

Admissions to psychiatric facilities

continued

Other notable statistics on admissions for a drug disorder in 2018 include the following:

- Less than one-half of cases hospitalised for a drug disorder stayed under one week (48%), while 99% were discharged within three months. It should be noted that admissions and discharges represent episodes or events and not persons.
- 17% of first-time admissions were involuntary.
- Similar to previous years, the rate of first-time admissions was higher for men (13.8 per 100,000 population) than for women (3.5 per 100,000 population).

Seán Millar

1 Daly A and Craig S (2019) *Activities of Irish psychiatric units and hospitals 2018.* Dublin: Health Research Board. https://www.drugsandalcohol.ie/30746/

National Self-Harm Registry annual report, 2018

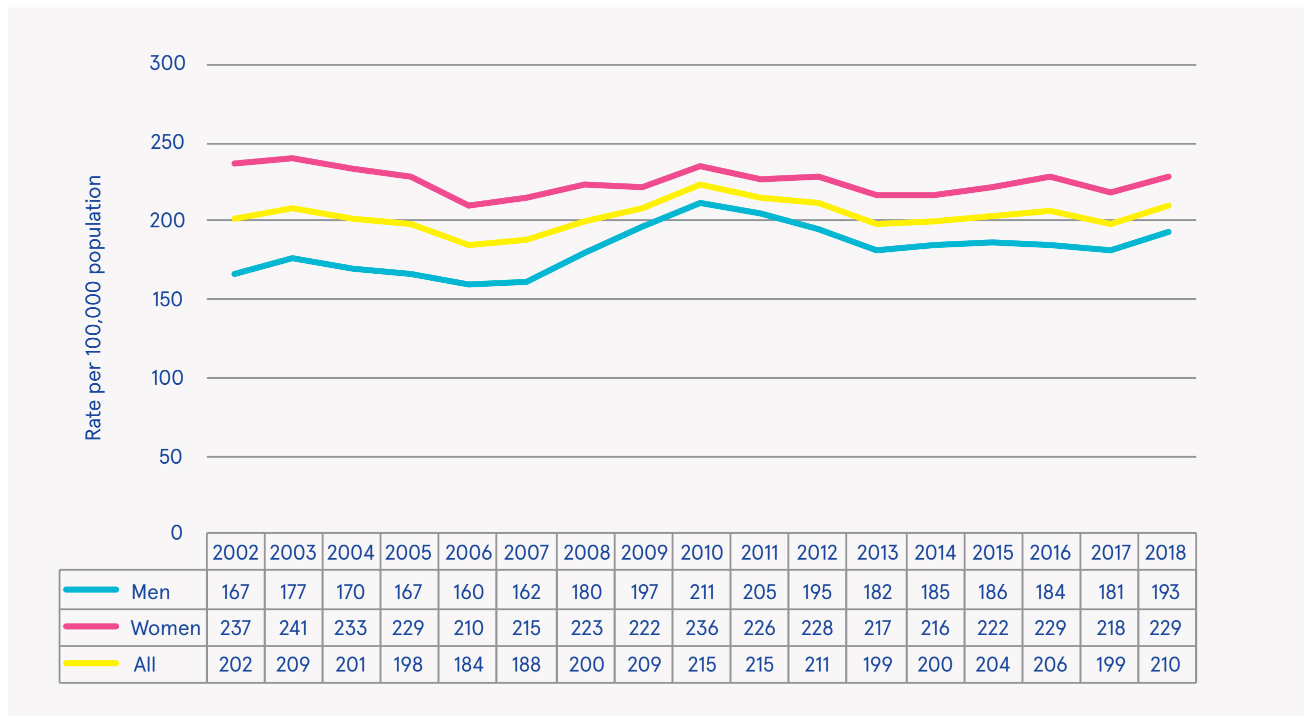
The 17th annual report from National Self-Harm Registry Ireland was published in 2019.[1] The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in Ireland in 2018 and complete national coverage of cases treated. All individuals who were alive on admission to hospital following deliberate self-harm were included, along with the methods of deliberate self-harm that were used. Accidental overdoses of medication, street drugs, or alcohol were not included.

Rates of self-harm

There were 12,588 recorded presentations of deliberate self-harm in 2018, involving 9,785 individuals. Taking the population into account, the age-standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm was 210 per 100,000 population. This was a significant increase of 6% compared with the rate recorded in 2017 (199 per 100,000 population). The rate in 2018 was 12% higher than in 2007, the year before the economic recession (see Figure 1).

In 2018, the national male rate of self-harm was 193 per 100,000 population, 7% higher than in 2017. The female rate was 229 per 100,000 population, which was 5% higher than in 2017. With regard to age, the peak rate for men was in the 20–24-age group, at 543 per 100,000 population. The peak rate for women was among 15–19-year-olds, at 766 per 100,000 population.

Figure 1: Person-based rate of deliberate self-harm from 2002 to 2018 by gender



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Men	167	177	170	167	160	162	180	197	211	205	195	182	185	186	184	181	193
Women	237	241	233	229	210	215	223	222	236	226	228	217	216	222	229	218	229
All	202	209	201	198	184	188	200	209	215	215	211	199	200	204	206	199	210

Source: National Suicide Research Foundation (2019)
'All' in the legend refers to the rate for both men and women per 100,000 population.

National Self-Harm Registry annual report, 2018

continued

Self-harm and drug and alcohol use

Intentional drug overdose was the most common form of deliberate self-harm reported in 2018, occurring in 7,792 (61.9%) of episodes. As observed in 2017, overdose rates were higher among women (66.9%) than among men (55.8%). Minor tranquillisers and major tranquilisers were involved in 35% and 10% of drug overdose acts, respectively. In total, 34% of male and 48% of female overdose cases involved analgesic drugs, most commonly paracetamol, which was involved in 30% of all drug overdose acts. In 69% of cases, the total number of tablets taken was known, with an average of 29 tablets taken in episodes of self-harm that involved a drug overdose.

In 2018, there was an increase in the number of self-harm presentations to hospital involving street drugs by 27% (from 583 to 742). Since 2007, the rate per 100,000 of intentional drug overdose involving street drugs has increased by 54% (from 9.9 to 15.3 per 100,000 population). Cocaine and cannabis were the most common street drugs recorded by the registry in 2018, present in 5% and 3% of overdose acts, respectively. Cocaine was most common among men, involved in 15% of overdose acts by 25–34-year-olds. Cannabis was most common among men aged 5–24 years old, and was present in 8% of overdose acts. Alcohol was involved in 30% of all self-harm presentations in 2018, and was significantly more often involved in male episodes of self-harm than females (34% vs 27%, respectively).

Street drugs and self-harm

The sharp increase in the use of street drugs involved in self-harm presentations in 2018 – in particular cannabis – was discussed. A recent systematic review and meta-analysis found that cannabis consumption in adolescence was associated with increased risk of developing major depression in young adulthood, and an increased risk of suicidal ideation and suicide attempts in young adulthood.[2] The report authors suggest that public health policies to address the use of illegal substances should be further developed.

Seán Millar

1 Griffin E, McTernan N, Wrigley C, *et al.* (2019) *National Self-Harm Registry Ireland annual report 2018*. Cork: National Suicide Research Foundation. https://www.drugsandalcohol.ie/31193/

2 Gobbi G, Atkin T, Zytynski T, *et al.* (2019) Association of cannabis use in adolescence and risk of depression, anxiety, and suicidality in young adulthood: a systematic review and meta-analysis. *JAMA Psychiatry*, 76(4): 426–434.

New clinical guidelines for management of opioid substitution in hospital setting

In December 2016, the Health Service Executive (HSE) launched its clinical guidelines for opioid substitution treatment (OST)[1] in conjunction with the College of Psychiatrists of Ireland, the Irish College of General Practitioners, and the Pharmaceutical Society of Ireland. Appropriate policies and standard operating procedures for the delivery of inpatient OST are essential for patient safety when treating a person with an opioid dependency.

Following the publication of those guidelines, it became apparent that there was a need for a specific set of guidelines covering inpatient aspects for the prescribing and dispensing of OST within the hospital setting.[2]

Having identified the specific need for guidance within the hospital setting, the new document is an adjunct to *Clinical guidelines for opioid substitution treatment*. It is divided into seven sections, each covering the different aspects of OST treatment: the guiding principles; rehabilitation and psychosocial components of OST; principles and key operational stages of pharmacological interventions of OST; assessment of dependence and management of OST; drug testing; OST and associated health considerations; and specific treatment situations and populations.[3,4]

A brief summary of the key points specific to the hospital setting is provided below.

OST in hospital setting

- The main objective of drug treatment in hospital is to stabilise drug misuse as quickly as possible in order to treat a drug-related or non-drug-related condition.
- Occasionally, patients may use the opportunity afforded by a hospital admission to reduce their drug use or to complete a detoxification. This may be useful, but if unplanned, it is likely to result in relapse upon leaving hospital, in turn exposing the patient to a higher risk of overdose.
- Transfer of care upon both admission and discharge require a coordinated response by treating staff.
- Routine planned admissions to hospital are preferable.
- Acute hospital settings and mental health inpatient units should have access to naloxone in case of opioid overdose.
- Substitute opioids or other controlled drugs should only be prescribed following a comprehensive assessment.

OST guidelines continued

Assessment aims

1. Facilitate treatment of an emergency or acute problem or for an elective procedure to take place
2. Confirm the patient is taking drugs (history, examination, urinalysis)
3. Identify any complications of drug misuse and evaluate risk behaviours (blood-borne viral screening, nutrition, alcohol intake)
4. Consider psychiatric comorbidity.

Patients currently being prescribed methadone or buprenorphine

Prescribing should be a straightforward continuation of the patient's usual dose of OST while in hospital. Communication between the hospital and community is vital for safe patient care. The Central Treatment List (CTL) should be contacted to confirm that the patient is receiving OST. The CTL is available 9am–5pm, Monday to Friday, at 01 648 8638.

- Confirmation of the dose by the patient alone is not adequate.
- Confirmation of the last dose received at the clinic should be sought by contacting the clinic or dispensing pharmacy directly.

Patients not receiving OST

Where there is uncertainty about recent compliance, care must be exercised when initiating OST. Local drug treatment services should be contacted upon initiation to ensure continuity of care upon discharge.

Initial dosing schedule for opioid-dependent patients admitted to hospital

- OST should only be prescribed following an assessment.
- Polydrug and alcohol misusers may develop multiple withdrawal syndromes, so these may need to be discerned in order to prioritise treatment.
- Methadone may initially mask alcohol or benzodiazepine withdrawal symptoms.
- Care should be exercised when prescribing additional drugs, such as sedatives, to individuals who may also be using illicit substances. Interactions between street drugs and psychotropic drugs should always be considered.
- Clinicians should refer to a relevant text, such as Maudsley Prescribing Guidelines (2018).[5]
- Where it is appropriate to initiate opioid substitution in hospital to reduce risk of withdrawal, methadone or buprenorphine can be used.
- OST induction should always follow the methadone treatment protocol (MTP). However, close supervision in hospital may allow for a modified protocol.
- Signs of intoxication, such as drowsiness, slurred speech, or pupil constriction, indicate the need to discontinue or reduce the dose of the drug.
- Hospitals should contact the CTL before prescribing buprenorphine products to ensure continuity post-discharge, as HSE approval is required before buprenorphine products can be reimbursed in the community setting.

Other drugs of misuse

Opioid-dependent patients in hospital may be taking other drugs and misusing alcohol.

- Misuse of benzodiazepines or alcohol could lead to associated withdrawal symptoms and seizures.
- Benzodiazepine prescribing should only be initiated once the level of dependence has been established through history taking and noting any symptoms of withdrawal.

Within the inpatient setting, it is appropriate to provide a withdrawal regimen over one to four weeks, with a starting dose of diazepam no more than 30 mg daily, administered in divided doses.

- For useful tools and schedules, see the 2016 community detoxification guidelines issued by Ana Liffey Drug Project.[6]
- Routine prescribing of benzodiazepines, Z-drugs, or gabapentinoids should be avoided while in hospital, especially the use of pregabalin as an anxiolytic.
- Patients may also need a simultaneous detoxification from alcohol.

Pain management

Management of patients if nil by mouth (NPO).[7]

- Specialist advice should be sought from the anaesthetist for perioperative and NPO instructions.
- Postoperatively methadone should be restarted once the NPO instruction has been removed.
- Should the NPO instruction remain postoperatively, both potential opioid withdrawal and pain should be managed using a conventional opioid, such as morphine injection/infusion. Intravenous methadone should not be used instead of the oral methadone due to differences in dose equivalence by route of administration.
- If monitoring indicates the patient may be in opioid withdrawal or pain, referral to a specialist pain team may be required.

Discharge from hospital

For drug misusers not previously in treatment, attendance at the emergency department or hospital admission may present a window of opportunity to put them in touch with other services. It is essential to link with services well in advance of discharge to ensure continuity of care. This is in line with the HSE Code of Practice for Hospital Integrated Discharge Planning.

On discharge, the following information should be given:

- General health promotion advice
- Contact details for further help, such as needle exchange, drug treatment services, or self-help groups. (Refer to the directory of services for your area on www.drugs.ie)
- Advice on overdose prevention
- Advice on reducing the risk of blood-borne viruses and hepatitis B vaccination
- Advice on loss of tolerance in hospital.

OST guidelines continued

Where a patient is receiving an opioid prescription upon admission from the community, this should be continued on discharge with prescribing responsibility transferring back to the GP or HSE addiction clinic. Discharge planning is best done in collaboration with local drug treatment services, the GP, and the community pharmacy.

On the day of discharge, confirm the following with the community services:

- Patients should receive their substitution dose on the day of discharge; their clinic or GP and community pharmacy should be contacted to confirm they have received that day's dose.
- Details of other drugs prescribed while an inpatient should be provided.
- Prior to discharge, confirmation should be provided that the patient is registered with a methadone-prescribing GP and a community pharmacy for continuation of OST.

Suzi Lyons

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

2 Health Service Executive (2020) *Clinical guidelines for opioid substitution treatment*: *guidance document for OST in the hospital setting* Dublin: Health Service Executive. https://www.drugsandalcohol.ie/31766/

3 Note that the prescription of OST in hospital settings is covered under the Misuse of Drugs (Supervision of Prescription and Supply of Methadone and Medicinal Products containing Buprenorphine authorised for Opioid Substitution Treatment) Regulations 2017. The regulations add certain buprenorphine medicinal products authorised for OST to the schedule of products that fall within the scope of these regulations. These regulations replace the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998 (SI No. 225 of 1998).

4 Lyons S (2017) New clinical guidelines for opioid substitution treatment. *Drugnet Ireland*, 62: 27–30. https://www.drugsandalcohol.ie/27752/

5 Taylor DM, Barnes TRE and Young AH (2018) *The Maudsley prescribing guidelines in psychiatry,* 13th edn. Chichester: Wiley Blackwell.

6 Ana Liffey Drug Project (2016) *National community detoxification: methadone guidelines*. Dublin: Ana Liffey Drug Project. https://www.drugsandalcohol.ie/26888/

7 British Pain Society (2007) *Pain and substance misuse: improving the patient experience. A consensus statement prepared by the British Pain Society in collaboration with the Royal College of Psychiatrists, the Royal College of General Practitioners and the Advisory Council on the Misuse of Drugs*. London: British Pain Society. https://www.drugsandalcohol.ie/6343/

National Drugs Library

UPDATES

Recent publications

PREVALENCE AND CURRENT SITUATION

Competing priorities and second chances – a qualitative exploration of prisoners' journeys through the hepatitis C continuum of care

Crowley D, Cullen W, Lambert JS and Van Hout MC (2019) *PLoS ONE*, 14(9): e0222186.
https://www.drugsandalcohol.ie/31836/

This study aimed to explore Irish prisoners' experience of prison and community-based HCV [hepatitis C virus] care. We conducted one-to-one interviews with 25 male prisoners with chronic HCV infection. Data collection and analysis was informed by grounded theory.

The study generated a substantive theory of the need to increase the importance of HCV care among the routine competing priorities associated with the lives of PWID [people who inject drugs]. HCV infected prisoners often lead complex lives and understanding their journeys through the HCV continuum can inform the development of meaningful HCV care pathways. Many challenges exist to optimising HCV treatment uptake in this group and incarceration is an opportunity to successfully engage HCV infected prisoners who underutilise and are underserved by community-based medical services. Support and linkage to care on release is essential to optimising HCV management.

Assessing the European impact of alcohol misuse and illicit drug dependence research: clinical practice guidelines and evidence-base policy

Pallari E, Soukup T, Kyriacou A and Lewison G (2020) *Evidence-Based Mental Health*, 23(2): 67–76.
https://www.drugsandalcohol.ie/31815/

This study sought to (1) evaluate European research outputs on alcohol misuse and drug addiction in 2002–2018 in the Web of Science, (2) compare these with their burden of disease and (3) determine their impact in several ways.

The volume of research on illicit drug addiction is commensurate to the European burden, whereas alcohol misuse is far below what is needed to curb a significant source of harm.

The research asymmetries call for attention to the causes of the problem. Development of research-based solutions to a serious social harm is needed, including minimum pricing and collaborative work to harmonise efforts on disease management and treatment practices across European countries.

Trends in the use of mind-altering drugs among European adolescents during the Great Recession

Balbo N, Carpella P and Toffolutti V (2020) *Health Policy,* 124(5): 568–574.
https://www.drugsandalcohol.ie/31775/

This study uses data on adolescents between 15 and 17 years old from 25 European countries to test, if and how, the substance-use pattern has changed during the Great Recession.

Social protection expenditure reduces the use of inhalants, whereas ecstasy consumption rises. The pattern for cocaine is unclear.

Memory and attention during an alcohol hangover

Devenney LE, Coyle KB and Verster JC (2019) *Human Psychopharmacology*, 34(4): e2701.
https://www.drugsandalcohol.ie/31736/

This study aims to investigate attention, memory functioning, and mood in a natural setting with real-life alcohol consumption levels.

Selective attention was significantly impaired during alcohol hangover. The differences between the hangover and control group did not reach significance for other forms of attention or memory.

Media coverage of major sporting events: alcohol, crowd shots and the Rugby World Cup 2019

Houghton F and McInerney D (2020) *Irish Journal of Medical Science*, Early online.
https://www.drugsandalcohol.ie/31703/

This examination focuses on Raidió Teilifís Éireann (RTÉ) coverage of the recent Rugby World Cup match between Ireland and New Zealand on Saturday, 19 October 2019.

Recent publications continued

Factors associated with requests for premature discharge and the decision to support a service user through the discharge against medical advice process

Kavanagh A, Donnelly J, Dunne N, Maher T, Nichol M and Creedon J (2020) *International Journal of Mental Health Nursing,* 29(4): 716–724.
https://www.drugsandalcohol.ie/31702/

This study is a retrospective review of clinical records to identify factors associated with requests for premature discharge. Considerations of clinicians making the decision to detain the person or to support them through the discharge against medical advice process were also elucidated. Data were collected from clinical records of service users who requested discharge and were subsequently discharged against medical advice or detained involuntarily.

Discharge against medical advice represented 3.5% of all discharges. The most frequent reasons for requests for discharge against medical advice were dissatisfaction with treatment, lack of engagement due to addiction, and leaving without notifying staff. Requests for discharge against medical advice frequently occurred out of hours, and nurses were the clinicians most likely to receive such requests.

Adding more 'spice' to the pot: a review of the chemistry and pharmacology of newly emerging heterocyclic synthetic cannabinoid receptor agonists

Alam RM and Keating JJ (2020) *Drug Testing and Analysis*, 12(3): 297–315.
https://www.drugsandalcohol.ie/31691/

At present, little information is available regarding the chemical syntheses of the newly emerging classes of synthetic cannabinoid receptor agonists (SCRAs), from a clandestine perspective.

When compared with previous generations of indole- and indazole-type SCRAs, current research suggests that many of these heterocyclic SCRA analogs maintain high affinity and efficacy at both CB_1 and CB_2 (cannabinoid receptor type 1 and 2) but largely evade legislative control. This review highlights the importance of continued research in the field of SCRA chemistry and pharmacology, as recreational SCRA use remains a global public health issue and represents a serious control challenge for law enforcement agencies.

A descriptive survey of online gaming characteristics and gaming disorder in Ireland

Columb D, Griffiths MD and O'Gara C (2020) *Irish Journal of Psychological Medicine*, Early online, pp. 1–9.
https://www.drugsandalcohol.ie/31665/

The aim of this study was to carry out the first ever study of gaming characteristics of individuals engaging in online gaming in Ireland and to ascertain whether features of gaming disorder are present in this population.

A small percentage of gamers in Ireland demonstrate disordered gaming characteristics and gaming disorder, consistent with data from other international studies. Epidemiological studies are required in Ireland to enhance our knowledge of this disorder.

High-cost, high-need users of acute unscheduled HIV care: a cross-sectional study

Grant C, Bergin C, O'Connell S, Cotter J and Ní Cheallaigh C (2020) *Open Forum Infectious Diseases*, 7(2): ofaa037.
https://www.drugsandalcohol.ie/31664/

High-cost, high-need users are defined as patients who accumulate large numbers of emergency department visits and hospital admissions that might have been prevented by relatively inexpensive early interventions and primary care. This phenomenon has not been previously described in HIV-infected individuals.

A small number of HIV-infected individuals account for a high volume of acute unscheduled care. Intensive engagement in outpatient care may prevent some of this usage and ensuing costs.

Journeying with fear: young people's experiences of cannabis use, crime and violence before treatment entry

Comiskey C, James P and Smyth B (2020) *Journal of Child and Adolescent Psychiatric Nursing*, 33(2): 61–66.
https://www.drugsandalcohol.ie/31639/

The experiences of crime and policing from the perspective of adolescent cannabis users before treatment entry are not often understood by practitioners.

Findings of this study highlight the commonality of fear and the seriousness of personal and familial violent harms. The need for targeted developmental preventions in vulnerable settings is proposed. Parents and professionals need to have an awareness of money in the home and the role of intergenerational substance use.

Do interruptions to the continuity of methadone maintenance treatment in specialist addiction settings increase the risk of drug-related poisoning deaths? A retrospective cohort study

Durand L, O'Driscoll D, Boland F, Keenan E, Ryan B, Barry J, *et al.* (2020) *Addiction,* Early online.
https://www.drugsandalcohol.ie/31615/

This study aimed to examine the risk of mortality associated with interruptions to the continuity of methadone maintenance treatment (MMT), including transfers between services, in opioid-dependent individuals attending specialist addiction services.

Interruptions to the continuity of methadone maintenance treatment by treatment provider do not appear to be periods of risk for drug related poisoning or all-cause mortality deaths. Risk of drug related poisoning and all-cause mortality deaths appears to be greatest during the first four weeks of treatment initiation/re-initiation and after treatment cessation.

Recent publications continued

Risk and protective factors for psychotic experiences in adolescence: a population-based study

McMahon EM, Corcoran P, Keeley H, *et al.* (2020) *Psychological Medicine*, Early online, pp. 1–9.
https://www.drugsandalcohol.ie/31608/

The aims of this study were to examine associations between psychotic experiences (PEs) and a range of factors including psychopathology, adversity and lifestyle, and to investigate mediating effects of coping style and parental support on associations between adversity and PEs in a general population adolescent sample.

We have identified potential risk factors for PEs from multiple domains including adversity, mental health and lifestyle factors. The mediating effect of parental support on associations between adversity and PEs suggests that poor family relationships may account for some of this mechanism. These findings can inform the development of interventions for adolescents at risk.

Association between electronic cigarette use and smoking cessation in the European Union in 2017: analysis of a representative sample of 13 057 Europeans from 28 countries

Farsalinos KE and Barbouni A (2020) *Tobacco Control*, Early online.
https://www.drugsandalcohol.ie/31605/

This study aimed to examine the association between electronic cigarette (e-cigarette) use and smoking cessation in the European Union (EU) in 2017 according to e-cigarette use frequency and smoking cessation duration.

Current daily e-cigarette use in the EU in 2017 was rare among former smokers of >10 years and was positively associated with recent (≤5 years) smoking cessation. Former daily e-cigarette use was also positively associated with recent (≤2 years) smoking cessation.

POLICY

AIDS inside and out: HIV/AIDS and penal policy in Ireland and England & Wales in the 1980s and 1990s

Weston J and Berridge V (2020) *Social History of Medicine,* 33(1): 247–267.
https://www.drugsandalcohol.ie/31606/

This article compares the policy decisions made by the prison services of the Republic of Ireland and England & Wales in response to HIV/AIDS in the 1980s and 1990s, bringing together the histories of penal policy and HIV/AIDS for the first time. It develops our understanding of contemporary policy history, and demonstrates the value of a comparative approach to both penal and health histories. Policy-making was shaped by both national and more localised traditions and trends, from attitudes to criminal justice and responses to HIV/AIDS at the national level, to the histories, structures, and staffing of prison services themselves.

Enhancing implementation of smoke-free places: a comparative qualitative study across seven European cities

Mlinarić M, Hoffmann L, Lindfors P and Richter M (2020) *Social Science & Medicine*, 247: 112805.
https://www.drugsandalcohol.ie/31599/

The aim of this qualitative comparative study is to identify and classify the smoke-free (SF) policy implementation processes and types undertaken at the local level in seven European cities according to the views of local bureaucrats and sub-national stakeholders.

This study found four SF implementation types two mechanisms of progressive expansion and defensive closure. Development and enhancement of smoking bans requires a suitable national policy environment and indirect national-level support of self-governed local initiatives. Future SF policies can be enhanced by laws pertaining to places frequented by minors.

Recent publications continued

RESPONSES

Methadone, Pierre Robin sequence and other congenital anomalies: case–control study

Cleary B, Loane M, Addor M-C, *et al.* (2020) *Archives of Disease in Childhood* (Fetal and Neonatal edn), 105(2): 151–157.
https://www.drugsandalcohol.ie/31690/

Methadone is a vital treatment for women with opioid use disorder in pregnancy. Previous reports suggested an association between methadone exposure and Pierre Robin sequence (PRS), a rare craniofacial anomaly. We assessed the association between gestational methadone exposure and PRS.

The findings suggest that gestational methadone exposure is associated with PRS. The association may be explained by unmeasured confounding factors. The small increased risk of PRS in itself does not alter the risk-benefit balance for gestational methadone use. The association with cleft palate, a more common CA [congenital anomalies], should be assessed with independent data.

Electronic cigarettes and obstetric outcomes: a prospective observational study

McDonnell BP, Dicker P and Regan CL (2020) *BJOG*, 127(6): 750–756.
https://www.drugsandalcohol.ie/31784/

This study aimed to compare the obstetric outcomes and socio-demographic factors in electronic cigarette (EC) users with cigarette smokers and non-smokers in pregnancy.

The birthweight of infants born to EC users is similar to that of non-smokers, and significantly greater than cigarette smokers. Dual users of both cigarettes and EC have a birthweight similar to that of smokers.

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

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

© Health Research Board, 2020

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