drugnet Ireland

In this issue

Review on treatment services for people who are homeless
See page **21–26**

Publication of EU Drugs Strategy 2021–2025

On 18 December 2020, the EU Drugs Strategy 2021–2025 was approved by the Council of Europe.[1] The strategy outlines the overarching political framework and priorities of the drugs policy of the European Union (EU) for the period.

The aim of the EU strategy is:

to protect and improve the well-being of society and of the individual, to protect and promote public health, to offer a high level of security and well-being for the general public and to increase health literacy. The strategy takes an evidence-based, integrated, balanced and multidisciplinary approach to the drugs phenomenon at national, EU and international level. It also incorporates a gender equality and health equity perspective. (p. 2)[1]

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Contents

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

Governments have always planned for the future, with varying degrees of success. However, the State's efforts to anticipate the needs of future generations rarely capture the imagination of populations more focused on current economic conditions, access to public services, and social stability. The events of 2020/2021 may signal a shift in the priorities of electorates. There has been a move towards climate realism in wealthier countries and a recognition of the need to prepare for the next pandemic. Making changes now to avert possible catastrophes decades in the future is no longer seen as a distraction from current policy concerns, but as an inevitable and core part of the State's responsibilities to its present and future citizens.

These are global concerns and the response will have to be based on multilateralism and compromise, and the policies of individual nation states will largely be defined by goals set at an international level. Of course, individual states make detailed projections and decisions now that will have economic, social, and environmental impacts far into the future. But the idea of imagining the full range of possible scenarios across all policy areas, and developing the capacity to decide how these may impact resource allocation, is a relatively new one.

This is the aim of strategic forecasting. It is an approach to policymaking that attempts to manage uncertainty by identifying a number of possibilities. Governments, institutions, non-governmental organisations, and other national and international collective entities can develop anticipatory capacity by making better use of what is known already. Naturally, data are important but just as important is the wisdom of those who have spent many years learning about and working with current social and environmental problems. The discipline of strategic foresight puts particular emphasis on harnessing existing knowledge, not just from datasets but also from the minds of those most active, committed, and thoughtful.

The current European Commission has accorded strategic foresight an important position in the management of European Union (EU) policy implementation, which is evident in the recently published *EU Drugs Strategy 2021–2025*, the topic of two articles in this issue. Other international institutions, such as the Organisation for Economic Co-operation and Development (OECD) and the United Nations Educational, Scientific and Cultural Organization (UNESCO), have embraced strategic foresight. There is, as yet, no evidence of this approach in Irish strategies or policy documents, but it is likely to become more important to policymakers in the next few years. Strategic foresight does not involve attempting to predict the future, but rather systematically examining current sources of information to imagine possible developments and consider what this means for current policymaking. Methods include horizon scanning to identify weak signals of change; megatrends analysis to explore global changes and their implications for local policy; and scenario planning and working back from an image of the future to decide the steps to achieve or avoid such an outcome.

Drug use patterns can alter rapidly in response to societal change or movements in popular culture. In the past, governments have used emergency measures with unpredictable outcomes to deal with this. Strategic forecasting, building on careful analysis of emerging trends data, may provide the opportunity to ensure society is better prepared when sudden change happens in the future.

EU Drugs Strategy 2021–2025
continued

This article describes the background to the new strategy, some of its key features, and how it compares with the EU's 2013–2020 strategy.[2] It also comments on the continuing alignment with Ireland's national drugs strategy.[3]

Background to strategy

The EU Drugs Strategy 2021–2025 sets out to meet its aim by providing a common and evidence-based framework within which to respond to what it terms the drugs phenomenon, within and outside the EU.

The strategy is underpinned by the principles of EU law and its founding values (respect for human dignity, liberty, democracy, equality, solidarity, the rule of law, and human rights) and is aligned with relevant European and international laws and policies. Some of the international legal and policy documents cited by the strategy as being aligned with are the United Nations (UN) Conventions,[4] the 2016 UNGASS outcome document,[5] relevant goals of the 2030 Agenda for Sustainable Development,[6] and the International Guidelines on Human Rights and Drug Policy[7]: 'All women, men and children, including people with drug-use disorders, have the right to enjoy the highest attainable standard of physical and mental health, including freedom from violence' (p. 3).[1]

Development of strategy

The strategy is the latest in a line of EU drugs policy documents, the first of which was published in 1990.[8] Figure 1 presents a timeline of these documents. Since the EU Drugs Strategy 2000–2004,[9] there has been a policy cycle in which a strategy is agreed and adopted, a linked action plan is developed to support its delivery, and these are subsequently evaluated to inform the development of the next strategy. The first strategy evaluation was carried out in 2004[10] and the first external evaluation in 2012.[11]

Each strategy is developed through a rigorous process in which member states work together to develop the strategic approaches in a series of negotiations, evaluations, and compromises so that consensus can be reached in the form of a new strategy document.[12] This process has become increasingly evidence based. The strategy is underpinned by various evidence sources (including evaluations of the previous strategy) as well as relevant EU and international law and policy documents.

Source: Based on EMCDDA (2019) p. 4[12]

Figure 1: New timeline of EU strategies, action plans, and evaluations

EU Drugs Strategy 2021–2025
continued

Structure of strategy

The new strategy is a well-structured document and more detailed than its predecessors. It contains more detail on its strategic priorities and how it proposes to address these. Unlike the 2013–2020 strategy that was structured around two policy areas (drug demand reduction and drug supply reduction), the new strategy is structured around three:

I   Drug supply reduction: enhancing security

II   Drug demand reduction: prevention, treatment, and care services

III Addressing drug-related harm

These are supported by three cross-cutting themes that reflect those in the earlier strategy:

IV   International cooperation

V   Research, innovation, and foresight

VI   Coordination, governance, and implementation.

Eleven strategic priorities underpin these policy areas and themes, with a list of priority areas to address. See the accompanying article, 'EU Drugs Strategy 2021–2025: policy areas, themes, and strategic priorities', on page 7, for a full list.

Focus of new strategy

While a more comprehensive document than its predecessors, the new strategy signals a continuation in the overall direction for the EU in its approach through a balance of supply and demand reduction activities. However, there appears to be an increased focus on the consequences of drug use and its related harms, which is apparent in a new policy area on 'addressing drug-related harm'. It focuses on measures and policies aimed at preventing or reducing the health and social risks and harms for people who use drugs, for society, and for those in prison settings.

Most of the priority areas contained in the strategy (including in the new policy area 'addressing drug-related harm') are not new to EU drug policy. However, they are presented in more detail which illustrates with greater clarity both the EU's position and how the drug landscape has evolved since the previous strategy was published in 2012. For example, drug markets have changed significantly. Dealing with the use of social media platforms, apps, and internet/darknet marketplaces for the sale of illicit drugs and the associated payment systems has become a priority area for the EU. There has been an increase in drug-related violence which is also reflected in the new strategy. For example, the need to recognise the impact of drug-related crime, particularly on communities, and to counter the exploitation of children by organised crime groups is acknowledged. An example of a completely new issue to feature in the strategy is environmental crime related to illicit drug production and trafficking. This relates to the environmental impacts, hazards to health, and costs associated with the chemical waste generated by illicit synthetic drug production, as well as the handling and destruction of seized substances.

Alignment with Irish drugs strategy

While the Department of Health did not set out to mirror the EU's 2013–2020 strategy when developing Ireland's national drugs strategy (2017–2025), there was significant overlap between the two. There continues to be close alignment with the new EU strategy, in the overarching goals and policy areas and in the objectives and strategic priorities. Ireland's drugs strategy reflects a similarly balanced approach to addressing both supply and demand reduction activities, although there is more emphasis in the Irish strategy on taking a health-led rather than a criminal-justice-led approach. Very similar priorities are identified across the board, including in the areas of prevention, treatment, harm reduction, rehabilitation/recovery/reintegration, drug markets, legislation, law enforcement, and drug monitoring. Given the move by the EU towards a strategy with an increased focus on health and drug-related harm, the strategies are now more

EU Drugs Strategy 2021–2025
continued

closely aligned. When welcoming the new EU strategy, Frank Feighan TD, Minister of State for Public Health, Wellbeing and the National Drugs Strategy, said that Ireland had advocated for this increased focus on health:[13]

I welcome the new focus on the health needs of people who use drugs in the EU strategy, which mirrors the health-led approach in our national strategy, Reducing Harming, Supporting Recovery. *Ireland strongly advocated for the inclusion of harm reduction in the strategy, along with traditional policies to reduce the supply and the demand for drugs.*[13]

Both strategies emphasise the importance of research and adopting an evidence-based approach to implementation. A strong commitment to upholding human rights underpins the EU's position and is also apparent in the Irish strategy. However, the language in the Irish strategy is framed around the health-led approach rather than using the language of human rights as such.

The Irish strategy explicitly aligns itself with the EU and other international partners on a range of activities: for example, on intercepting drugs – and precursors for diversion to the manufacture of drugs – being trafficked to Ireland, and on early warning and emerging trends networks. As part of an action to strengthen Ireland's drug monitoring system, the Irish strategy commits to using European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) protocols to monitor the drug situation and to be able to respond to new data monitoring requests from the EU. This national approach fits well with that outlined in the EU strategy.

Moving forward, this alignment is set to continue. Both the EU and Ireland are due to agree new action plans for the period from 2021 to deliver on their strategies. Minister Feighan has stated that there will be synergy between the two action plans:

The EU Drugs Strategy and the forthcoming action plan are very timely as it will inform the mid-term review of actions in the national drugs strategy. Ireland cannot address the drugs issue in isolation from our European colleagues. I want to ensure that there is a synergy between the EU and national strategies and to avail of the opportunities provided in the EU strategy to share learning and good practice between member states.[13]

Concluding comment
The new EU drugs strategy is a more comprehensive document than its predecessors. It signals an ongoing commitment to a balance of supply and demand reduction activities to address the drugs phenomenon, although an increased emphasis on addressing the consequences and harms of drug use is apparent. There is synergy in the approaches of Ireland and the EU, which would suggest having opportunities to collaborate and draw on the evidence base and experience of other European member states. The EU Action Plan on Drugs (2021–2025) currently being drawn up, and which is set to be adopted during Portugal's presidency of the EU later in 2021, will inform Ireland's action plan for the remainder of the national strategy's lifetime.

Lucy Dillon

1   Council of the European Union (2020) *EU drugs strategy 2021–2025.* Brussels: Council of the European Union.
    https://www.drugsandalcohol.ie/33750/

2   Council of the European Union (2012) *EU drugs strategy (2013–2020).* Brussels: Council of the European Union.
    https://www.drugsandalcohol.ie/19034/

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

4   These include the 1961 UN Single Convention on Narcotic Drugs, as amended by the 1972 Protocol; the 1971 UN Convention on Psychotropic Substances; and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

EU Drugs Strategy 2021–2025

continued

5   European Commission (2015) *European Union common position on UNGASS 2016*. Brussels: European Commission.
https://www.drugsandalcohol.ie/29224/

6   United Nations (2015) *Transforming our world: the 2030 Agenda for Sustainable Development*. New York: United Nations.
https://www.drugsandalcohol.ie/33751/

7   United Nations Development Programme (2019) *International guidelines on human rights and drug policy*. New York: United Nations Development Programme.
https://www.drugsandalcohol.ie/30447/

8   European Committee to Combat Drugs (CELAD) (1990) *European plan to combat drugs*. Brussels: European Council.
https://www.drugsandalcohol.ie/33749/

9   Council of the European Union (1999) *European Union drugs strategy (2000–2004)*. Brussels: Council of the European Union.
https://www.drugsandalcohol.ie/6104/

10   Commission of the European Communities (2004) *Communication from the Commission to the Council and the European Parliament on the results of the final evaluation of the EU drugs strategy and action plan on drugs (2000–2004)*. COM(2004)707 final. Brussels: Commission of the European Communities.
https://www.drugsandalcohol.ie/33757/

11   Culley DM, Skoupy J, Rubin J, Hoorens S, Disley E and Rabinovich L (2012) *Assessment of the implementation of the EU Drugs Strategy 2005–2012 and its Action Plans*. Santa Monica, CA: Rand Europe/European Commission Directorate General for Justice.
https://www.drugsandalcohol.ie/17312/

12   European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019) *The EU drugs strategy: a model for common action*. Lisbon: EMCDDA.
https://www.drugsandalcohol.ie/31190/

13   Department of Health (2021) *Minister Feighan welcomes the approval of the EU Drugs Strategy 2021–2025* [Press release]. 25 February 2021. Dublin: Department of Health. Available online at:
https://www.gov.ie/en/press-release/769c1-minister-feighan-welcomes-the-approval-of-the-eu-drugs-strategy-2021-2025/

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POLICY AND LEGISLATION

EU Drugs Strategy 2021–2025: policy areas, themes, and strategic priorities

This article outlines the policy areas, cross-cutting themes, and strategic priorities of the EU Drugs Strategy 2021–2025, as they appear in the published document.[1] The policy areas and themes are listed in Table 1.

Table 1: Policy areas and cross-cutting themes of EU Drugs Strategy 2021–2025

No.	Policy area
I	Drug supply reduction: enhancing security
II	Drug demand reduction: prevention, treatment, and care services
III	Addressing drug-related harm
IV	International cooperation
V	Research, innovation, and foresight
VI	Coordination, governance, and implementation

EU Drugs Strategy 2021–2025
continued

Policy area I: Drug supply reduction – enhancing security

An objective of the strategy is to respond, through an evidence-based approach, to the challenging development of European Union (EU) drug markets, which are characterised by high availability of various types of drugs, ever larger seizures, increasing use of violence, and huge profits. The strategy aims to contribute to the disruption of traditional and online illicit drug markets; the dismantling of organised crime groups involved in drug production and trafficking; efficient use of the criminal justice system; effective intelligence-led law enforcement; a reduction in the levels of violence associated with the illicit drug markets; and increased intelligence sharing to ensure a common approach on the part of all responsible stakeholders.

Strategic priority 1

Disrupt and dismantle high-risk drug-related organised crime groups operating in, originating in or targeting the EU member states; address links with other security threats and improve crime prevention.

Priority areas to address:

1.1 Target high-risk organised crime groups active across the EU and cross-border drug markets; set priorities in synergy with the EU policy cycle for organised and serious international crime (EMPACT)[2]; disrupt criminal business models, especially those that foster collaboration between different organised crime groups; and address links with other security threats.

1.2 Track, trace, freeze and confiscate the proceeds of and instruments used by organised crime groups involved in the illicit drug markets.

1.3 Prevent drug-related crime with particular focus on the need to counter violence, limit corruption, and address the exploitation of vulnerable groups by addressing the underlying factors that lead to their involvement in illicit drug markets.

Strategic priority 2

Increase the detection of illicit wholesale trafficking of drugs and drug precursors at EU points of entry and exit.

Priority areas to address:

2.1 Counter the smuggling of drugs and drug precursors in and out of the EU by using established legitimate trade channels.

2.2 Increase monitoring of border crossings that are not part of established trade channels to more effectively prevent illicit or undeclared crossings of the EU external borders.

Strategic priority 3

Tackle the exploitation of logistical and digital channels for medium- and small-volume illicit drug distribution and increase seizures of illicit substances smuggled through these channels in close cooperation with the private sector.

Priority areas to address:

3.1 Tackle digitally enabled illicit drug markets.

3.2 Target drugs trafficking via postal and express services.

3.3 Reinforce monitoring and investigation methods for cross-EU rail and fluvial channels and the general aviation space.

Strategic priority 4

Dismantle illicit drug production and counter illicit cultivation; prevent the diversion and trafficking of drug precursors for illicit drug production; and address environmental damage.

Priority areas to address:

4.1 Counter illicit production of synthetic drugs and illicit cultivation of drugs.

4.2 Tackle the diversion and trafficking of drug precursors and the development of alternative chemicals.[3]

4.3 Address environmental crime related to illicit drug production and trafficking.

EU Drugs Strategy 2021–2025
continued

Policy area II: Drug demand reduction – prevention, treatment, and care services

In the area of drug demand reduction, the objective of the strategy is to contribute to the healthy and safe development of children and young people and to a reduction in the use of illicit drugs. It aims to delay the age of onset, to prevent and reduce problem drug use, to treat drug dependence, to provide for recovery and social reintegration through an integrated, multidisciplinary, and evidence-based approach and by promoting and safeguarding coherence between health, social, and justice policies.

Strategic priority 5

Prevent drug use and raise awareness of the adverse effects of drugs.

Priority areas to address:

5.1   Provide, implement, and, where needed, increase the availability of evidence-based environmental and universal prevention interventions and strategies for target groups and environments, in order to increase resilience and strengthen life skills and healthy life choices.

5.2   Provide, implement, and, where needed, increase the availability of evidence-based targeted prevention interventions for young people and other vulnerable groups.

5.3   Provide, implement, and, where needed, increase the availability of evidence-based early intervention measures.

5.4   Disseminate the latest scientific evidence on prevention to decision-makers and practitioners and provide them with training.

5.5   Address drug-impaired driving.

Strategic priority 6

Ensure access to and strengthen treatment and care services.

Priority areas to address:

6.1   Ensure voluntary access to treatment and care services that work in close coordination and collaboration with other health and social support services.

6.2   Promote peer work.

6.3   Identify and remedy the barriers to accessing treatment and ensure and, where needed, extend coverage of treatment and care services based on individual needs.

6.4   Reduce stigma.

6.5   Widely implement treatment and care addressing the specific needs of women.

6.6   Implement models of care that are appropriate for groups with special care needs.

6.7   Provide and, where needed, improve access to availability and appropriate use of substances for medical and scientific purposes.

Policy area III: Addressing drug-related harm

The use of drugs may cause health and social harm to users but also to their family and the wider community. This policy area focuses on measures and policies that prevent or reduce the possible health and social risks and harm for users, for society, and in prison settings.

Strategic priority 7

Risk-reduction and harm-reduction interventions and other measures to protect and support people who use drugs.

Priority areas to address:

7.1   Reduce the prevalence and incidence of drug-related infectious diseases and other negative health and social outcomes.

7.2   Prevent overdoses and drug-related deaths.

7.3   Promote civil society participation and ensure sustainable funding.

7.4   Provide alternatives to coercive sanctions.

EU Drugs Strategy 2021–2025
continued

Strategic priority 8

Address the health and social needs of people who use drugs in prison settings and after release.

Priority areas to address:

8.1 Assure equivalence and continuity of healthcare provision in prison and by probationary services.

8.2 Implement evidence-based measures in prison settings to prevent and reduce drug use and its health consequences, including measures to address the risk of drug-related deaths and the transmission of blood-borne viruses.

8.3 Provide overdose prevention and referral services to ensure continuity of care on release.

8.4 Restrict the availability of drugs in prisons.

Cross-cutting theme IV: International cooperation

Strategic priority 9

Strengthening international cooperation with third countries, regions, international, and regional organisations, and at multilateral level to pursue the approach and objectives of the strategy, including in the field of development. Enhancing the role of the EU as a global broker for a people-centred and human rights-oriented drug policy.

Priority areas to address:

9.1 Continue shaping the international and multilateral agendas on drug policy.

9.2 Ensure a sustainable level of dialogue and information sharing on the strategies, aims, and relevant initiatives with third countries or regions.

9.3 Foster international cooperation by further involving competent EU agencies within their respective mandates.

9.4 Continue and establish new cooperation programmes with third countries or regions and other partners based on regular evaluations of such programmes.

9.5 Address all the policy aspects of the strategy in international cooperation, including in the fields of security and judicial cooperation as well as the health-related aspects of drugs issues.

9.6 Strengthen the commitment to development-oriented drug policies and alternative development measures.

9.7 Protect and promote adherence to international human right standards and obligations in global drug policies.

Cross-cutting theme V: Research, innovation, and foresight

Strategic priority 10

Building synergies to provide the EU and its member states with the comprehensive research evidence base and foresight capacities necessary to enable a more effective, innovative, and agile approach to the growing complexity of the drugs phenomenon, and to increase the preparedness of the EU and its member states to respond to future challenges and crises.

Priority areas to address:

10.1 Strengthen and broaden research capacities and encourage the greater sharing and use of results.

10.2 Foster innovation so that policy and actions shift from a reactive to a proactive mode.

10.3 Develop strategic foresight and a future-oriented approach.

10.4 Strengthen coordination and synergies, and support the central role of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Europol, and the Reitox network of national focal points in research, innovation, and foresight.

10.5 Ensure adequate financing for drug-related research, innovation, and foresight.

EU Drugs Strategy 2021–2025
continued

Cross cutting theme VI: Coordination, governance, and implementation

Strategic priority 11

Ensuring optimal implementation of the strategy and of the action plan, coordination by default of all stakeholders, and the provision of adequate resources at EU and national levels.

While this strategic priority does not have a list of specific priority areas to address, it is underpinned by 10 points for delivery.

Ten points for delivery

11.1 An action plan will be developed to guide delivery of the strategy.

11.2 Implementation should facilitate synergies and consistencies between EU and national level policies.

11.3 The strategy and action plan will be subject to external evaluation.

11.4 Appropriate and targeted resources should be allocated for the implementation of the objectives of this strategy at both EU and national level.

11.5 The European Commission will present a proposal to revise the mandate of the EMCDDA to ensure that the agency plays a stronger part in addressing the current and future challenges of the drug phenomenon. The EMCDDA and Europol should be provided with the relevant resources to enable them to fulfil their roles.

11.6 There should be coordination with agencies, bodies or organisations that have relevance for the drugs field, within their respective mandates both within and outside the EU.

11.7 The Horizontal Working Party on Drugs (HDG), as the main coordinating body on drug policy in the Council of the EU, should be kept informed of possible work linked to drugs issues, carried out by other preparatory bodies of the council.

11.8 Coordination and synergies should be sought between the drug policy and the other policies, including in the security and health areas.

11.9 Externally, the EU and its member states should promote the approach and objectives of the strategy with one voice.

11.10 The meaningful participation and involvement of civil society should be ensured in the development and implementation of drug policies, at national, EU, and international levels.

Compiled by Lucy Dillon

1 Council of the European Union (2020) *EU drugs strategy 2021–2025*. Brussels: Council of the European Union. https://www.drugsandalcohol.ie/33750/

2 Europol (2020) *EU policy cycle – EMPACT*. The Hague: Europol. Available online at: https://www.europol.europa.eu/empact

3 The term 'alternative chemicals' covers the wide range of substances variously referred to in both official and unofficial reports as 'designer precursor', 'masked precursor', 'pre-precursor', or 'masked drug'. See page 2 of European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019) *Drug precursor developments in the European Union*. Luxembourg: Publications Office of the European Union. https://www.drugsandalcohol.ie/31363/

Evaluation of EU Drugs Strategy 2013–2020

The new European Union (EU) Drugs Strategy 2021–2025[1] was published in December 2020 and is discussed in other articles in this issue of *Drugnet*. It is informed by the findings of the evaluation of the EU Drugs Strategy 2013–2020 and the EU Action Plan on Drugs 2017–2020, which was published in July 2020.[2,3]

The evaluation was one of a suite of documents launched as part of the European Commission's EU Security Union Strategy 2020–2025,[4] which considered drugs within the broader context of fostering security for all those living in Europe:

From combatting terrorism and organised crime, to preventing and detecting hybrid threats and increasing the resilience of our critical infrastructure, to promoting cybersecurity and fostering research and innovation, the strategy lays out the tools and measures to be developed over the next 5 years to ensure security in our physical and digital environment.[4]

Scope of the evaluation

The EU Drugs Strategy 2013–2020[5] was based on a five-pillar structure that consisted of two main policy areas – the reduction of both drug demand and supply – and three cross-cutting themes: coordination; international cooperation; and research, information, monitoring, and evaluation. The EU Action Plan on Drugs 2017–2020[6] followed on from the EU Action Plan on Drugs 2013–2016[7] and set out to facilitate the implementation of the priorities laid out in the strategy. As with its predecessor, the 2017–2020 action plan was structured around the objectives aligned to the five pillars, which were further divided into a set of concrete actions allocated to relevant stakeholders with a timeline for implementation. Indicators and data collection mechanisms were identified to support monitoring and evaluation.

The evaluation aimed to assess the implementation of the strategy and the 2017–2020 action plan in terms of outputs, results, and impacts. These were considered in the context of the five mandatory evaluation criteria set out in the European Commission's Better Regulation Guidelines[8]: relevance, coherence, effectiveness, efficiency, and EU-added value. A mixed-method approach was taken in the evaluation, which involved accessing a wide range of data sources and consultation with stakeholders. Those consulted through the process included EU member states, competent authorities, civil society organisations, and the general public.

In its simplest terms, the analytical framework of the evaluation compares the baseline situation in the EU in 2013 (for each of the five pillars and objectives) with how things stood in 2020 (the implementation state of play). It then examines the extent to which the actions and outputs that can be observed through relevant evidence sources (including feedback from stakeholders) correspond to what was expected to have been achieved by the strategy through its action plans. For a more detailed description of the methodological approach and its limitations, readers should access the full evaluation report.[3]

Findings of the evaluation

The key findings, as laid out in the evaluation report and its executive summary, were:

- The technological, social, political, and environmental context affecting the demand and supply of drugs was found to have evolved considerably since 2013, making the strategy and action plan only partially relevant to the drug situation at the time of the evaluation.

- The strategy and action plan were found to have remained largely consistent with relevant European legislation and policy at international level. However, changes in the drug situation since 2013 were considered to have weakened the coherence between the strategy and the broader policy fields of health and security.

- The strategy and action plan were found to have been only partially effective in achieving

Evaluation of EU Drugs Strategy 2013–2020   continued

the drug demand reduction objective. Progress had been made in some areas: for example, there were increases in the variety of general and specific prevention and treatment interventions that had been implemented across many EU member states. However, there had not been a reduction in drug demand across the EU in comparison with 2013. In fact, prevalence of drug use 'increased across most types of drugs across most member states since the baseline year. The overall increase was particularly pronounced amongst young people. Finally, drug-related deaths across the EU have also increased' (p. 21).[3]

- Similarly, the strategy and action plan were only partially effective in achieving the drug supply reduction objective. The evaluation found progress had been made in terms of effective law enforcement coordination and cooperation within the EU. However, it also found that the estimated availability of most types of drugs had increased in the EU since 2013. Drug purity had also largely increased over the same period. It also notes that the large-scale operations conducted seemed to have been largely insufficient to disrupt the illicit drug markets.

- Where the strategy and action plan had been most effective was in delivering on the three cross-cutting objectives (coordination; international cooperation; and research, information, monitoring, and evaluation). Overall, drug policy was found to be effectively coordinated at EU and international levels; the EU spoke with 'one voice' on drug policy on the international stage.

- In light of the findings, the evaluators conclude that 'generally speaking, it would seem that the strategy did not make significant contributions towards achieving its planned overall impact to *ensure a high level of human health protection, social stability and security*' (p. 38).[3]

- In terms of efficiency, there was no conclusive evidence on whether the results attributed to the strategy and action plan were achieved at a reasonable or unreasonable cost. The evaluators could not carry out a sound assessment on efficiency as quantifiable data regarding drugs-policy-related costs were not widely available from member states.

- One of the successes of the strategy and action plan was that they generated EU-added value insofar as they achieved results that national or other European initiatives would not have achieved. This included establishing 'a common strategic framework' and 'bridging' between member states and different levels of governance. They 'encouraged cross-border coordination and exchange of information and evidence-based best practices among member states and thus created economies of scale in terms of synergies and efficiencies' (p. 39).[3]

- The stakeholder consultations found continued support from member states and civil society organisations for strategic EU involvement in drugs policy; it was argued that to discontinue an EU-wide drugs strategy would likely have negative effects.

Recommendations of the evaluation

In terms of feeding into the next strategy (2021–2025), the evaluation made recommendations related to its structure and focus. It was recommended that it be more concrete in its actions and priorities and that the monitoring system should be simplified. It was also recommended that it should cover a shorter period of time. Taking account of changes in the drugs landscape, it recommended that future priorities need to consider trends such as:

…increased poly-criminality of organized crime groups and their adaptive and innovative modus operandi*; role of the EU as a producer and exporter; increased levels of violence and corruption that enable the drug trade; technologic enablers such as darknet marketplaces, cryptocurrencies and encryption technology for buying/selling drugs; new patterns of drug consumption*

Evaluation of EU Drugs Strategy 2013–2020   continued

between young people and the aging population, as well as gender differences; societal and environmental effects. The consequences of the drug phenomenon are becoming more complex and intertwined, extend across different sectors and go beyond EU's borders. The future strategic approach to EU drugs policy must be evidence-based, balanced and further integrated to reflect the relevant trends that the EU will be facing in the coming years. (p. 2)[2]

Conclusion

The findings of the evaluation reflect the complexities of the drugs landscape and the policies and interventions required to address the issues it presents. While the evaluation illustrates the effectiveness of an EU-wide strategy in supporting cross-cutting objectives, it struggles to show the impact on elements of the drug demand and supply pillars, which are central to the strategy. The new EU drugs strategy is discussed in other articles in this issue of *Drugnet*. It is clear that the recommendations of this evaluation that relate to structure and focus were taken into account in its development. However, challenges identified in this evaluation will remain. For example, how to adapt to an ever-evolving landscape and how to capture the necessary evidence to understand whether the approach adopted in the strategy is the most effective in addressing the needs. More importantly, how better to achieve drug demand and supply reductions.

Lucy Dillon

1   Council of the European Union (2020) *EU drugs strategy 2021–2025.* Brussels: Council of the European Union. https://www.drugsandalcohol.ie/33750/

2   European Commission Directorate-General for Migration and Home Affairs (2020) *Executive summary of the evaluation of the EU drugs strategy 2013–2020 and the EU action plan on drugs 2017–2020.* Brussels: European Commission. https://www.drugsandalcohol.ie/33772/

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4   European Commission (2020) *EU Security Union Strategy: connecting the dots in a new security ecosystem* [Press release]. Brussels: European Commission. Available online at: https://ec.europa.eu/commission/presscorner/detail/en/ip_20_1379

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Most recent regulations of Public Health (Alcohol) Act 2018 implemented

October 2018 saw the much-anticipated enactment of the Public Health (Alcohol) Act[1] and heralded a recognition by the Irish Government that our nation's harmful relationship with alcohol could no longer be ignored. The legislation seeks to limit the damage to the nation's health, society, and economy by reducing alcohol consumption; delaying the initiation of alcohol consumption by children and young people; reducing the harms caused by the misuse of alcohol; and ensuring the supply and price of alcohol is regulated and controlled in order to minimise the possibility and incidence of alcohol-related harm.

The most recent measures from the Act that commenced are Section 22 (structural separation) and Section 23 (restrictions on the sale and supply of alcohol products).

Section 22 – structural separation of alcohol from grocery products

Limiting the physical availability of alcohol is an important measure to reduce alcohol consumption and consequently alcohol-related harm. The Act recognises that alcohol is 'no ordinary product'.[2] This is particularly pertinent to Section 22 of the Act, which requires that alcohol products are kept separate from other grocery products in mixed retail outlets such as supermarkets, grocery stores, convenience stores, and petrol stations. It also requires that alcohol products and advertisements for alcohol products are not visible outside of these designated areas.

Section 22 is intended to ensure that access to alcohol products and the advertising of same is more controlled and less likely to be on display near grocery products, thereby discouraging their purchase as part of everyday household grocery shopping, and less visible to children. Section 22 was commenced on 12 November 2018 and retailers had a two-year lead-in period until 12 November 2020 when they were legally obliged to store alcohol products in one of following options (see Figure 1).[3]

- **Option A:** A single area reserved for alcohol and alcohol-related products separated by a barrier.
- **Option B:** Enclosed storage unit(s) adjacent to each other containing alcohol products and advertisements for alcohol products with height and visibility restrictions.
- **Option C1:** Display of alcohol products and advertisements for alcohol products within a maximum of three adjacent storage units with height and width restrictions on each unit.
- **Option C2:** Closed storage unit behind the counter.

The new regulations, monitored by Health Service Executive (HSE) environmental health officers, do not apply to standalone off-licences, airports, or passenger aircraft.

Section 23 – restrictions on the sale and supply of alcohol products

Section 23 of the Act refers to the 'sale and supply of alcohol products' and four of its regulations came into effect on 11 January 2021. Section 23 regulations[4] are intended to prohibit promotions encouraging risky drinking, that is, that encourage individuals to purchase or drink more than they intended or to drink faster than they intended.

1 **Regulation 3** applies to the award of or use of bonus or loyalty card points in relation to the sale of alcohol products. Bonus or loyalty card points cannot be awarded from the sale of alcohol or cannot be used to purchase alcohol. This includes loyalty card points awarded on the use of a fuel service station, credit card, energy service provider, phone service provider, holiday breaks, or insurance. Loyalty card points converted to vouchers may not be used to purchase alcohol, including in a restaurant, theatre, cinema, or any other venue providing a similar service.

Public Health (Alcohol) Act 2018
continued

2 **Regulation 4** applies to the sale and advertisement of alcohol products at a reduced price or free of charge when sold with one or more alcohol products, or another product or service: for example, 'buy one get one free' or 'buy one, get one half price'. The same applies in licensed premises, that is, two drinks bought together for less than the price of two individual drinks. A free glass of wine offered at, for example, a nail bar, hairdressers or barbers is not permitted. The purchase of a service such as a manicure or haircut may not result in the offer of an alcohol product free of charge.

3 **Regulation 5** applies to the sale and advertisement of alcohol products at a reduced price for a period of three days or less: for example, 'Student Night' or 'Happy Hour'.

4 **Regulation 6** covers the prohibition of advertising any of the 'discount' promotions outlined above in Regulations 4 and 5.

The regulations apply to the online sale and supply of alcohol products on Irish websites but not to the sale of alcohol by wholesale. A person who contravenes these prohibitions commits an offence and is subject to penalties ranging from a Class A fine or up to three years' imprisonment.

Conclusion

The implementation of these regulations are welcomed and timely given that we are reportedly drinking more than usual during the Covid-19 pandemic and are buying alcohol from mixed retail outlets due to the closure of pubs.[5,6] It is crucial that the remaining elements of the Act are implemented given the current high rates of alcohol consumption, binge drinking, and alcohol dependence in Ireland.

Anne Doyle

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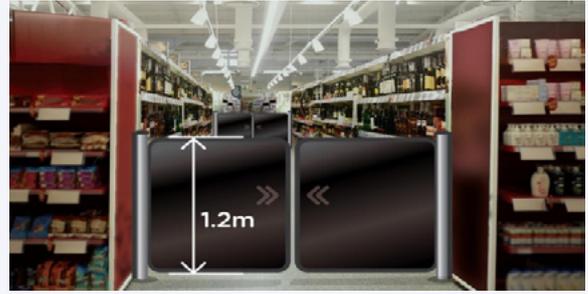

Option A: In an area of the shop that is separated by a physical barrier with height restrictions. Shoppers should not have to pass through the separated area to gain access to another area of the shop or to make a purchase of products other than alcohol.

Option B: In a maximum of three adjacent units. The units must not contain products other than alcohol products and advertisements for alcohol products.

Option C1: In one or more closed adjacent storage units or cabinets on the shop floor with height and visibility restrictions (so alcohol products cannot be seen when the unit is closed). The unit should remain closed when not in use.
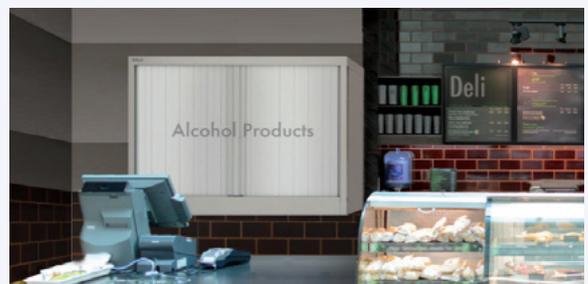
Option C2: In a closed storage unit behind the counter. The unit may indicate that it contains alcohol products but shall not be accessible to members of the public and should remain closed when not in use.

Figure 1: Options for storing alcohol products under new regulations

Public Health (Alcohol) Act 2018
continued

2   Babor T, Caetano R, Casswell S, *et al.* (2010) *Alcohol: no ordinary commodity – research and public policy.* 2nd edn. Oxford, UK: Oxford University Press.

3   Tobacco and Alcohol Control Unit (DOH) and National Environmental Health (HSE) (2019) *Public Health (Alcohol) Act 2018 (Number 24 of 2018) guidance for industry section 22.* Dublin: Department of Health and Health Service Executive. https://www.drugsandalcohol.ie/33711/

4   Public Health (Alcohol) Act 2018 (Sale and Supply of Alcohol Products) Regulations 2020 (S.I. No. 4 of 2020). Available online at: http://www.irishstatutebook.ie/eli/2020/si/4/made/en/print

5   Central Statistics Office (CSO) (2020) *Social impact of COVID-19 survey: changes in consumption April 2020.* Cork: CSO. Available online at: https://www.cso.ie/en/releasesandpublications/ep/p-syi/statisticalyearbookofireland2020/covid-19/csoc/si/

6   McQuinn C (2020) More spent on alcohol despite Covid-19 closure of pubs as people switch from beer to wine. *Independent.ie,* 14 September. Available online at: https://www.independent.ie/irish-news/more-spent-on-alcohol-despite-covid-19-closure-of-pubs-as-people-switch-from-beer-to-wine-39529995.html

Coordination, framing, and innovation: the political sophistication of public health advocates in Ireland

Policy researchers have long been interested in the processes that facilitate major policy change.[1] A 2021 study[2] explores the role of the public health advocacy coalition in promoting the passage of the Public Health (Alcohol) Bill in Ireland. Following a five-year campaign, the Public Health (Alcohol) Bill was approved by the Government in December 2015 and after a protracted and contested process the legislation was signed into law on October 2018.

The alcohol industry and the public health community formed two opposing coalitions during the policy debate.[3] The alcohol industry's success in resisting population-level approaches to alcohol policy has been identified in Ireland[4,5,6,7–11] and elsewhere.[12–20] In contrast, public health advocates have typically had limited success. Yet in this case, public health advocates in Ireland have developed sophisticated political strategies to foster major alcohol policy change.

Methodology

The study constructed a record of the public health advocacy coalition and its campaign to promote the Public Health (Alcohol) Act 2018 in Ireland. To identify the key actors and issue frames, a thematic analysis was undertaken using primary documents produced by advocates, newspaper articles, and semi-structured interviews with key advocates, public health experts, and elected officials.

This analysis documented the growing political sophistication and effectiveness of public health advocates in Ireland. First, a broad-based coalition enabled advocates to pool resources and coordinate their strategy and messaging. Second, issue-framing was critical in shifting the focus of the debate to alcohol-related harm. This placed pressure on politicians by making available evidence on the extent of the problem. Finally, evidence of political learning was presented, where advocates' knowledge of the political system spurred innovations in campaigning.

Public health advocates in Ireland
continued

These three strategies – coalition-building,[21] issue-framing,[22] and political learning[23,3] – are discussed in more detail below.

Coalition-building

The public health alcohol advocacy community in Ireland had traditionally comprised a relatively small group of non-governmental organisations (NGOs), public health experts, and public health officials. However, a concerted push to professionalise advocacy since the 2000s saw Alcohol Action Ireland (AAI), a national advocacy organisation, participating in numerous policy deliberations including the National Substance Misuse Strategy (NSMS) Steering Group. When the Government announced it would be acting on the policy recommendations of the NSMS report, AAI mobilised a cross-party group of senators and TDs.

Interest in alcohol policy also extended to the Irish medical establishment, leading to the formation of an alcohol policy group in 2012. Key figures in the Royal College of Physicians of Ireland (RCPI) and AAI decided to mobilise other organisations who supported the key principles of the Bill. This Alcohol Health Alliance Ireland brought together 62 organisations.

The establishment of this broad coalition allowed members to effectively pool their limited resources. Drawing 'on the strength and the reputations' of its membership helped to strengthen the advocates' credibility giving them 'more clout with the public, with politicians, and with the media'.[2] As one advocate explained, AAI had been 'a small charity, a small voice, [and] a lone voice, with a limited budget', and so the inclusion of organised medicine enabled the alliance to 'speak with more authority' on alcohol harms.

The coalition coordinated its strategy and maintained message discipline by advising experts ahead of their media appearances. As one member remarked, traditionally there were 'lots of disparate voices shouting out in an uncoordinated way'.[2] The alliance ensured that when an issue was raised in the media, the most effective voice articulated the public health position.

The alliance also recruited individuals from member organisations who possessed a background in public affairs, including those with prior roles as journalists and as political advisers, thus possessing an intimate knowledge of the political system. The close working relationships with politicians and key officials within the Department of Health allowed the alliance to keep 'on top of what was happening in government … and what … might have been said in the media'.[2]

Issue-framing

A key framing strategy was to focus on the content of the problem – the health harms – rather than the particular measures within the Bill itself. Advocates made extensive use of social media and developed multimedia strategies to establish their preferred framing. The alliance used its website and other communication materials, including infographics, to highlight the harms caused by high levels of alcohol consumption. Advocates released hundreds of documents, including reports and press releases, to generate media coverage. Advocates also used social media, press interviews, and editorials at key stages of the Bill's progression to underline the principal harms frame.[24–27]

Although it faced entrenched alcohol industry positioning, it found ways to pivot when confronting less advantageous frames. For example, when industry identified the economic costs of the Bill, advocates responded by highlighting the healthcare costs associated with the status quo. According to one citation, the alliance's 'expert stakeholder alliances and evidence-based communications'[2,28] succeeded in keeping alcohol on the agenda for more than three years, despite facing a 'well-resourced and culturally-embedded opposition'.[28]

Political learning

There is evidence of political learning[23] where advocates' prior experiences and knowledge of the political system in Ireland spurred innovations in campaigning. Key lessons had

Public health advocates in Ireland
continued

been drawn from other successful public health campaigns including the smoking ban.

The specific expertise of the advocates was critical to the Bill's passage, including experience in politics, journalism, and in campaigning organisations. Politicians were targeted and close relationships were formed with those who were sympathetic, broadening the coalition, and leveraging these interactions to shape the legislative process. Local grassroots organisations also played a key role in reinforcing this tactic at a local level. These strategies were interdependent and mutually reinforcing, and succeeded in building support for public health advocates' preferred policies among politicians and the general public.

Advocates exhibited sophistication throughout the debates over the Bill. One expert, who was not formally involved in the coalition, had this to say about its influence:

> *[The alliance] was pivotal because they made it a campaign and they ran it like a campaign ....Campaigns are not accidental things ... they have to have many arms ... they have to have a communications arm, a political arm, a policy arm, [and] a civil service arm ... I think they covered all the bases ... I think the public health side [was] strong and ... more savvy than before.*[2]

Discussion

These findings provide insights into the developing capacity of advocates to drive major policy change. The success of the alcohol advocacy coalition in its campaign to pass the Public Health (Alcohol) Bill was a hard-fought campaign but other equally hard-fought advocacy campaigns preceded it, including the ban on smoking in public places as well as national referenda on divorce, abortion, and same-sex marriage. Such successes generate momentum and are relevant to appreciating how the broader advocacy community has professionalised over time.

Ireland's long-standing problematic relationship with alcohol as well its failure to get to grips with the problem is another important consideration.[4–6,8] Several Irish experts have been instrumental in generating high-level awareness of the existence of a problem, gradually reframing the problem away from an issue affecting a subgroup of 'alcoholics' towards a fuller population-level understanding of alcohol harms. Politicians were receptive to major policy change due in part to sustained public attention to alcohol as a problem.[8]

This study contributes to a broader research programme on the alcohol industry and the role of evidence in alcohol policymaking.[18,29–31] A recurring finding on the alcohol industry is the advantages it holds over its opponents with respect to resources and lobbying efforts.[28] This study, however, shows that experts often possess unique capabilities or attributes – such as public trust – which can help to mitigate the industry's resource advantage.

Finally, the prolonged development of alcohol policy innovation in Ireland underscores the perennial role of conflict. The Irish advocacy coalition saw itself as fighting a war with industry in pursuit of rational policymaking, based on using high-quality scientific evidence to reduce avoidable harms caused by alcohol. In such terms, an important series of battles have been won, culminating in the passage of what has become the Public Health (Alcohol) Act 2018. However, the political war will not end with legislative enactment. Researchers will need to focus on policy implementation, examining how each coalition seeks to advance its interests and ideas in this next stage of the policy process.

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RECENT RESEARCH

Evidence review of drug treatment services for people who are homeless and use drugs

The Irish national drugs strategy aims to improve access to treatment services for people who are homeless who use drugs and have complex needs. On behalf of the Department of Health, the Health Research Board commissioned the Salvation Army Centre for Addiction Services and Research (SACASR), the University of Stirling, and the Public Health Institute at Liverpool John Moores University to systematically review and synthesise the international evidence on the efficacy of interventions designed to serve this population. This synthesis will inform policies, currently under review, regarding the provision of services to people who are homeless.

This report[1] comprises two parts: the first part presents a description of the current trends relating to drug use and of the services in Ireland in primary care, mental health, and drug treatment settings for people who experience homelessness and use drugs; the second part is an integrative review of the international research literature providing a systematic evaluation of the evidence on interventions that aim to address the needs of this population.

Introduction
People who are homeless have complex and challenging lives. They tend to have worse physical and mental health and are more likely to report problem substance use than the general population. Substance use is more prevalent among people who are homeless than in the general population and providing support services and drug treatment in a holistic way for this population should be a priority. Increasing the provision of evidence-based support may lead to improvements in health, wellbeing, and quality of life (QoL), and to a reduction in costs to healthcare and wider public services.

Overview of services in Ireland for people who are homeless and use drugs
There are a wide range of services in Ireland for people who are homeless and use drugs. These include health and social care services specific to substance use, such as counselling; drop-in centres; assessment and intervention advice; information and education; ongoing support; follow-up care; and a drug-screening facility. Outreach clinics are also available across Ireland.

Evidence review   continued

Specific programmes relevant for people who are homeless include the Health Service Executive (HSE) Social Inclusion programme, which is designed specifically for marginalised groups to help enable and improve their access to mainstream services. For example, the Inclusion Health Service at St James's Hospital, Dublin attends to the complex needs of marginalised groups, such as people who are homeless and those who use drugs. Other existing services include abstinence-based drug treatment services, such as residential rehabilitation and harm reduction drug services (e.g. prescribing services, including opioid substitution therapy – OST); and static, pharmacy, and outreach needle and syringe programmes services. There are also housing support services across Ireland, such as transitional housing and emergency accommodation provision. It is important to note that many nationwide services provide a holistic approach to treatment and support; therefore, it is not possible to fit them neatly into service type. In particular, many third-sector organisations offer a range of services in order to best meet people's needs. These can include drug treatment services, other harm reduction services, housing support services, and other more general health and social care services, among others.

Evidence review on effective interventions for people who are homeless and use drugs

This report is a systematic review of reviews and aimed to synthesise international evidence on effective interventions for this population. Twenty-two publications (18 published papers and four grey literature reports) published between 2004 and 2020 were included. Thirteen of the 18 publications included academic reviews deemed to be systematic (with two of these also including a meta-analysis) and five were deemed to be non-systematic. Twelve of the reviews included quantitative studies only; eight included different study type/mixed designs (including one realist synthesis); one presented a meta-ethnography and included qualitative studies

only; and one was a review of reviews. Ten of the reviews were undertaken in the United Kingdom (UK); four in the United States of America (USA); four in Canada; three in Europe (Spain, Ireland, and a Dutch/Belgian collaboration); and one was an international collaboration by researchers from Switzerland, the UK, and Canada. Despite this, nearly all of the reviews (n=19) were international in focus, although two reviews focused on the USA only and one focused on the UK only. Even though the focus of most of the reviews was international, the majority of the authors were based in the UK, and the majority of primary studies were undertaken in the USA. This may affect the generalisability of the findings to non-USA contexts.

The focus of the included reviews varied, and a large number of interventions were investigated. The largest number of reviews (n=6) focused on housing interventions, including Housing First (HF) initiatives. Of the remaining reviews, four focused on interventions for people with co-occurring serious mental health and alcohol/drug issues (COSMHAD); three focused on substance use treatment specifically; two investigated healthcare treatments and interventions in general; two focused specifically on case management interventions; one focused solely on assertive community treatment (ACT); one focused on sexual health promotion interventions; one investigated the impact of harm reduction interventions on the incidence of hepatitis C virus; one examined the effectiveness of intentional peer support (IPS) for people who are homeless; and one examined emergency-department-based interventions. The primary outcomes of interest were treatment engagement and retention as well as successful treatment completion. The study also synthesised information relating to substance use outcomes, housing outcomes, and 'other' outcomes (primarily health and wellbeing outcomes).

Treatment engagement and retention

Treatment engagement and retention for the homeless population can be problematic regardless of intervention type. ACT can lead to increased engagement rates for people who experience homelessness and use drugs. In

Evidence review   continued

contrast, treatment engagement with intensive case management (ICM) can be low, with more than two-thirds of participants experiencing both substance use problems and homelessness who enrol in shelter-based ICM services dropping out of these programmes. There is some evidence to suggest that motivational interviewing and motivational enhancement therapy can increase treatment engagement during the short term for those experiencing homelessness and COSMHAD. Adherence to highly active antiretroviral therapy (HAART) among people who use drugs is comparable to that among people who do not use drugs; however, the addition of OST to HAART for those who use drugs increases treatment adherence and leads to better treatment outcomes. Data from studies of HF interventions suggest that engagement can be difficult, possibly due to the fact that while supported and encouraged through a harm reduction approach, treatment engagement within HF is ultimately self-determined.

Finally, there is evidence suggesting that the way in which interventions are delivered can play a crucial role in treatment engagement and retention, with compassion, warmth, and a lack of judgement and stigma from the staff supporting individuals being paramount.

Successful treatment completion

There is a lack of studies reporting on successful treatment completion, while (limited) data were only presented in two of the included reviews. One low-quality review presented evidence from four randomised controlled trials and one meta-analysis of a linear, rigorous abstinence-contingent housing approach (called 'Birmingham house'), which suggests that treatment completion rates in such an approach (65% in the most recent trial) can be higher than the approximate 50% for social interventions (such as case management, congregate living, and vocational training), and comparable to those of modified therapeutic communities. There is some evidence that integrated approaches in short-term residential

programmes (lasting six months or less) for people with COSMHAD were associated with higher rates of programme completion. Moreover, there was evidence that monetary and non-monetary incentives can increase completion rates of directly observed preventive therapy in young people with latent tuberculosis who are homeless; however, it was not specified whether they were also experiencing problem substance use. Also, there was some evidence that for people experiencing homelessness who also inject drugs, an accelerated hepatitis B virus immunisation schedule (with doses administered at 0, 7, and 21 days, and a booster at 12 months) can result in superior completion rates, compared with traditional schedules that have similar seroconversion rates.

Evidence shows that monetary and non-monetary incentives can increase completion rates of directly observed preventive therapy in young people with latent tuberculosis who are homeless; however, it was not specified whether they were also experiencing problem substance use. Lastly, integrated approaches in short-term residential programmes (lasting six months or less) for people with COSMHAD were associated with higher rates of programme completion.

Treatment outcomes: substance use

All the included reviews reported on some element of substance use outcomes and, overall, the results were mixed. First, there is a large number of intervention types available for people experiencing homelessness with concurrent substance use problems. In general, the greater the level of integration and partnership between programmes and agencies dealing with people who are homeless and have co-occurring substance use problems, the better the outcomes.

Evidence suggests that harm reduction interventions can lead to decreases in drug-related risk behaviour (e.g. needle sharing) in this population in the same way as they do for other groups. Co-locating a number of harm reduction approaches together (termed 'full harm reduction') creates additional opportunities for clients that can lead to better outcomes than single (partial) harm reduction interventions.

Evidence review   continued

The reviews suggested that HF does not seem to impact either positively or negatively on substance use outcomes.

Treatment outcomes: housing

Reviews which reported on housing outcomes largely support the HF approach in terms of its effectiveness in increasing housing stability and retention, and indicate the HF approach as a preferred option due to the flexibility and harm reduction ethos associated with it. However, the reviews identified some issues relating to programme fidelity and type of HF housing (scattered versus single site). There is also some evidence that supportive housing can have a positive effect on housing stability. Other non-housing-specific interventions can also have a positive effect on housing outcomes. Most notably, peer support interventions, with IPS specifically being assessed, can lead to a decrease in the number of homeless days and a reduction in relapse to homelessness. Evidence regarding case management interventions and their impact on housing outcomes is mixed and varies between intervention types.

Treatment outcomes: other

Some treatment outcomes that were not related to housing or substance use were reported. These related primarily to mental health and wellbeing outcomes, with mixed evidence regarding the effectiveness of the different interventions studied. There is some evidence from interventions delivered in the USA that permanent supportive housing for people experiencing homelessness and who have additional mental health problems can lead to a reduction in mental health symptoms, compared with a control condition. There is strong evidence that HF can improve measures of physical health in the short term for 'housing-vulnerable' adults. This included moderate-strength evidence for positive effects on personal wellbeing, mental health, and locality-related wellbeing (i.e. wellbeing related directly to one's living situation and conditions), with no effects on personal finance or community wellbeing being reported. There is some

evidence that the HF congregate model (where all residents live in one apartment block) can lead to greater improvements in mental health and QoL than the scattered HF model (where residents live in various individual locations). Lastly, there is evidence that integration of services and holistic treatment for people with comorbidities and COSMHAD leads to better psychosocial and substance use outcomes.

Policy and research recommendations

People who experience homelessness and problem substance use are a population with complex needs. However, it is important to note that they are not a homogenous group. Individuals will be dealing with severe challenges by virtue of being homeless, but may also be facing concurrent issues relating to substance use. There are gaps in monitoring and other routinely reported data that would provide better insights into the needs of this population and the harms associated with substance use. This includes regular prevalence surveys; data on drug-related deaths in people who are homeless; and infectious disease and blood-borne virus prevalence monitoring in people who inject drugs, including data on housing needs.

A substantial evidence base exists regarding effective interventions for people who experience homelessness and for people with problem substance use, but not enough research has been conducted focusing on the unique needs of people who experience both, despite these issues commonly co-occurring. To ensure needs are well met, targeted provision can be helpful and specific subgroups do exist within this wider population, for example, people who experience homelessness and COSMHAD, whose needs can be even more complex. Other identity characteristics, such as gender, age, ethnic background, and experiences of physical disability/physical health problems, will also have an impact on a person's needs, preferences, and overall treatment experience. Unfortunately, there are few studies that focus on making sure that people with these very complex and challenging experiences are well heard.

While people who experience homelessness and problem substance use experience different circumstances and have different needs, wants,

Evidence review continued

and preferences, which are also likely to change over time, making listening to individuals and providing choice is critically important. A balance is therefore needed between providing an approach that is tailored specifically to each individual and delivering key components of evidence-based services and interventions. Currently, there is a lack of standardisation of measures and outcomes, which can make meaningful comparisons between different types of service models – and, subsequently, any distillation of key elements of success – challenging.

Regarding specific intervention types, the evidence suggests that the HF model supports a flexible harm reduction approach that enables referral to other services needed by the residents. The evidence base strongly suggests consistent positive housing outcomes and the absence of negative effects on substance use, alongside some evidence for positive effects regarding physical health and wellbeing. The review found that case management-type interventions can be effective, both when applied on their own and when combined with other interventions, such as contingency management, positive reinforcement or incentives, art therapy, and health prevention and promotion programmes. ACT has consistently produced positive effects on housing stability and has been found to be cost-effective, but this model seems to be suitable mainly for those experiencing homelessness and COSMHAD. Finally, the evidence suggests that formal IPS can lead to positive housing, substance use, and wellbeing outcomes, and that it has the potential to have a positive impact on the peers who provide the support.

For this reason, the authors of the study recommend the development of peer support interventions for people who experience both homelessness and problem substance use. However, due care must be given to planning for the embedding of peers in services in order to ensure that they are respected, valued, and offer meaningful support and training opportunities.

Key messages

- A lack of international research exists on effective interventions for people who are homeless and use drugs. There is also a lack of Irish research, in particular which examines this intersection in depth.

- People who are homeless and use drugs are not a homogenous population. More research, particularly qualitative research, should be conducted to explore the 'missing voices'.

- Treatment for this population group should be needs-led and person-centred. However, most research has examined complete treatment interventions and service models, with a lack of evidence on the effect of tailoring these.

- Treatment failure often stems from the service providers not recognising the breadth and complexity of individual needs.

- Mindful of choice for service users, a flexible system which provides opportunities for both harm reduction and abstinence-based approaches is recommended.

- Consensus on outcome measures (including treatment outcomes and treatment completion indicators for this population) should be reached to help research standardisation and support meaningful comparisons between interventions.

- Research is required on the optimal length of treatment for this population. This has implications for practice, as research findings may lead to a need to secure funding for extended periods of treatment.

- The findings highlight the importance of integration between different services, especially for people who are homeless and who experience COSMHAD.

- How interventions are delivered (e.g. non-judgemental, compassionate), providing choices, and respecting service users' preferences for approach is an important determinant of success.

- In the reviewed research, there are insufficient data on treatment retention and completion available and/or synthesised.

- Housing interventions, especially HF, lead to improvements in housing outcomes, but evidence regarding HF interventions and health and wellbeing outcomes is mixed. Evidence suggests that HF does not impact on substance use outcomes.

- Case management-type interventions can be effective, but ACT seems suitable primarily for those experiencing homelessness and mental health problems or COSMHAD.

- Peer support interventions can lead to positive housing, substance use, and wellbeing outcomes, but care must be taken when embedding peers into services due to common challenges experienced in such roles.

Brian Galvin

1   Miller J, Carver H, Masterson W, Parkes T, Jones L, Maden M and Sumnall H (2021) *Evidence review of drug treatment services for people who are homeless and use drugs.* HRB Drug and Alcohol Evidence Review 7. Dublin: Health Research Board. https://www.drugsandalcohol.ie/33910/

Debts, threats, distress, and hope: drug-related intimidation in Dublin's north east inner city

It has been known that drug-related intimidation (DRI) impacts on many Irish communities. The Drug-Related Intimidation Initiative (DRII) project was established in 2019 to examine this issue in Dublin's north east inner city (NEIC). The main objectives of the initiative were twofold: first to provide support to individuals experiencing DRI and second to conduct research into these experiences to increase knowledge and understanding from the perspective of the victim, perpetrator, or both, with the final aim of developing good practice guidelines to respond to DRI (p. 6).[1] In January 2021, Ana Liffey Drug Project (ALDP) published the final report of the DRII.[1] The research was carried out by

ALDP under the supervision of Dr Matt Bowden, School of Languages, Law and Social Sciences at Technological University Dublin.

Literature review

The report contained a detailed literature review examining a range of related topics, such as victims of DRI; illicit drug markets and violence; and drug-related crime. Several Irish studies were identified which either examined DRI as an issue or found that DRI was an issue within the sample examined. Within these studies several themes emerged:

- Low-level intimidation was evident in communities where drug hierarchies retained control.

- Low-level intimation resulted in a breakdown of community trust and spirit, leading to an exacerbation of fear and a sense of helplessness.

- There was unwillingness to report incidents of DRI to An Garda Síochána (AGS).

- There was an increased likelihood of parents experiencing DRI, more so mothers of those who use drugs, because of drug debts.

Debts, threats, distress, and hope

continued

- Drug activity hotspots were viewed as 'no-go areas' by residents (p. 15).

- Low-debt thresholds, such as €50, could result in someone becoming a target of DRI.

In Ireland, one intervention that has been applied is the National Drug-Related Intimidation Reporting Programme (NDRIRP). The NDRIRP, which consists of a high-ranking AGS member from each Garda division across Ireland, aims to respond to intimidation experienced by people who use drugs, their friends or family, or others that are affected within the community because of drug debts. A recent review of this programme found that while NDRIRP was shown to be a useful tool in supporting employees' responses to unpredictable challenges, awareness of the programme was limited. The need to enhance communication between NDRIRP members and key stakeholders was highlighted.

Methodology

The study utilised a mixed-methods approach consisting of desk and field research. Initially, a literature review identified academic and policy research related to DRI. Next, a mapping exercise identified community services that targeted or were related to DRI problems in the NEIC. Finally, the field research was carried out and included three approaches:

- Online surveys were carried out via SurveyMonkey between June 2020 and early August 2020 (n=471).

- Participants (n=18) from 12 organisations participated in three focus groups in July 2020.

- Semi-structured interviews were carried out with individuals who had direct experience of DRI in the NEIC (n=4).

Findings

Table 1 shows a summary of the main findings of the study, incorporating the online survey, focus groups, and interviews grouped together by theme.

Table 1: Findings of study by theme

Themes	Findings
Knowledge of DRI	Awareness of DRI issues in the NEIC was reported by 83% of survey respondents. Similarly, 'deep awareness' (p. 31) was illustrated by participants in focus groups and interviews
Experience of DRI	Nearly one-quarter of online survey respondents indicated that they had direct experience of intimidation (23%). Some of these experiences occurred in the month before the survey (32%), while for others the experience occurred in the previous year or over a year, 38% and 30%, respectively
Form of DRI	Direct experiences of DRI took several forms: physical harm (67%; 34/51); movements tracked (53%; 27/51); threat of vandalism or property takeover (45%; 23/51); and threat of sexual violence (12%; 6/51)
Perceptions as to why DRI occurred	Individuals with direct experience of DRI put forward several reasons as to why they were targeted or believed they were targeted. The top five reasons were: 1. As a warning or to frighten people in the community (55%) 2. Other (51%) 3. Money owed from buying drugs (43%) 4. Under pressure to participate in drug supply or drug-related crime (43%) 5. Someone known to the respondent owed money for purchasing drugs (35%)

Debts, threats, distress, and hope
continued

Themes	Findings
People involved in DRI	The top five categories identified by respondents as being most at risk of DRI included: people who use drugs (88%); partners of people who use drugs (80%); parents of people who use drugs (79%); young people (75%); people who sell drugs (69%)
The where of DRI	39% of respondents reported that DRI can take place in more than one place (at home, at work/school/college, at a community service, on the streets or other), followed by on the streets (31%) and at home (16%)
The when of DRI	While DRI could take place at any time, 35% indicated that it occurred between 5pm and midnight
Perceptions of safety and community	Respondents mainly considered the NEIC area unsafe or very unsafe (41%); this was more so for individuals with direct experience of intimidation (76%, 38/50) than those who had none (36%; 126/346)
Responses to DRI	Reporting rates of DRI experiences were low (18%); 82% of this population did not report the experience to anyone. Only eight of those who reported the experience reported it to AGS. Several reasons were identified for not reporting: fear (67%); lived near to perpetrator (21%); fear for someone close who owed money (19%); victim owed money (19%); fear of impact on tenancy (19%)

Study limitations

As acknowledged by the authors, the sample self-selected and hence may not be representative of the NEIC population. As only adults took part in the survey, the views of children under 18 are unknown. Participants in focus groups and interviews self-selected or were put forward by their organisation. Qualitative interviews involved only male participants. The survey was carried out online, hence access to the internet and being able to work online would have been necessary to participate.

Guidelines

When dealing with DRI, five guidelines were put forward for consideration:

1. DRI is multifaceted. Hence, interventions need to consider what aspect of the issues is being targeted.

2. There is recognition that interventions are not neutral. Hence, the impact of the interventions must be considered to ensure that they do not unintentionally result in increased risk.

3. For an intervention to be successful, the community must be invested in its success and therefore needs to be placed at the centre of it.

4. Interventions need to be local and tailored to that specific location to increase buy-in from that community.

5. It is important to manage not solve, as there is no 'quick fix' solution to DRI. As long as illicit drug markets exist, violence and intimidation will be associated with resolving problems.

Debts, threats, distress, and hope
continued

Recommendations

Recommendations by the authors focused on interventions, which were categorised into two areas:

- **Community-level interventions:** These interventions need to be implemented within the NEIC community. For example, training on DRI; information packs on responding to DRI; increased awareness of NDRIRP; empowering local residents to address DRI; and support policing in the local community. The DRII can action some of these without additional resourcing. However, other interventions will need more resourcing and commitment to implement.

- **Policy-level interventions:** These interventions are beyond the remit of community operations and policies will need to be progressed at a national level. For example, areas to be explored include:

  - The current regulatory framework controlling drugs needs to be examined to assess whether it is fit for purpose or whether more regulation is needed to control supply.

  - Interventions are needed to target young people at risk, with the aim of preventing or delaying entry into the drug market.

  - DRI affects marginalised communities the most. Policymakers therefore need to determine whether existing systems support those that experience challenges such as poverty, stigma, or lack of opportunity.

Conclusion

The work that went into the report was commended by Minister for Finance, Pascal Donohue TD. While Minister Donohoe acknowledged the importance of involving leadership and interagency partnership, he emphasised that the voices of the local community who are facing intimidation were needed to inform how to tackle the problem.

In agreement, Tom Duffin, CEO of ALDP, reiterated how DRI impacted on communities along with the complexity of the problem:

> *It's easy to think of drug-related intimidation as a purely transactional issue – people get into debt from drug use and then experience intimidation as suppliers seek to recover their money. However, what this work shows is that drug-related intimidation is more complex than this; and that in reality, even living in a location where dealing takes place can be sufficient for a person to become a target of intimidation. The sad truth is that many people do not feel safe in their communities, and this is something that we should all have an interest in addressing.*[2]

Ciara H Guiney

1 McCreery S, Keane M and Bowden M (2021) *Debts, threats, distress and hope: towards understanding drug-related intimidation in Dublin's north east inner city.* Dublin: Ana Liffey Drug Project. https://www.drugsandalcohol.ie/33682/

2 Ana Liffey Drug Project (2021) *Report highlights need to work together to address drug-related intimidation* [Press release]. Dublin: Ana Liffey Drug Project. Available online at: https://www.aldp.ie/news/report-highlights-need-to-work-together-to-address-drug-related-intimidation/

Lifting the lid on Bluetown and Redtown

On 27 January 2021, Minister for Justice Helen McEntee TD launched ground-breaking research carried out by the Research Evidence into Policy Programmes and Practice (REPPP) Project team at the University of Limerick. Overall, there were three reports: *Lifting the lid on Bluetown,*[1] *Lifting the lid on Redtown,*[2] and a national prevalence study.[3] This article presents a synthesis of the Bluetown and Redtown studies.[1,2]

Background

The Bluetown and Redtown studies are two replication case studies carried out to determine whether the findings of the Greentown study could be generalised to other locations in Ireland.[4,5] The original Greentown study in 2016 examined the effect of a criminal network on offending behaviour of children.[4,5] The results of this study indicated that a criminal network was in operation in Greentown and responsible for enabling increased criminal activity in children in this area. Five main findings emerged in the Greentown study:

1   A criminal network existed and contained key network actors.

2   The network was hierarchical in nature.

3   The hierarchical structure was supported by powerful processes and a sympathetic embedded culture.

4   Power and influence were mediated by geography, obligation, and the intensity of the relationships with patrons.

5   The network compelled some children in the area into abnormal patterns of offending behaviour (p. 10).[4]

Aims of replication study

The aim of the replication case studies was to determine what factors influence young people's engagement and retention within a criminal network and how these factors may influence their crime trajectories. The main research questions addressed in this study included:

1   From the Garda respondents' perspective, what are the factors that influence young people's engagement and retention within the Bluetown/Redtown criminal network?

2   How do members of An Garda Síochána portray the influence of engagement in the Bluetown/Redtown network on young people's patterns of crime?

Methodology

Similar to the Greentown study, the Bluetown and Redtown studies were centred on a case study design and consisted of the following sequential steps:

*   Burglary and drugs for sale and supply detection data for offences committed by young people (aged <18 years) and collated on An Garda Síochána's PULSE (Police Using Leading Systems Effectively) system between 2014 and 2015 were analysed and ranked.

*   A criminal network map was developed by Garda analysts using the PULSE data and illustrated how offenders who carried out burglary or drugs for sale and supply and robbery offences between 2014 and 2015 in Bluetown/Redtown linked together via common offences.

*   To ensure anonymity of individuals on the criminal network map, Twinsight methodology developed for the Greentown study was utilised.[4] Two versions of the map were developed: a 'live' version and a 'researcher' version. The live version contained personal details of the offenders involved and was only seen by Garda members or analysts. The second version, a researcher version, was similar to the first version, except there was no identifying or personal information and was used only by the researcher. The maps shared unique identifier codes, which allowed Garda respondents (n=16) taking part in semi-structured interviews to 'ground' (p. 24) their views by linking real events to the individuals on the map via the unique identifier.[4]

Lifting the lid on Bluetown and Redtown   continued

- Garda respondent interviews focused on network members and contexts and were embedded in specific events.

- Transcribed interviews were imported into NVivo software, where they were coded and analysed.

- Two quantitative diagnostic tools were used to identify and develop case profiles of significant members within the network.

- The themes found increased the understanding of how the network operated.

Bluetown study

Findings

Bluetown was a large urban Garda subdistrict.[1] Findings from the Bluetown study were grounded in Garda narratives and centred mainly on their significance to the research questions. Three key findings emerged from the analysis.

Finding 1: Four area-based criminal networks existed in Bluetown that were distinct from each other.

Of the four criminal networks identified, three were operational (Area A, Area B[n=2], and Area C). Individuals living in Area D were no longer considered involved in crime. The criminal network map was adapted to show key differences between locations and networks that emerged in Garda narratives. Bluetown covered a larger area than the Greentown and Redtown studies. The impact of this was that Garda respondents could only provide information regarding areas they patrolled. Table 1 shows a summary of networks and some of their key characteristics.[1]

Table 1: Summary of Bluetown network characteristics

Themes	Network	Characteristics
Area A	**Network 1**	• Family based and hierarchical in nature and has existed for generations • Led by husband-and-wife team, B46 and B55 • Members included their sons (B54 and B56) and extended family (B43, B44, B45, B47, B48, B53) • Focused on property crime • Considered a 'massive organisation' (p. 22) • Proceeds of crime given to the family • Network was structured with a level of organisation • Viewed as intergenerational career criminals
Area B	**Network 2**	• Emerging crime gang centred on five members (B11, B7, B5, B12 and B5) living near each other • No family ties • Centred on peer and 'associate'-based relations (p. 27) • Initially committed minor offences, moved on to more complex burglaries and assault and robbery as they aged • 3/5 members were serving long prison sentences at time of study

Lifting the lid on Bluetown and Redtown   continued

Themes	Network	Characteristics
Area B	Network 3	• Highest level of burglary detections • Consisted of five core members who grew up together (B21, B19, B17, B20 and B10) • Responsible for violent and aggravated burglaries • Internal group friendship and trust sustained network in the area • Considered a 'dangerous crew' (p. 29) • 4/5 members (B21, B10, B17 and B19) were in prison at time of study
Area C	Network 4	• Close-knit group of friends who lived near to one another • Those involved included retail-level drug street dealers, those carrying the drugs, those vulnerable, and those at risk of being caught • G24, the network's leader, did not exist on the network map
Area D	–	• Individuals no longer participated in serious or atypical crime except for one (B29) • Information emerged via a common robbery incident • Desistance from crime evident

Source: O'Meara Daly, Redmond and Naughton (2020)[1]

Finding 2: A combination of risk factors was linked to young people developing more serious and prolific offending patterns across all networks.

A thematic analysis showed a relationship between 'shared common risk factors' and 'more serious and prolific offending patterns' in all identified networks (p. 39).[1] There were four subthemes:
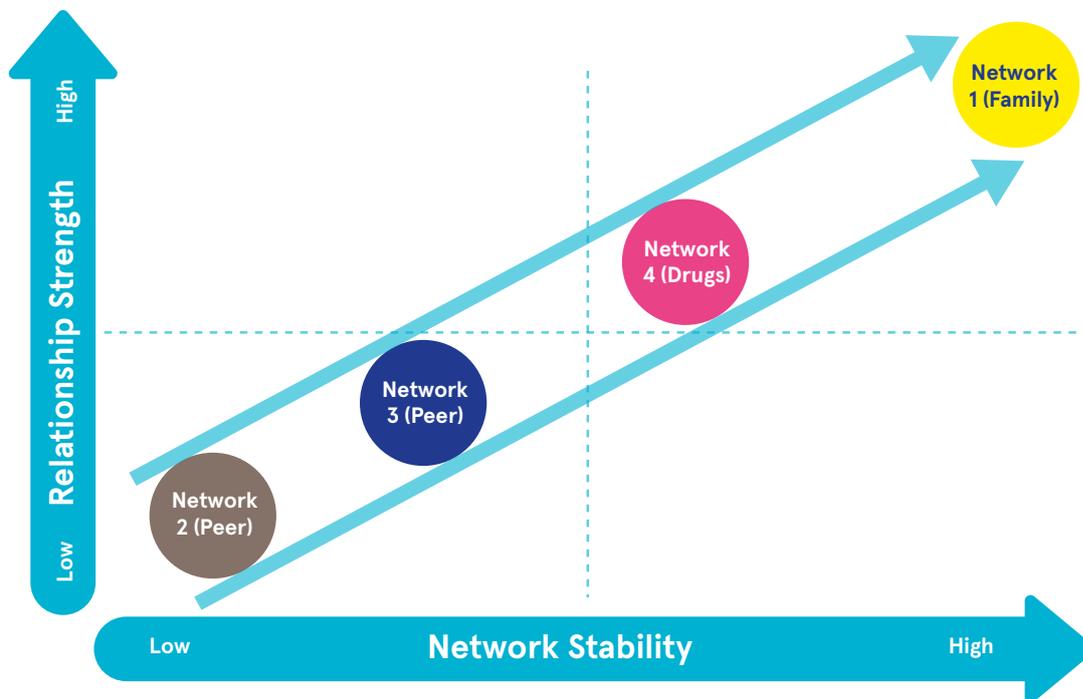
• Family ties to crime

• Proximity to a network of offending peers

• Individual risk factors

• Pro-criminal norms.

Finding 3: Criminal network strength and stability was enhanced by the quality of 'trust' in relationships between members and influenced by fear and intimidation.

Based on thematic analysis, relationship strength between network members was shown to have varying levels; higher levels of trust contributed to greater network stability, as shown in Figure 1.

• Network 1 is strongest with regard to relationship strength and network stability.

• Networks 2 and 3 were centred on co-offending relationships that emerged from living near to each other and other risk factors.

• Network 4 was centred on a drugs hierarchy and utilised a more organised structure.

• Fear and intimidation contributed to the strength and stability of Bluetown networks.

Lifting the lid on Bluetown and Redtown continued

Figure 1: Network position from low strength and stability to high

Strengths and limitations

There were several strengths and limitations to the study. The findings in this study were centred on third-party observations and perspectives. The Twinsight methodology developed in the Greentown study allowed for in-depth knowledge and context to be captured. However, there were challenges, as the area covered by Bluetown was a large urban area. As a result, knowledge reported by Garda respondents was limited and centred on their own patrol or catchment area; hence, some information on offenders was from a broader perspective rather than focused on specific individuals. As acknowledged by the authors, similar to the Greentown study, there were limitations to utilising PULSE data to develop the map.[6,7] Nevertheless, Garda respondents believed that the map was accurate, giving it an average rating of 8.36 out of 10 for accuracy (p. 48).[1]

Redtown study

The Redtown study was of a small provincial town. It was ranked third in the Garda subdistricts list because of the number of youths aged under 18 years involved in burglary and drugs for sale and supply. Hence, this location was considered ideal to enable a deep exploration of the factors that may contribute to criminality in this cohort.[2]

Findings

The analysis of Garda respondent narratives resulted in two main themes emerging: family influences and drug-related crime. Each will be described separately.

Theme 1: Family influences – adversity, pro-criminal norms, and exclusion

Three young people, aged 16 years, who were repeatedly involved in burglary offences between 2014 and 2015 along with their engagement with the Redtown criminal network were the focus

Lifting the lid on Bluetown and Redtown   continued

of Garda narratives. Criminal activity was mainly viewed as normal by their peers and more so by their families who had criminal histories. The main characteristics of the family were that they were of low status, experienced financial poverty, and had high levels of adversity. In addition, families were rooted within the Redtown criminal network via 'extended family and drugs-related links' (p. 16).[2] These young people had a tendency to be excluded from the mainstream Redtown community. These factors together influenced young people's involvement with both criminality and the Redtown criminal network.

Theme 2: Drug-related crime – organised or chaotic

Drug-related offences were the main activity carried out by the Redtown network. How a network member was involved and the organisational level of the drug-related offence centred on how vulnerable the individual was and their personal drug use (p. 16).[2] Three interconnected groupings were identified:

- Fund personal use (chaotic)
- Carrying and distribution of drugs
- Organised.

'Organised' network members mainly carried out 'higher-level sale and supply' (p. 16)[2] and remained 'undetected' on the network map. While most of the network members could be classified as 'chaotic', they carried out lower-level sale and supply of drugs and other crime to pay for drugs for personal use. This group are considered susceptible to exploitation. Figure 1 provides a summary of the theoretical framework the authors put forward showing the interconnections between themes, subthemes as processes of engagement, and retention of network membership. Further detail on the key network members can be found in section 3.1.1 Part A of the report (p. 17).[2]
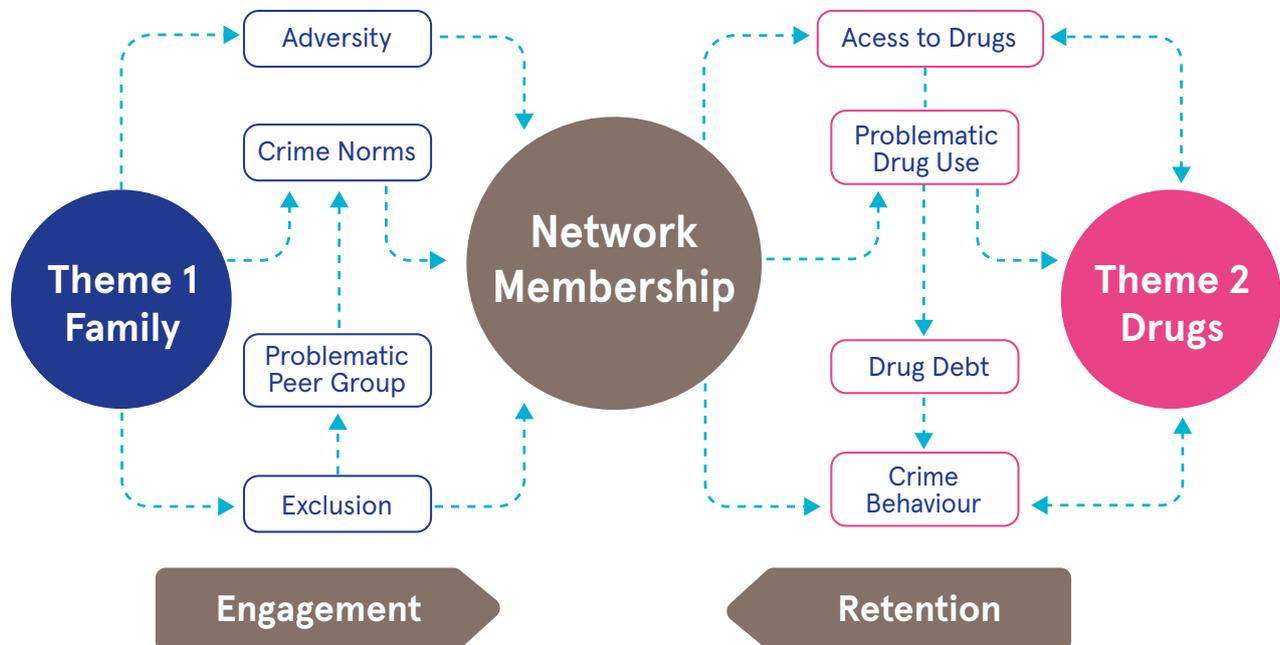
Source: Figure 16 extracted from Naughton, Redmond and O'Meara Daly (2020), p. 402

Figure 2: Network membership theoretical framework for Redtown

Lifting the lid on Bluetown and Redtown   continued

Strengths and limitations

Several strengths and limitations were identified. For example, due to the level of young people involved in criminality in Redtown, it was viewed as an 'untapped source' (p. 41).[2] The Twinsight method allowed for both group and individual level analysis to be applied. Moreover, this approach allowed for the network to be examined longitudinally, both before and after the 2014–2015 timeframe. Garda respondents were advised that the focus was on young people, which may have influenced their responses. Despite this, the intergenerational nature of offending behaviour was evidenced by the involvement of older family members in the network. More methodological strengths and limitations can be found in all three Greentown Project reports.[1,2,4]

Conclusion

The aim of these studies was to explore whether criminal networks influenced children moving into a life of crime. The results are believed to provide hope and opportunities for children drawn into serious and prolific crime. Minister McEntee thanked Dr Sean Redmond and his colleagues for their work and acknowledged the importance of breaking the connection between criminal networks and young people. The Greentown Project has provided the information needed to help prevent young people from becoming part of these networks. She noted that the research evidence shows the seriousness of this issue and requires a 'serious and rapid criminal justice response' (p. 1).[8]

Ciara H Guiney

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Correlates of cannabis use and cannabis use disorder in Ireland

Background and methods

The prevalence of cannabis use has increased in many developed countries in recent years. In the Republic of Ireland, the most recent national survey, conducted in 2014/15, found that 27.9% of people aged 15–64 years had used cannabis at some point in their lives, with 7.7% and 4.4% having used cannabis within the last year or last month, respectively.[1] Concurrent with higher rates of use, the number of people entering treatment for a cannabis use disorder (CUD) has also increased; in Ireland, for new entrants to treatment in 2017, cannabis replaced opiates as the most commonly reported primary problem drug.[2] Cannabis is also now the most common substance involved in drug-related admissions to psychiatric hospitals in Ireland.[3,4] As proposals to liberalise cannabis laws are currently being explored in many countries, knowledge of factors relating to patterns of cannabis use and CUD is important for informing drug policy.

A new Irish study[5] determined factors associated with recent and current cannabis use and having a CUD – defined as abuse or dependence using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). In this research, published in the *European Journal of Public Health*, data were analysed from Ireland's 2010/11 and 2014/15 National Drug Prevalence Surveys, which recruited 5,134 and 7,005 individuals, respectively, aged 15 years or more, living in private households. Multinomial logistic regression was used to identify factors associated with recent (last-year) and current (last-month) cannabis use compared with ever cannabis use. Binary logistic regression was used to determine factors related to CUD among current cannabis users.

Results

The weighted prevalence of ever cannabis use for the combined surveys was 18.3%, with 3.0% and 3.3% of participants indicating recent or current use, respectively. Twenty-four per cent of recent users and 41.3% of current users scored positive for a CUD – either cannabis abuse or dependence. In multivariable analysis, factors associated with both recent or current cannabis use included younger age, not having dependent children, and current use of tobacco or alcohol. In addition, a positive attitude towards cannabis legalisation was found to be significantly related to both recent and current use. Regarding problem cannabis use, key findings were that the odds ratio (OR) of having a CUD was higher among males (OR=2.01, 95% CI: 1.13–3.57); participants aged 25–34 (OR=1.88, 95% CI: 1.04–3.39) and those aged 15–24 years of age (OR=4.22, 95% CI: 2.11–8.46); and individuals who had very low educational attainment levels (OR=3.62, 95% CI: 1.93–6.77).

Conclusions

The authors noted that the high prevalence of CUD among current users found in this study is concerning but not unexpected, as research has demonstrated that greater frequency of cannabis use increases the likelihood of developing problematic use. Consequently, these findings do suggest that health professionals should have a high level of suspicion regarding the possibility of a CUD where current cannabis use is reported. Given the potential public health implications of cannabis legalisation, it is imperative that valid and reliable information on cannabis use, CUD, and cannabis-related harm is collected to ensure that the impact of any changes arising from cannabis legalisation can be accurately measured. The authors suggest that findings from this study may be used to better inform public health efforts to improve prevention of CUD and in the identification and referral of CUD clients to appropriate treatment services.

Correlates of cannabis use
continued

Seán Millar

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4   Smyth BP, Daly A, Elmusharaf K, *et al.* (2020) Legislation targeting head shops selling new psychoactive substances and changes in drug-related psychiatric admissions: a national database study. *Early Interv Psychiatry,* 14(1): 53–60. https://www.drugsandalcohol.ie/30436/

5   Millar SR, Mongan D, O'Dwyer C, *et al.* (2021) Correlates of patterns of cannabis use, abuse and dependence: evidence from two national surveys in Ireland. *Eur J Public Health,* 31(2): 441–447. https://www.drugsandalcohol.ie/33859/

Factors associated with early and later dropout from methadone maintenance treatment in specialist addiction clinics

Background and methods

Opioid use disorder (OUD) is a significant contributor to morbidity and premature mortality and represents a major public health problem worldwide. Drug overdose is the leading cause of death among people with OUD and interventions such as opioid agonist treatment (OAT) have been widely implemented to circumvent preventable fatalities within this population.[1] Methadone maintenance treatment (MMT) is the most common OAT in Ireland and has been shown to be cost-effective, safe, and beneficial in reducing risk behaviour and improving health and social outcomes.

Despite the strong evidence base supporting the use of MMT, during the first four weeks of treatment initiation and following treatment cessation, the mortality risk for clients remains high.[2] This risk is reduced if individuals are retained in MMT, therefore, efforts to improve retention are essential. A 2020 systematic review demonstrated that retention rates in MMT decrease over time, with most dropouts occurring early in treatment, and a number of factors that influence retention were identified.[3] However, despite clients often transitioning in and out of treatment, most of the studies included did not consider these risk factors as time-varying covariates and also failed to model the time to dropout of successive treatment episodes as recurrent event data.

In a 2021 research paper, published in the journal *Drug and Alcohol Dependence,*[4] the authors conducted an observational cohort study of individuals who had experienced at least one episode of MMT lasting greater than seven days in Irish specialist addiction services (Dublin Southwest and Kildare) between 1 January 2010 and 31 December 2015. Data were gathered through the Central Treatment List and the Methadone Treatment Scheme. Client records were also linked to the General Medical Services (GMS) pharmacy claims database

Dropout from methadone maintenance treatment   continued

and the National Drug-Related Deaths Index. Using a statistical model, this study identified determinants of time to dropout of MMT at three months and at 12 months across multiple treatment episodes.[4]

Results

The 2,035 clients included in the study experienced a total of 4,969 MMT episodes over the observation period. The median age was 34 years at the time of initial treatment episode and 68% were men. Almost 42% of clients received a median methadone dose below the recommended optimal range of 60–120 mg/day. The study observed:

- 2,724 dropout events occurred during the six-year observation period.

- 82.8% of all dropouts occurred within the first 12 months of treatment.

- 49.7% of dropout events occurred in the first three months.

Dropout at three months was associated with low dose methadone (<60 mg/day) and a history of previous dropout. Adherence to treatment, defined as not missing doses over the previous 30 days, was shown to be protective. Low dose methadone and previous dropout remained as increased risks of dropout at 12 months. Being male, having a prescription for benzodiazepines, and a higher number of comorbidities were also identified as additional risk factors in the longer-term model. Once again, adherence was protective at this time point.

Conclusions

The factors identified in this study could serve as indicators to risk stratify clients and provide service enhancements to increase engagement and retention in treatment. Previous dropout or missing doses are suggestive of instability and these clients should be identified as high risk of both early and later dropout. It is noted that no study thus far has examined the persistent prescribing of low dose methadone, but it is

suggested by the study authors that a review of prescribing practices should be considered. Adherence was protective at three and 12 months and should be actively encouraged. The authors recognise both the strengths and limitations of this current research and note that further testing and validation is required to build on the associations identified here in understanding the determinants of dropout from OAT.

Emma McGrath

1   Degenhardt L, Grebely J, Stone J, *et al.* (2019) Global patterns of opioid use and dependence: harms to populations, interventions, and future action. *Lancet*, 394 (10208): 1560–1579.

2   Sordo L, Barrio G, Bravo MJ, *et al.* (2017) Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*, 357: j1550.

3   O'Connor AM, Cousins G, Durand L, Barry J and Boland F (2020) Retention of patients in opioid substitution treatment: a systematic review. *PLoS One*, 15(5): e0232086. https://www.drugsandalcohol.ie/32009/

4   Durand L, Boland F, O'Driscoll D, *et al.* (2021) Factors associated with early and later dropout from methadone maintenance treatment in specialist addiction clinics: a six-year cohort study using proportional hazards frailty models for recurrent treatment episodes. *Drug Alcohol Depend*, 219: 108466. https://www.drugsandalcohol.ie/33611/

Pathways to 'recovery' and social reintegration: experiences of Irish long-term clients of methadone maintenance treatment

Background

Approaches to addiction treatment remain a source of ongoing policy debate worldwide. Advocates for a recovery-focused approach have questioned the dominance of harm reduction strategies, particularly in regard to their record in social integration and other non-treatment outcomes, such as employment and education. Traditionally, some recovery advocates have argued that an abstinence-centred system best serves the social reintegration of its clients.[1] Critics of this outlook have insisted that it is limited given the wide range of other personal and socioeconomic challenges faced by people who use drugs, and that it is grounded more in ideology than scientific evidence.[2] Currently, there is an accommodation between the two perspectives, whereby most supporters of recovery do not view drug-based treatment as inimical to the goal of social reintegration and a fulfilling life.

In Ireland, the authors of a 2005 study assert that a covert implementation of harm reduction strategies occurred in response to the opiate epidemic and emergence of HIV in the 1980s.[3] Irish drug policymaking has since given way to a more transparent process through the introduction of national drug strategies and has shifted towards an aspirational focus on 'rehabilitation'. Although differing slightly in terminology, this rehabilitation framework largely reflects the recovery concept of other jurisdictions. The current drugs strategy is characterised by two main themes: integrated care pathways that provide a journey towards recovery and service provision that is respectful to clients and promotes their involvement as active partners in the planning and delivery of their care.[4]

A 2021 research paper, published in the *International Journal of Drug Policy*, examined how the lived experiences of service users on long-term methadone maintenance treatment (MMT) compare with Ireland's current drug policy goals.[5]

Methods

In-depth qualitative interviews were recorded with 25 long-term clients who had been enrolled in MMT at least 10 years prior to participating in the study. Recruitment focused primarily on clients of specialist addiction clinics in the Dún Laoghaire-Rathdown area of South Dublin. The interviews were topic-centred but allowed flexibility to accurately capture service users' personal experiences. Analysis was guided by a grounded theory approach and thematic analysis was used to identify patterns within the data collected between August 2017 and February 2018.

Results

Positive impacts

Most of the study participants reported that MMT had positively impacted one or more aspects of their lives, with the benefits concentrated on providing a sense of stability and normality. Clients reported such stability had resulted in better management of daily life and responsibilities, more positive engagement with children and family, and improved health and wellbeing. Male interviewees particularly recounted a reduction in criminal activity and contact with the criminal justice system.

Inability to progress

While MMT promoted daily stability, a journey to recovery was not reflected in the accounts of the study participants. Individuals generally described their circumstances as stagnant with a significant lack of progress or change. One

Pathways to 'recovery' and social reintegration continued

respondent described treatment as 'stalling' rather than 'fixing' the problem and many expressed feelings of being trapped in a cycle, with references to 'liquid handcuffs' and being held 'hostage', highlighting the perception of an unending process rather than a pathway to recovery.

Lack of involvement and control

Negative viewpoints towards the treatment setting were also conveyed by respondents, with a perceived lack of caring or interest shown in the personal circumstances, issues or challenges faced by the service user. Study participants depicted a sense of passivity in their care and felt there was little opportunity to provide input or influence their treatment plan. One interviewee explained: 'They're giving out maintenance too quick [without] asking "What do you think?".' Participants drew attention to a particular unwillingness of prescribing doctors to lower the clients' daily dose, with such requests viewed negatively or refused without detailed explanation or engagement in discussion. Several respondents described the difficulty in establishing trust with doctors in the clinic. Overall, the ability to exert agency over their treatment was largely absent in the experiences recorded for this research.

Obstacles to reintegration

Several barriers to social reintegration were expressed by participants, most of whom were unemployed at the time of interview. Many felt the labour market was generally out of reach due to low educational qualifications, stigmatisation, and concerns around balancing MMT with employment. Daily life for interviewees was often depicted by feelings of isolation and loneliness, with family relationships remaining tenuous, difficulty maintaining friendships, and lacking a sense of belonging in their communities. One interviewee explained how he found it 'pretty hard to reintegrate into normal society', with the same sentiments of marginality shared among the majority of study participants.

Conclusions

The authors conclude that there is a clear disparity between Irish drug policy aims of recovery and social reintegration and the lived experiences of those who are long-term MMT clients. Participants did not view themselves on a pathway to rehabilitation and that the current system did not facilitate client input or autonomy over their ongoing care, while reinforcing feelings of social exclusion and stigmatisation. This study indicates that the current rehabilitation framework has not yet delivered improved outcomes for opioid-dependent clients and practices of service-user involvement have not been meaningfully implemented. To improve the quality of life for service users, a more realistic policy approach is urgently needed.

Emma McGrath

1   Advisory Council on the Misuse of Drugs (2015) *How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users?* London: Advisory Council on the Misuse of Drugs.

2   Best D, Bamber S, Battersby A, *et al.* (2010) Recovery and straw men: an analysis of the objections raised to the transition to a recovery model in UK addiction services. *J Groups Addict Recover*, 5(3–4): 264–288.

3   Butler S and Mayock P (2005) 'An Irish solution to an Irish problem': harm reduction and ambiguity in the drug policy of the Republic of Ireland. *Inter J Drug Policy*, 16(6): 415–422. https://www.drugsandalcohol.ie/6779/

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

5   Mayock P and Butler S (2021) Pathways to 'recovery' and social reintegration: the experiences of long-term clients of methadone maintenance treatment in an Irish drug treatment setting. *Inter J Drug Policy*, 90: 103092. https://www.drugsandalcohol.ie/33604/

PREVALENCE AND CURRENT SITUATION

Self-harm in Irish prisons

The Self-Harm Assessment and Data Analysis (SADA) Project was set up in Ireland in 2016 to provide robust information relating to the incidence and profile of self-harm within prison settings as well as individual-specific and context-specific risk factors relating to self-harm. In addition, it examines patterns of repeat self-harm (both non-fatal and fatal). The Health Service Executive's National Office for Suicide Prevention and the National Suicide Research Foundation assist the Irish Prison Service with data management, data analysis, and reporting. This article highlights findings from a report presenting data in the analysis of all episodes of self-harm across the Irish prison estate during the year 2018.[1]

Episodes of self-harm

Between 1 January and 31 December 2018, there were 263 episodes of self-harm recorded in Irish prisons, involving 147 individuals. The majority of prisoners who engaged in self-harm were male (82.3%), but taking into account the male prison population, the rate of self-harm among males was 3.4 per 100 prisoners. Twenty-six female prisoners engaged in self-harm in 2018, equating to a rate of 19.3 per 100 prisoners, which is 5.7 times higher than the rate among male prisoners.

Methods, severity, and intent

The most common method of self-harm recorded was self-cutting or scratching, which was present in 69% of all episodes. The other common method of self-harm was attempted hanging, which was involved in 20% of episodes. In 27% of self-harm episodes, no medical treatment was required, while over one-half (59%) of all episodes required minimal intervention/minor dressings or local wound management. One in eight episodes required hospital treatment (12%). Over two-thirds (70%) of self-harm episodes were recorded as having

no/low suicidal intent, with 17% recorded as having medium intent. Approximately one in eight acts was rated as having high suicidal intent (13%).
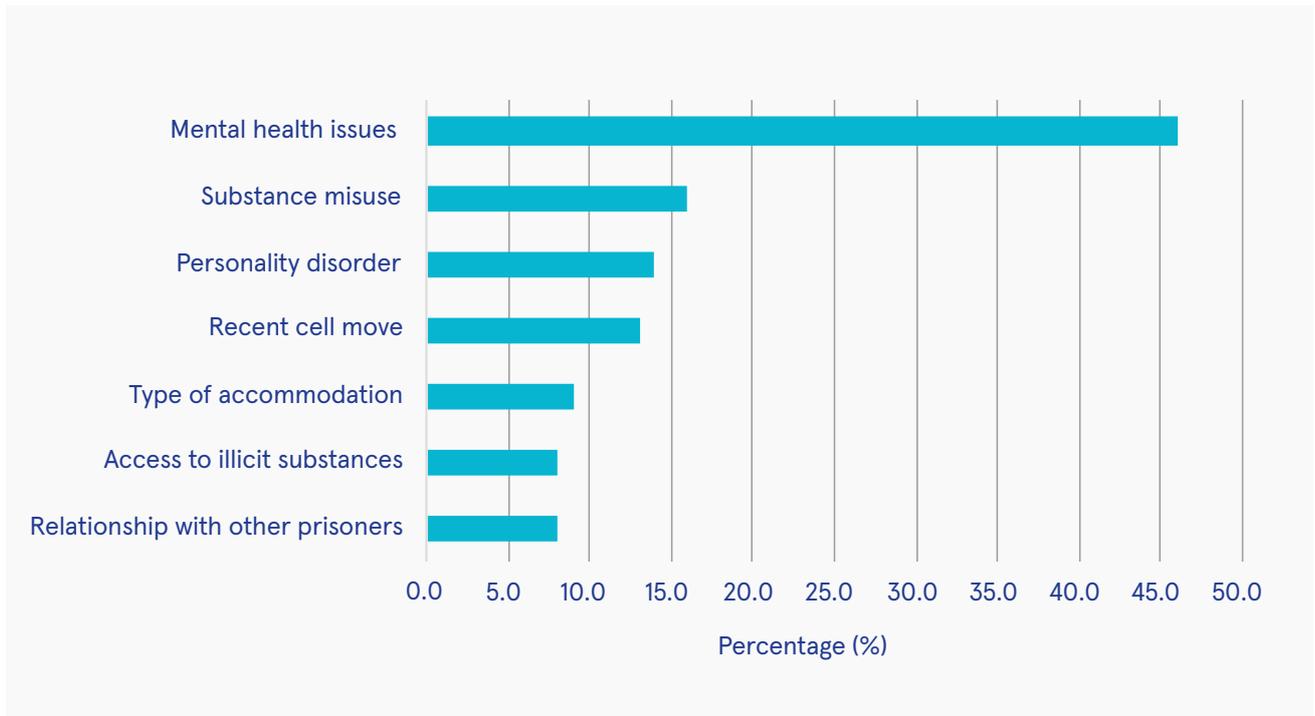
Contributory factors

The most common contributory factors to self-harm are shown in Figure 1. The majority of contributory factors recorded related to mental health (45.6%). The category of mental health issues included mental disorders as well as problems with coping and emotional regulation. Substance misuse, including drug use and drug seeking, was the next most common factor recorded (16.3%).

Other findings and recommendations

Other findings highlighted in the report include the following:

- Three-quarters (73%) of self-harm episodes involved prisoners in single cell accommodation. Considering the overall prison population, 51.9% of prisoners who self-harmed were accommodated in single cells in 2018.

- The rate of self-harm was higher among prisoners on remand or awaiting trial than among sentenced prisoners (5.0 vs 3.7 per 100 prisoners).

- In line with previous findings, substance abuse continues to be one of the primary factors associated with self-harm among the prison population in Ireland. The report authors suggest that there is a need for active consultation and collaboration between the mental health services and addiction treatment services for prisoners who present with dual diagnoses in line with action 2.1.24 of *Reducing harm, supporting recovery* to 'improve outcomes for people with co-morbid severe mental illness and substance misuse problems'.[2]

Self-harm in Irish prisons   continued

Source: McTernan *et al.* (2020)

Figure 1: Most common contributory factors to self-harm in Irish prisons, 2018

Seán Millar

1   McTernan N, Griffin E, Cully G, *et al.* (2020) *Self-harm in Irish prisons 2018: second report from the Self-Harm Assessment and Data Analysis (SADA) Project*. Dublin: Irish Prison Service. https://www.drugsandalcohol.ie/32840/

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/

Irish drug quantification trends for cocaine, diamorphine, and amphetamine 2016–2019

Forensic Science Ireland (FSI) is an associated office of the Department of Justice delivering comprehensive scientific analysis, independent expert opinion, advice, and training to support the Irish criminal justice system. The analysis of substances that are suspected to contravene the Misuse of Drugs legislation comprises the majority of submitted cases to FSI. Analysis of these cases is carried out by the Chemical Analysis Department in FSI and cases range in both content and complexity.

The Chemical Analysis Department contributes to the European Union (EU) Early Warning System for the reporting of emerging drug trends via the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the drugs working group in the European Network of Forensic Science Institutes (ENFSI), and the Early Warning and Emerging Trends (EWET) group in Ireland. The majority of drugs cases brought to FSI are submitted by An Garda Síochána (AGS) and, in addition to the reporting of these cases, FSI provides intelligence data to AGS. These data support the understanding of the illicit drug market in Ireland and include quantification data for some of the most commonly seized materials.

Quantification data are produced for intelligence purposes for three substances: cocaine, diamorphine (heroin), and amphetamine. Data are presented below. These were the second, third, and tenth most commonly seized drugs, respectively, in 2019.[1] The data also include the most commonly identified adulterants. An adulterant is defined as any extraneous substance found in addition to the analyte of interest. Two distinct levels of seizure are analysed for quantification of cocaine and diamorphine: street level and importation level. Street-level samples are defined as those submitted from seizures less than 30 g, primarily between 25 and 30 g, while importation-level samples are defined as those submitted from seizures primarily over 500 g. For amphetamine, all seizures over 25 g were quantified.

Cocaine

Cocaine was the most commonly seized stimulant in Ireland across the four-year period (2016–2019) examined and the second most commonly identified compound after cannabis in FSI in 2019.[2–6] In 2019, 26% of all drugs cases analysed in FSI contained cocaine, which was equivalent to 222 kg of powder/substance.[1] Figure 1 illustrates the annual average cocaine content during the time period examined. The content has remained broadly consistent over the four-year period, with an increase at street level noted. European data support the increase in cocaine content seen in Ireland over the time interval detailed in this report. An increase in trafficking routes, supply, seizures, and seizure volumes are noted in this time period, ultimately leading to an increase in cocaine content for users.[2] The importation-level content is consistently higher than the average at street level.

In the three analytes examined as part of the quantification project, cocaine demonstrates the widest variety in adulterants. Figure 2 depicts the range of compounds detected as part of the submitted cocaine samples. With the exception of 2017, benzocaine is the most commonly detected adulterant across the time period, closely followed by levamisole. Some of the other adulterants not named in Figure 2 include creatine/creatinine and hydroxyzine.
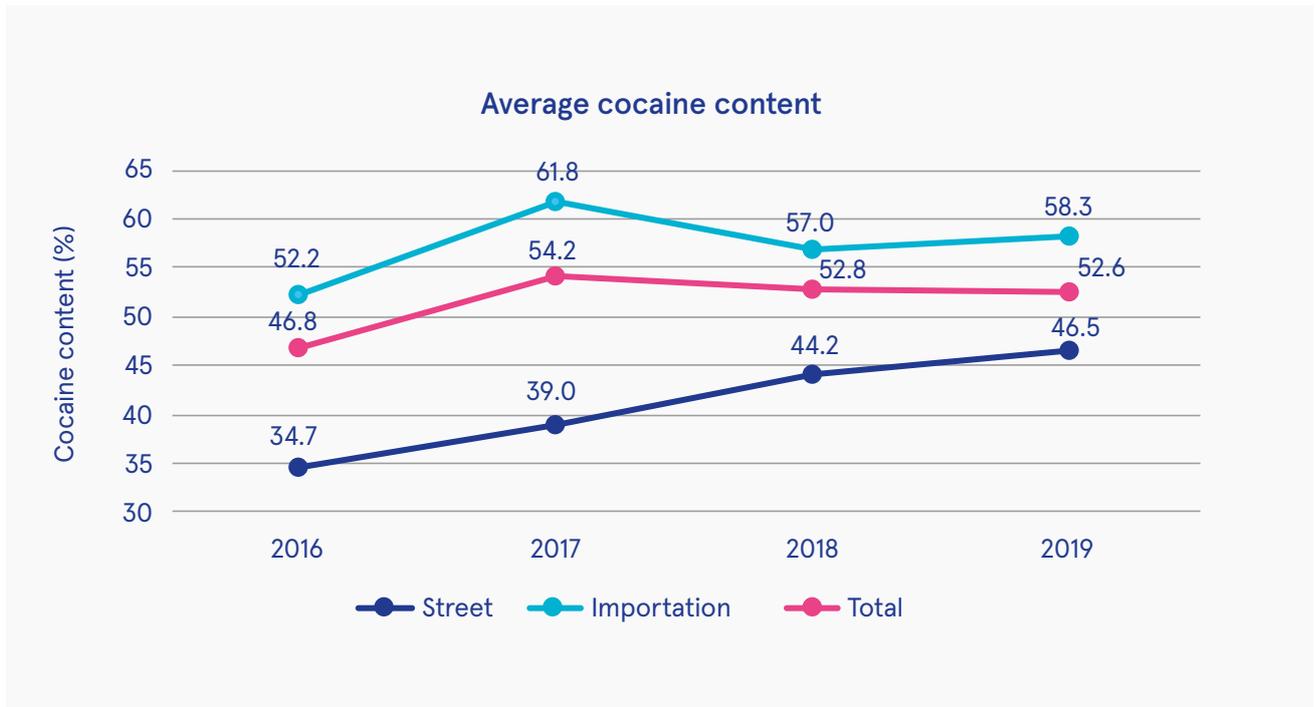
Irish drug quantification trends

continued

Average cocaine content

Figure 1: The average cocaine content at street and importation level, 2016–2019
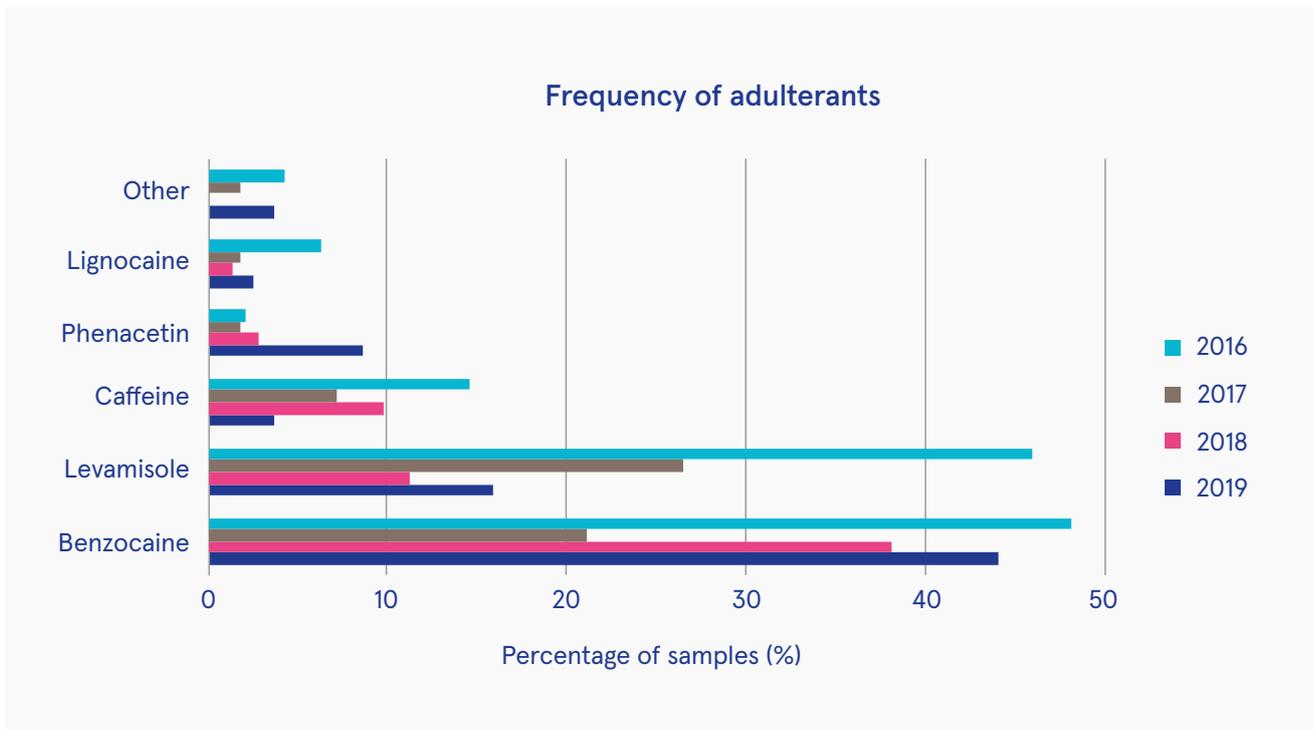
Frequency of adulterants

Figure 2: Comparison of the adulterants in submitted cocaine samples across street-level and importation-level seizures, 2016–2019

Irish drug quantification trends
continued

Diamorphine (heroin)

Diamorphine is a semi-synthetic product produced by the acetylation of morphine, which occurs as a natural product in opium. The drug is controlled in the Republic of Ireland. Diamorphine is the most commonly encountered opioid in Ireland and throughout the EU and was the third most commonly identified compound in FSI in 2019.[2-6] In 2019, 15% of all drug cases analysed in FSI contained diamorphine, which was equivalent to 50 kg of powder/substance.[1] Figure 3 shows the annual average diamorphine content over the four-year period. Some year-to-year variability is noted, with the importation-level average content higher than street-level. A stable supply of diamorphine from established trafficking routes is consistent with data from other European countries.[2] The diversifying opioid market worldwide, specifically in North America, has largely evaded the EU, which is also the case in Ireland.

Caffeine and paracetamol are the most commonly detected adulterants in diamorphine seizures. Caffeine and paracetamol were found together in 49.5% of all samples analysed as part of the quantification project over the four-year period; this figure is higher at street level (64.1%) than at the importation level (42.5%). Other adulterants detected by the FSI method include clotrimazole and MDMA.

Amphetamine

Amphetamine is the second most commonly encountered phenethylamine in Ireland, after MDMA. It was the tenth most commonly identified compound in FSI in 2019.[1] In 2019, 2.5% of all drugs cases analysed in FSI contained amphetamine, which was equivalent to 27 kg of powder/substance. Figure 4 illustrates the annual average amphetamine content over the four-year period. Average amphetamine content has remained broadly consistent over this time. EU regulations have largely focused on the control of precursor chemicals as the manufacture of amphetamines are generally local to the supply chain. A decrease from 2018 onwards after a peak in 2017 is potentially linked to the introduction of
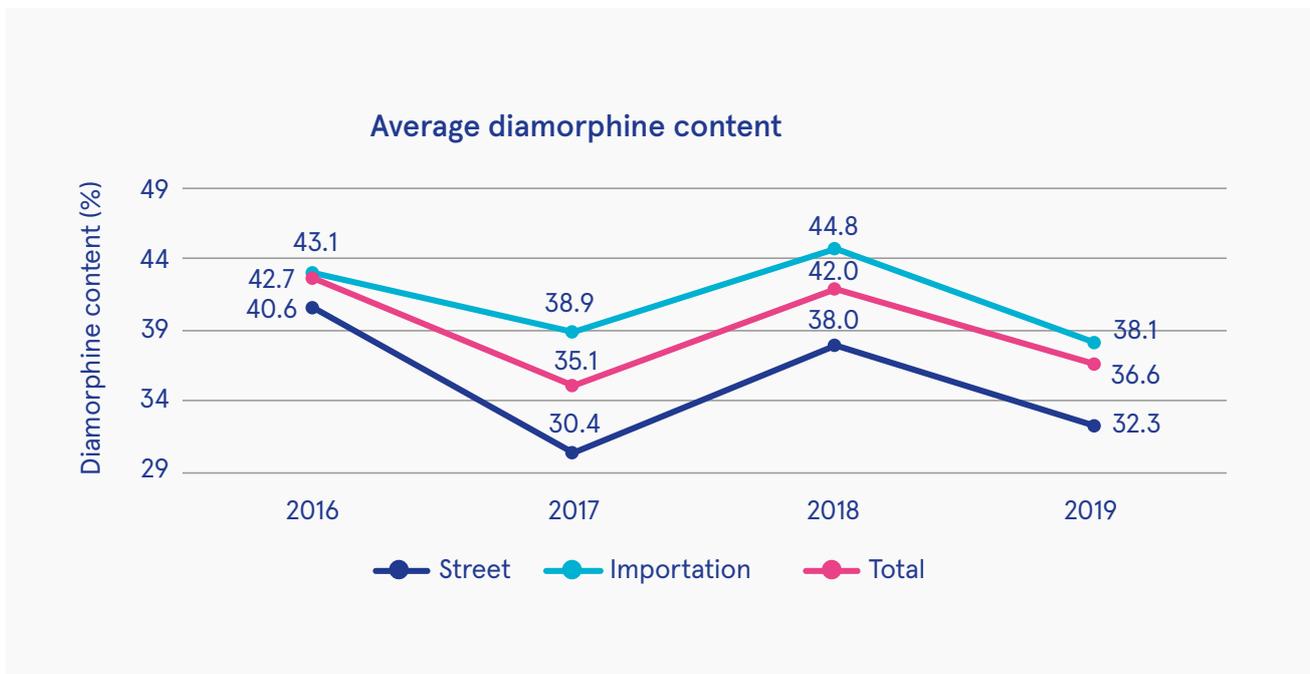

Average diamorphine content

Street: 2016 = 40.6, 2017 = 30.4, 2018 = 38.0, 2019 = 32.3
Importation: 2016 = 43.1, 2017 = 38.9, 2018 = 44.8, 2019 = 38.1
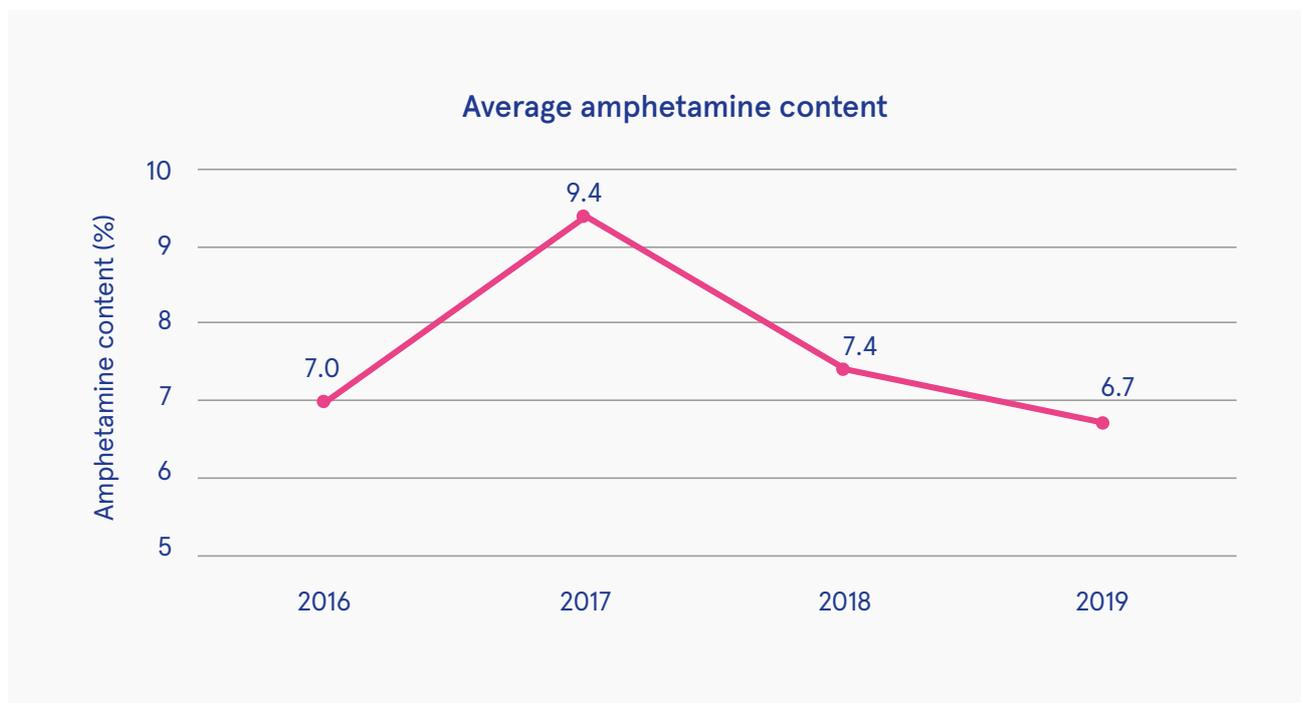Total: 2016 = 42.7, 2017 = 35.1, 2018 = 42.0, 2019 = 36.6

Figure 3: The average diamorphine content at street and importation level, 2016–2019

Irish drug quantification trends

continued

Average amphetamine content

Figure 4: The average amphetamine content, 2016–2019

controls to precursor chemicals such as alpha–phenylacetoacetamide (APAA) and derivatives of benzyl methyl ketone (BMK); a similar decline was noted in 2013 after similar controls were introduced in Europe.[2]

Caffeine is by far the most consistently detected adulterant in amphetamine seizures. In terms of adulterants, 86.25% of samples submitted for analysis over the four-year period were found to contain at least one adulterant. In the case of adulterated samples, caffeine was always detected.

Sarah Hanniffy and Yvonne Kavanagh

1   Forensic Science Ireland Case Data 2019 (unpublished).

2   European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019) *European drug report 2019: trends and developments*. Luxembourg: Publications Office of the European Union. https://www.drugsandalcohol.ie/30619/

3   An Garda Síochána (AGS) (2017) *An Garda Síochána annual report 2016*. Dublin: AGS. https://www.drugsandalcohol.ie/27780/

4   An Garda Síochána (2018) *An Garda Síochána annual report 2017*. Dublin: AGS. https://www.drugsandalcohol.ie/29532/

5   An Garda Síochána (2019) *An Garda Síochána annual report 2018*. Dublin: AGS. https://www.drugsandalcohol.ie/32192/

6   An Garda Síochána (2020) *An Garda Síochána annual report 2019*. Dublin: AGS. https://www.drugsandalcohol.ie/33478/
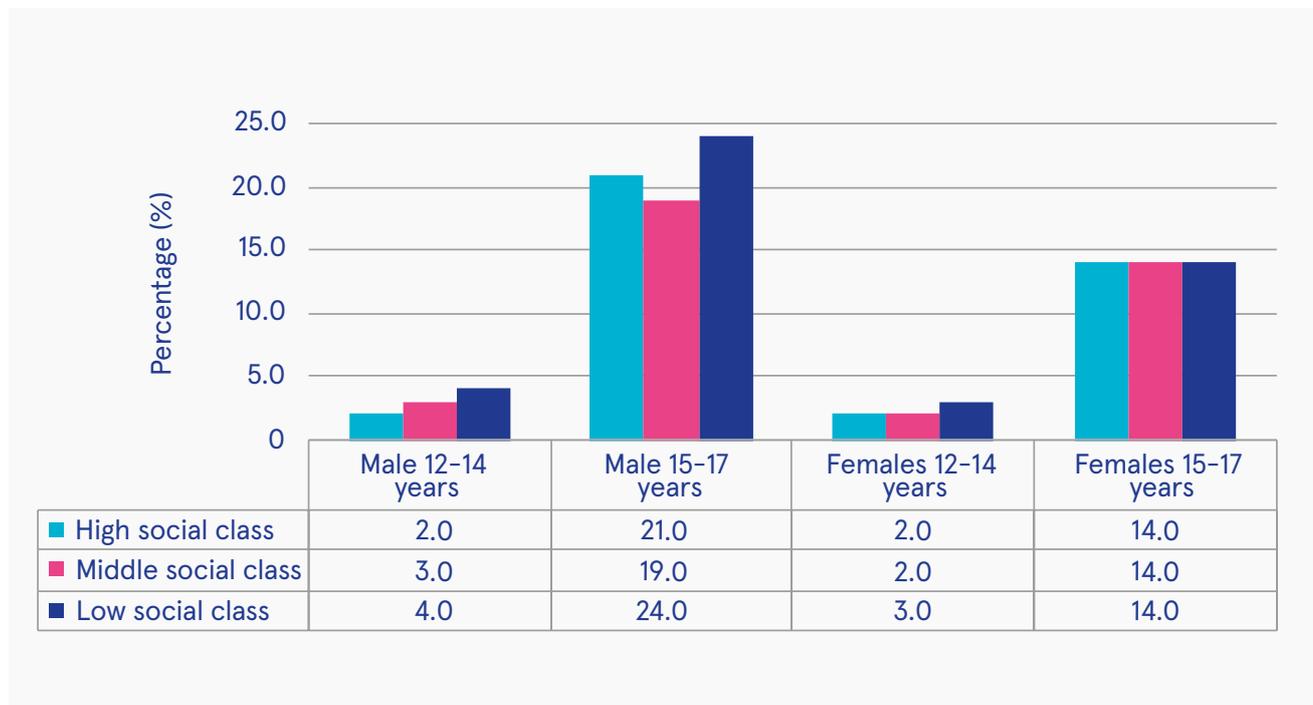
Cannabis use among Irish children: results from the 2018 Health Behaviour in School-aged Children Survey

The first Health Behaviour in School-aged Children (HBSC) Survey was conducted in Ireland in 1998 and has been repeated every four years ever since. In 2018, the study was conducted in Ireland for the sixth time. This survey included 15,557 children aged 8 to 18 years, drawn from a representative sample of 255 primary and post-primary schools across Ireland. Data were collected on general health, social class, smoking, use of alcohol and other substances, food and dietary behaviour, exercise and physical activity, self-care, injuries, bullying, and sexual health behaviours. Social class corresponds to high, middle, and low social class groups. The

categories used for social class are standard and were determined by the highest-reported parental occupation. High social class includes professional occupations (i.e. solicitor, doctor), and managerial occupations (i.e. nurse, teacher); middle social class includes non-manual occupations (i.e. sales person, office clerk) and skilled-manual occupations (i.e. hairdresser, carpenter); low social class includes semi-skilled occupations (i.e. postal worker, carer) and unskilled occupations (i.e. cleaner, labourer). The main results were published in January 2020.[1] Published findings regarding cannabis use are shown below.

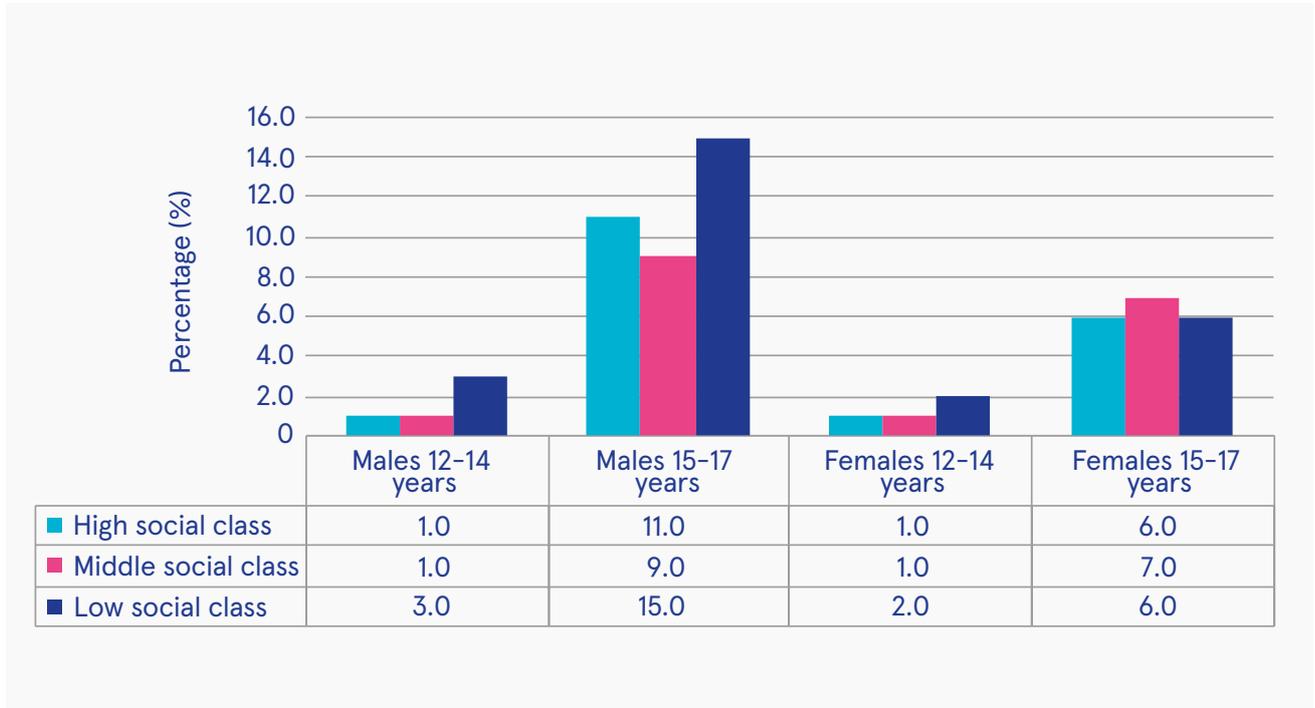## Last-year cannabis use among Irish school-aged children

Statistically significant differences by sex and age group were observed for last-year cannabis use. Overall, 8% of boys and 6% of girls reported cannabis use in the last 12 months. Younger children were less likely to report cannabis use in the last 12 months than older children. No statistically significant differences across social class groups were noted (see Figure 1).

	Male 12–14 years	Male 15–17 years	Females 12–14 years	Females 15–17 years
High social class	2.0	21.0	2.0	14.0
Middle social class	3.0	19.0	2.0	14.0
Low social class	4.0	24.0	3.0	14.0

Source: HBSC Ireland, 2018

Figure 1: Percentage of 12–17-year-olds reporting use of cannabis in the past year, 2018

Cannabis use among Irish children   continued

	Males 12–14 years	Males 15–17 years	Females 12–14 years	Females 15–17 years
■ High social class	1.0	11.0	1.0	6.0
■ Middle social class	1.0	9.0	1.0	7.0
■ Low social class	3.0	15.0	2.0	6.0

Source: HBSC Ireland, 2018

Figure 2: Percentage of 12–17-year-olds reporting use of cannabis in the past 30 days, 2018

Current use of cannabis among Irish school-aged children

Statistically significant differences by sex and age group were reported for current use of cannabis. Overall, boys (4%) were more likely than girls (3%) to report cannabis use in the last 30 days. Younger children were also less likely to report cannabis use in the last 30 days than older children. As with last-year cannabis use, no statistically significant differences across social class groups were found (see Figure 2).

Seán Millar

1   Költő A, Gavin A, Molcho M, Kelly C, Walker L and Nic Gabhainn S (2020) *The Irish Health Behaviour in School-aged Children (HBSC) study 2018*. Dublin: Department of Health and National University of Ireland Galway.
https://www.drugsandalcohol.ie/31531/

RESPONSES

Dublin NEIC progress report

In December 2020, the fourth progress report of the North East Inner City's (NEIC) Programme Implementation Board (PIB) was launched by Minister for Finance Paschal Donohoe TD.[1] NEIC's vision is of making the north east inner city a safe, attractive, and vibrant living and working environment for the community and its families with opportunities for all to lead full lives.

Background

In June 2016, a ministerial taskforce chaired by the then Taoiseach Enda Kenny was established to support the long-term economic and social regeneration of Dublin's NEIC. A report on the area and the challenges it faced was subsequently published, which outlined a plan for the area's regeneration, grounded in a combination of place-based and people-based approaches to inform regeneration in the NEIC.[2] The report led to the establishment of the PIB and four subgroups, each of which took on responsibility for one of the priority areas identified in the report: tackling crime and drugs; maximising educational/training opportunities/ creating local employment opportunities; creating an integrated system of social services; and improving the physical landscape.[3] Based on a growing understanding of the complex challenges facing the NEIC, it was agreed in 2018 to establish a fifth subgroup to focus on substance use and misuse and to enhance the services provided.

An evaluation assessment carried out in 2019 informed the PIB's decision to move forward using what was termed 'a more structured delivery approach to the programme' (p. 3).[4] Its aim was to support the programme and focus on long-term sustainable outcomes; ensure alignment of objectives across the subgroups; enhance cross-team collaboration; and ensure accountability for the delivery of priority actions (p. 3). To deliver on this, a three-year strategic plan for 2020–2022 was developed and implemented.

2020 progress report and substance use

The 2020 progress report outlines the wide range of projects and programmes delivered in the NEIC over the year. Activities are linked to the six priority workstreams as outlined in the strategic plan 2020–2022: enhanced policing; maximising educational, training, and employment opportunities; family wellbeing; enhancing community wellbeing and the physical environment; substance use, misuse, and inclusion health; and alignment of services.

The subgroup on substance use, misuse, and inclusion health focuses on improving health outcomes for people who use and misuse drugs and alcohol and on promoting inclusion health for socially excluded groups experiencing severe health inequalities. Its activities in 2020 included:

- Funding three drug and alcohol services delivered by voluntary providers. These were a drug and alcohol addiction response team, a homeless case management team, and a residential stabilisation programme. Given the 'significant benefits for local inhabitants' (p. 27)[1] of these services, the Department of Health made a commitment to provide them with mainstream funding for 2021.

- Funding the establishment of a community addiction assessment hub for people who use non-opioid drugs.

- Providing match funding with Healthy Ireland for a community health project to tackle health inequalities. Activities will include building community knowledge and skills around stress management, healthy food, smoking cessation, and health literacy.

- Supporting community initiatives, such as recovery coaches, dual diagnosis awareness and train-the-trainer workshops, and facilities for outdoor groupwork during Covid-19.

Among the priorities identified for the group in 2021 are to monitor and evaluate the inclusion health hub; to support the delivery of a health diversion programme; and to enhance services for dual diagnosis.

Dublin NEIC progress report
continued

Conclusion

The PIB progress report for 2020 illustrates the wide range of challenges facing those living in the NEIC, reflected in the profile of projects and programmes funded by the Government's 2020 allocation of €6.5 million. In launching the report, the Minister of Finance reiterated the commitment made in the Programme for Government to 'expand the Dublin North-East Inner City model to other comparative areas experiencing disadvantage' (p. 85).[5]

Lucy Dillon

1   Dublin City Council North East Inner City Programme Office (2020) *Dublin North East Inner City progress report 2020.* Dublin: NEIC Programme Office. https://www.drugsandalcohol.ie/33577/

2   Mulvey K (2017) *'Creating a brighter future':* an outline plan for the social and economic regeneration of Dublin's North East Inner City. Dublin: Government Publications. http://www.drugsandalcohol.ie/26859/

3   Dillon L (2017) Regenerating Dublin's North East Inner City. *Drugnet Ireland,* 61: 5–7. https://www.drugsandalcohol.ie/27214/

4   Dublin City Council North East Inner City Programme Office (2019) *The social and economic regeneration of Dublin's North East Inner City (NEIC): 2020–2022 strategic plan.* Dublin: NEIC Programme Office. https://www.drugsandalcohol.ie/33752/

5   Fianna Fáil, Fine Gael and the Green Party (2020) *Programme for Government: our shared future.* Dublin: Department of the Taoiseach. https://www.drugsandalcohol.ie/32212/

Brass Munkie winter 2020 issue published

UISCE, the Union for Improved Services, Communication and Education for People Who Use Drugs, published the 37th issue of *Brass Munkie* in winter 2020.[1] UISCE has been publishing the newsletter since 1992, with content written by service users and service providers. It includes news, interviews with service providers and users, information about services, advice about harm reduction interventions, opinion pieces, and other outputs, such as poems, relevant to the experiences of people who use drugs (PWUD). *Brass Munkie* covers a wide range of topics and the latest issue is no exception. Just some of the content of issue 37 is outlined in this article.

Work of UISCE

Central to UISCE's mission is working with service users to advocate for their needs. As an organisation it recognises the importance of
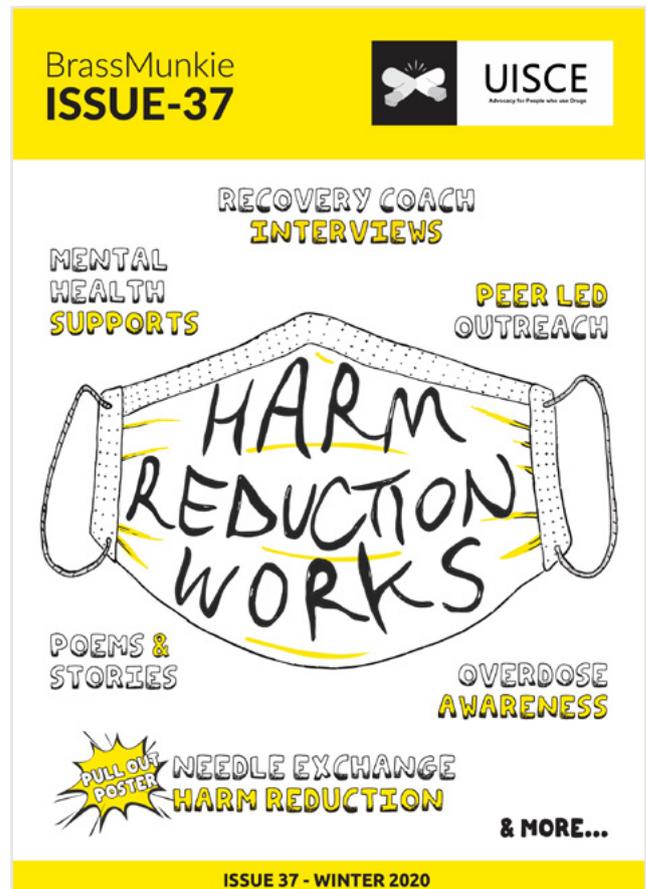
Brass Munkie issue 37, winter 2020

Brass Munkie winter 2020 issue published   continued

representatives from the PWUD community to be part of policymaking and working groups that affect them. To support this and other elements of their work, UISCE is further developing its peer support work and looking for peer-led outreach volunteers for whom they will provide training. UISCE's role as an advocate is also illustrated through the experience of one of their service users who needed support in making a complaint to their service provider.

Recovery Academy Ireland

Despite the barriers presented by the Covid-19 pandemic, seven people with lived experience completed their training with Recovery Academy Ireland as peer-to-peer recovery coaches in September 2020, having started the process in October 2019. Training included five days as a group and a placement in an addiction service, during which they completed 300 hours of recovery coaching. Interviews with two recovery coaches who completed the training show the benefits for both those who accessed their support and themselves as trainees. They describe a process through which they learned more about the value of peer-to-peer support and having a shared lived experience, gained confidence in their abilities, as well as having improved their chances of gaining employment: 'education will open employment doors for me' (p. 12).

National Family Support Network

The National Family Support Network (NFSN) works to support families who are impacted by a loved one's substance use. Covid-19 presented challenges to the delivery of its work, which tends to be face-to-face with individual families or groups. Rather than closing their services, those involved nationally continue to provide support online or over the telephone. Among the additional challenges facing the families due to the pandemic were:

- An increase in the number of families being impacted by drug-related intimidation, often for smaller amounts of debt

- Increased alcohol use in the family

- Increased occurrence of domestic violence.

Overdose awareness and naloxone training in Covid

A priority for UISCE is its work on overdose response and naloxone training. During 2020, it continued to train staff and peers on how to respond to an opioid overdose and administer naloxone, as well as distributing kits to people at risk of overdose. UISCE adapted its materials, training, and practices to take account of Covid-19. This work was carried out in collaboration with other stakeholders, including staff from Merchants Quay Ireland and the Health Service Executive's (HSE) Naloxone Implementation Project.

Other inputs

Other services contributing to this issue included Care After Prison; Donore Community Drug and Alcohol Team; Drug Related Intimidation Initiative; Sex Workers Alliance Ireland; North East Inner City Initiative; and the HSE. Among contributions from service users was an opinion piece by Rick Shaw entitled 'Unintended consequences and good intentions', which focuses the need for more investment by Government to address the root causes of poverty and addiction. While he expresses gratitude to those who work hard to provide services, the author considers current provision to be just 'a band aid over an amputation, utterly inadequate for the issue at hand' (p. 36).

As a publication, *Brass Munkie* highlights the complex challenges faced by service users, PWUD more broadly, and service providers. This issue illustrates how these challenges have been accentuated by the Covid-19 pandemic. However, it also demonstrates the ingenuity and commitment of all involved in their efforts to keep services running and to continue to meet the needs of PWUD.

Lucy Dillon

1   UISCE (2020) *Brass Munkie,* 37, Winter. Dublin: Union for Improved Services, Communication and Education for People Who Use Drugs (UISCE). https://www.drugsandalcohol.ie/33680/

National Drugs Library

Recent publications

PREVALENCE AND CURRENT SITUATION

Harm reduction in the time of Covid-19: case study of homelessness and drug use in Dublin, Ireland

O'Carroll A, Duffin T and Collins J (2020) *International Journal of Drug Policy*, 87: 102966. https://www.drugsandalcohol.ie/33306/

Dublin appears to have performed very well as compared to various scenarios for Covid-19 mortality amongst homeless and drug using populations. The experience, if borne out by further research, provides important lessons for policy discussions on the pandemic, as well as broader lessons about pragmatic responses to these key client groups irrespective of Covid-19. The overarching lesson seems that when government policy is well coordinated and underpinned by a science-driven and fundamentally pragmatic approach, morbidity and mortality can be reduced. Within this, the importance of strategic clarity and delivery, housing, lowered thresholds to methadone provision, benzodiazepine (BZD) provision and naloxone availability were key determinants of policy success. Further, this paper argues that the rapid collapse in policy barriers to these interventions that Covid-19 produced should be secured and protected while further research is conducted.

Trends in adolescent drinking across 39 high-income countries: exploring the timing and magnitude of decline

Vashishtha R, Pennay A, Dietze P, Marzan MB, Room R and Livingston M (2020) *European Journal of Public Health*, 31(2): 424–431. https://www.drugsandalcohol.ie/33435/

Evidence suggests adolescent alcohol consumption has declined since the turn of the millennium in almost all high-income countries. However, differences in the timing and magnitude of the decline have not been explored across countries.

Previous analyses of the decline in adolescent drinking have emphasized the wide reach of the changes and their near-coincidence in time. Our analysis points to the other side of the picture that there were limits to the wide reach, and that there was considerable variation in timing. These findings suggest that as well as broader explanations that stretch across countries, efforts to explain recent trends in adolescent drinking should also consider factors specific to countries and regions.

Recent publications   continued

Motivations to decrease and cease substance use in third-level students: a scoping review

Whelan E, Dockray S, Dick S, Davoren MP, Heavin C, Linehan C and Byrne M (2020) *PsyArXiv*.
https://www.drugsandalcohol.ie/33446/

The aim of this scoping review was to determine factors that relate to student motivations to reduce or stop their illicit use of substances, and to increase understanding of the factors that may be pertinent in behaviour change interventions for substance use in this population.

Few efforts have been made to identify motivations of third-level students to decrease or cease substance use. Promising avenues for future research on motivations to change in relation to substance use include the social contextual factors, perceptions of effects on social relationships, and actions of friends and family members to prompt contemplations of change.

Experiences of frontline workers' engagement with mental health services for homeless adults in Ireland

Devine G and Bergin M (2020) *European Journal of Homelessness*, 14(2): 193–211.
https://www.drugsandalcohol.ie/33400/

Ireland is experiencing a deepening homeless crisis with few sustainable solutions identified. This study explores front-line service providers' experiences in their engagement with mental health services for adult service users who are homeless within the South-East Region of Ireland. Strauss and Corbin's Grounded Theory approach was used to guide twenty in-depth interviews with front line service providers.

Five key service gaps emerged: (1) inter-agency communication and collaboration; (2) assertive community recovery-orientated care; (3) training, information sharing and up-skilling; (4) building and sustaining trust, and (5) discharge planning and resource constraints. The findings suggest that the provision of bespoke tailored Mental Health Services, improved inter-agency collaboration and the development of relevant staff educational programmes are required. Further research to inform targeted service provision, policy and practice development is recommended.

Is there a recent epidemic of women's drinking? A critical review of national studies

Keyes KM, Jager J, Mal-Sarkar T, *et al.* (2019) *Alcoholism, Clinical and Experimental Research*, 43(7): 1344-1359.
https://www.drugsandalcohol.ie/33359/

We review studies using US national data that examined time trends in alcohol consumption and alcohol-related harm since 2008.

Findings suggest that recent trends in gender differences in alcohol outcomes are heterogeneous by developmental stage. Among adolescents and young adults, both males and females are rapidly decreasing alcohol consumption, binge and high-intensity drinking, and alcohol-related outcomes, with gender rates converging because males are decreasing consumption faster than females. This pattern does not hold among adults, however. In middle adulthood, consumption, binge drinking, and alcohol-related harms are increasing, driven largely by increases among women in their 30s and 40s. The trend of increases in consumption that are faster for women than for men appears to continue into older adult years (60 and older) across several studies. We conclude by addressing remaining gaps in the literature and offering directions for future research.

Women negotiating power and control as they 'journey' through homelessness: a feminist poststructuralist perspective

Mayock P and Sheridan S (2020) *European Journal of Homelessness*, 14(2): 17–47.
https://www.drugsandalcohol.ie/33402/

Using a feminist poststructuralist framework, this paper examines homeless women's trajectories through and out of homelessness based on data from a qualitative longitudinal study of women's homelessness in Ireland.

The analysis uncovers women's agency, mobilised through acts of 'resistance' and 'conformity', as they navigated a landscape where assumptions about 'deserving' and 'undeserving' women prevailed and also significantly influenced their housing outcomes.

Recent publications   continued

Tackling substance misuse from a problem-solving justice approach

O'Hare G and Luney P (2020) *Irish Probation Journal*, 17: 43-62.
https://www.drugsandalcohol.ie/33454/

Organisations within the criminal justice system have been involved in a number of projects to tackle substance misuse, including the Substance Misuse Court (SMC) initiative. This initiative has its origins in 'problem-solving justice', which is an approach that seeks to tackle the root causes of offending behaviour. While the SMC is still in its infancy and evolving, early results are encouraging, with a sustained participant engagement in supervision and treatment rate of 87.5% recorded. This paper sets out the findings of an evaluation of the SMC conducted in 2019, and looks at the next steps in the development of this innovative project.

Access to cannabidiol without a prescription: a cross-country comparison and analysis

McGregor IS, Cairns EA, Abelev S, Cohen R, Henderson M, Couch D, *et al.* (2020) *International Journal of Drug Policy*, 85: 102935.
https://www.drugsandalcohol.ie/33370/

In this study, we compared the availability of CBD [cannabidiol] products and the associated legislative and regulatory background in nine selected countries.

There are a variety of approaches in how countries manage access to CBD products. Many countries appear to permit OTC [over-the-counter] and online availability of CBD products but often without legislative clarity. As consumer demand for CBD escalates, improved legislation, guidelines and quality control of CBD products would seem prudent together with clinical trials exploring the therapeutic benefits of lower-dose CBD formulations.

Paracetamol-related intentional drug overdose among young people: a national registry study of characteristics, incidence and trends, 2007–2018

Daly C, Griffin E, McMahon E, Corcoran P, Webb RT, Ashcroft DM and Arensman E (2020) *Social Psychiatry and Psychiatric Epidemiology,* 56: 773–781.
https://www.drugsandalcohol.ie/33297/

This study aimed to describe the characteristics, incidence, and temporal trends in paracetamol-related IDO [intentional drug overdose] among young people.

The increase in paracetamol-related IDO among specific groups of young people, particularly young females is an issue of growing concern. Interventions targeting IDO among young people are needed, incorporating measures to address the availability of paracetamol and aftercare following IDO.

Staff awareness of suicide and self-harm risk in healthcare settings: a mixed-methods systematic review

Dillon CB, Saab MM, Meehan E, Goodwin J, Murphy M, Heffernan S, *et al.* (2020) *Journal of Affective Disorders*, 276: 898-906.
https://www.drugsandalcohol.ie/33301/

This mixed-method systematic review aimed to appraise and synthesise evidence from studies that explored and promoted healthcare staff's knowledge and awareness of suicide and self-harm risk in healthcare settings.

Long-term, routine face-to-face group training programmes should be established to educate healthcare staff about suicide risk across all professions and in specific patient groups.

Recent publications   continued

Student mental health and well-being: overview and future directions

Hill M, Farrelly N, Clarke C and Cannon M (2020) *Irish Journal of Psychological Medicine,* Early online, 1–8.
https://www.drugsandalcohol.ie/33451/

This paper, by members of the Youth and Student Special Interest Group of the College of Psychiatrists of Ireland, contextualises student mental health currently and describes future directions for this emerging field. It is a call to action to develop a structure that supports the needs of students with mental health problems across the full range of the spectrum from mild to severe.

Not really a smoker? A study on the prevalence of and attitudes to occasional social smoking in a third level institution in Ireland

Murray SA, Lyne SJ, Cryan MD, Mullin M, McGrath D and Hayes CB (2020) *Irish Journal of Psychological Medicine,* Early online.
https://www.drugsandalcohol.ie/33449/

This study aimed (1) to determine prevalence of occasional/social smoking among third level students in an Irish university; (2) to evaluate students' attitudes to occasional/social smoking, including perceived benefits and harm; (3) to explore when students commenced occasional/social smoking, their reasons and continued smoking habits; and (4) to determine any influence of other factors, e.g. alcohol consumption, on occasional/social smoking.

Prevalence of self-reported occasional smoking among university students was higher than daily smoking. Most occasional smokers primarily smoked in social contexts. All current smokers reported that alcohol increased cigarette intake. Effective intervention campaigns tailored to determinants of occasional/social smoking are needed as part of induction to third level.

Pathways to 'recovery' and social reintegration: the experiences of long-term clients of methadone maintenance treatment in an Irish drug treatment setting

Mayock P and Butler S (2021) *International Journal of Drug Policy,* 90: 103092.
https://www.drugsandalcohol.ie/33604/

This paper examines the experiences of long-term clients of methadone maintenance treatment (MMT) in one area of Dublin in the context of a recent emphasis on rehabilitation and recovery in Irish drug policy.

The findings highlight a disconnect between policies that ostensibly aim to promote social reintegration and recovery and the experiences of individuals who are long-term clients of MMT. Irish policy aspirations of facilitating opiate-dependent clients to progress along a pathway to recovery are difficult, if not impossible, to realise given the marginal status of addiction services within the health system and the difficulties involved in securing ongoing cooperation from other public service sectors.

Recent publications   continued

Intelligence quotient decline following frequent or dependent cannabis use in youth: a systematic review and meta-analysis of longitudinal studies

Power E, Sabherwal S, Healy C, O'Neill A, Cotter D and Cannon M (2021) *Psychological Medicine,* 51(2), 194–200.
https://www.drugsandalcohol.ie/33710/

This study is a systematic review and meta-analysis. We preregistered our review with PROSPERO (ID no. CRD42019125624). We found seven cohort studies including 808 cases and 5308 controls. We found a significant effect for the association between frequent or dependent cannabis use in youth and IQ change, Cohen's d=-0.132 (95% CI -0.198 to -0.066) p<0.001. Statistical heterogeneity between studies was also low at I^2=0.2%. Study quality was moderate to high. This translates to an average decline of approximately 2 IQ points following exposure to cannabis in youth. Future studies should have longer periods of follow up to assess the magnitude of developmental impact.

Risk perception, changing social context, and norms prevent transition to regular injection among people who smoke heroin

Harris J, Shorter GW, Davidson G and Best P (2020) *Drug and Alcohol Dependence,* 208: 107878.
https://www.drugsandalcohol.ie/33688/

This qualitative study aims to improve understanding of environmental influences preventing people who smoke heroin from transitioning to regular injection.

Findings illuminate environmental influences surrounding and shaping drug consumption practices. Harm reduction strategies should develop and implement safer smoking rooms, community and peer interventions, and improve accessibility to opioid substitution therapy and low threshold outreach services to prevent transitioning to regular heroin injecting.

A qualitative study of physical activity and dietary practices of people accessing opioid agonist treatment in Ireland

Matthews E, Van Hout MC, Scheibein F and Cowman M (2021) *Heroin Addiction and Related Clinical Problems,* Early online.
https://www.drugsandalcohol.ie/33648/

This research aimed to explore service user experiences of change with respect to physical activity and dietary practices since entering opioid agonist treatment (OAT). This research also explored barriers and facilitators to positive lifestyle behaviours among those accessing OAT.

Lifestyle behaviours appear to be positively modified during OAT allied to additional health care supports in place for service users and a potential for improved health and social function. A number of barriers, particularly psychological, remain with respect to behaviour change for this population. This research explores these, with learnings for services to support behaviour change.

Recent publications   continued

An audit of the cervical screening programme in the National Drug Treatment Centre (NDTC)

Haran M, Kelly JR, Kennedy L, Hennigan K, Farid H, Herteu C, *et al.* (2021) *Irish Journal of Medical Science*, Early online.
https://www.drugsandalcohol.ie/33641/

This study aimed to audit adherence to the National Drug Treatment Centre (NDTC) Cervical Screening guidelines before and after the implementation of an awareness-raising educational intervention.

This completed audit cycle shows that an awareness-raising educational intervention can significantly improve adherence to a cervical screening programme in women with substance use disorders (SUDs).

A peer-led survey of student alcohol behaviours and motives in undergraduate students

McAleer A, Daly A, Leary S, Barry J, Mullin M and Ivers J-H (2021) *Irish Journal of Medical Science*, Early online.
https://www.drugsandalcohol.ie/33644/

This study examines Irish undergraduate students' behaviours and motives regarding alcohol consumption. The study explores both levels and patterns of consumption.

Given the high rates of hazardous drinking, the development of an alcohol intervention may be justified; given the high response rates to peer-screening, a peer-led intervention for alcohol-related harms may yield positive results.

'A slippery slope': a scoping review of the self-injection of unlicensed oils and fillers as body enhancement

Brennan R, Overbye M, Van Hout MC and McVeigh J (2021) *Performance Enhancement & Health*, 8(4): 100185.
https://www.drugsandalcohol.ie/33622/

This scoping review gathers what is currently known on the self injection of body fillers for aesthetic purposes, using Arksey and O'Malley's (2005) five stage iterative process scoping review methodology.

It was found that the majority of people who inject body fillers are male and do so to grossly increase muscle size. Injection of oils and other materials in the male genitalia was also described, in addition to female self-injection in the breast, hand and leg areas for augmentation. A range of health consequences were reviewed. Recommendations are made for further research into this unique phenomenon, which, although relatively rare, warrants future research attention considering the documented increase in DIY facial fillers and contemporary body image culture.

Recent publications   continued

Factors associated with early and later dropout from methadone maintenance treatment in specialist addiction clinics: a six-year cohort study using proportional hazards frailty models for recurrent treatment episodes

Durand L, Boland F, O'Driscoll D, Bennett K, Barry J, Keenan E, *et al.* (2020) *Drug and Alcohol Dependence*, 219: 108466.
https://www.drugsandalcohol.ie/33611/

This study aims to identify determinants of time to dropout of methadone maintenance treatment (MMT) across multiple treatment episodes in specialist addiction services in Ireland.

Clients with a previous history of treatment dropout and those on low dose methadone should be identified as high risk for both early and later dropout. Inversely, adherence to treatment, not missing methadone doses, is protective.

The suburban–city divide: an evaluation of emergency department mental health presentations across two centres

McLoughlin C, McLoughlin A, Jain S, Abdalla A, Cooney J and MacHale S (2021) *Irish Journal of Medical Science*, Early online.
https://www.drugsandalcohol.ie/33594/

This study aimed to evaluate the characteristics of mental health presentations to the emergency department (ED) in two different hospital settings.

A large proportion of ED referrals to psychiatry constitute patients with unmet social and addiction needs, who are seen out of hours. This prompts consideration of expanding both ED and community services to comprise a more multidisciplinary-resourced, 24/7 care model.

Risk factors for completed suicide among people who use drugs: a scoping review protocol

Murphy L, Lyons S, O'Sullivan M and Lynn E (2020) *HRB Open Research*, 3(45).
https://www.drugsandalcohol.ie/33653/

This paper presents a protocol for a scoping review that aims to systematically map and synthesise the extent and nature of published, unpublished and grey literature related to risk factors for suicide among people who use drugs (PWUD).

Collating and thematically categorising the various risk factors for suicide among this high-risk group will hold important implications for future research, policy and practice. The research will be disseminated through publication in a peer-reviewed academic journal and a conference presentation, and by sharing the findings with key stakeholders working within research, policy-making and professional practice contexts.

Psychiatry trainees' attitudes, knowledge, and training in addiction psychiatry: a European survey

Orsolini L, Rojnić Palavra I, Duccio Papanti G, Potočan M, Quattrone D, Martens M, *et al.* (2021) *Frontiers in Psychiatry*, 11: 1315.
https://www.drugsandalcohol.ie/33618/

Although psychoactive substance use disorders (PSUDs) are a domain of mental health, addiction psychiatry is only formally recognized as a subspecialty in a few European countries, and there is no standardized training curriculum.

Despite a growing spread of PSUDs in European countries, addiction psychiatry is a relatively poorly trained field within psychiatry training programs. Further research should investigate reasons for poor training and timings of the educational activities to optimize experiential education training in addiction psychiatry.

Recent publications   continued

Prevalence of illicit tobacco use and tobacco tax avoidance in pregnancy

McDonnell BP, McCausland R, Keogan S, Clancy L and Regan C (2021) *Irish Journal of Medical Science*, Early online.
https://www.drugsandalcohol.ie/33642/

The purpose of this study was to explore the purchasing habits of pregnant smokers with regard to tobacco expenditure and use of illicit tobacco.

Use of illicit tobacco is low and only a minority of women engaged in tobacco tax avoidance. As the average price of tobacco in Ireland increases, weekly expenditure on tobacco products is a significant financial impact on low-income women. Smoking cessation would deliver significant financial gains in addition to health benefits.

POLICY

The Public Health (Alcohol) Act: spatial issues and glaring gaps

Houghton F and McInerney D (2020) *Irish Geography*, 53(2): 179-184
https://www.drugsandalcohol.ie/33628/

The negative impact of alcohol on Irish society necessitates that the current opportunity to curtail this problem is not missed, as has happened in the past. Tackling youth and problematic alcohol use and misuse requires a robust response. The current Public Health (Alcohol) Act is a valuable start but contains a number of serious deficiencies that must be remedied. Past examples of equivocation by Government on this issue are unacceptable. Deficits in this legislation must be addressed through amendments as forthcoming sections are brought into force.

RESPONSES

Head shops and new psychoactive substances: a public health perspective

Smyth BP (2021) *Irish Journal of Psychological Medicine*, Early online.
https://www.drugsandalcohol.ie/33687/

In 2010, Ireland found itself at the eye of an international storm as a network of head shops emerged selling new psychoactive substances (NPS) and Irish youth rapidly became the heaviest users of NPS in Europe. Within months, the Irish government enacted novel legislation, which has since been copied by other countries, which effectively stopped the head shops selling NPS. Critics of this policy argued that it could cause harms to escalate. A number of separate studies indicate that a range of drug-related harms increased amongst Irish youth during the period of head shop expansion. Within months of their closure, health harms began to decline. NPS-related addiction treatment episodes reduced and admissions to both psychiatric and general hospitals related to any drug problem began to fall. Population use underwent sustained decline. Consequently, the closure of head shops can be viewed as a success in terms of public health.

Establishment of a national surveillance system to monitor community HIV testing, Ireland, 2018

Brady M, Shanley A, Hurley C, O'Donnell K, O'Tuathail M, Fitzgerald M, *et al.* (2020) *Irish Journal of Medical Science*, 189(4): 1507-1514.
https://www.drugsandalcohol.ie/33304/

Our aim was to pilot and then introduce sustained monitoring of VCBT [voluntary community-based HIV testing] in Ireland, through collaboration between statutory and non-statutory organisations.

Sustained national monitoring in community settings will help inform HIV testing guidelines and will enable assessment of the impact of local and regional community HIV testing strategies.

Recent publications   continued

Factors explaining variation in recommended care pathways following hospital-presenting self-harm: a multilevel national registry study

Griffin E, Gunnell D and Corcoran P (2020) *BJPsych Open*, 6(6): e145.

https://www.drugsandalcohol.ie/33453/

The aim of this study was to identify the specific hospital and individual factors associated with care pathways following hospital-presenting self-harm.

Characteristics of the presenting hospital and hospital admission rates influence the recommended care pathways following self-harm. Provision of onsite mental health facilities and specialist mental health staff has a strong impact on psychiatric care of these patients.

Physical illnesses associated with childhood homelessness: a literature review

Strashun S, D'Sa S, Foley D, Hannon J, Murphy A-M and O'Gorman CS (2020) *Irish Journal of Medical Science*, 189(4): 1331-1336.

https://www.drugsandalcohol.ie/33299/

Our aim was to identify and categorize the physical morbidities prevalent in homeless children.

This literature review summarized the physical illnesses prevalent among homeless children and the contributing factors leading to them. Gaps in the literature were also identified and included a dearth of studies focusing on younger children compared with adolescents. Further research into prevention and intervention programs for this vulnerable population is urgently needed.