The newsletter of Ireland's focal point to the EMCDDA

drugnet Ireland

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In this issue

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Launch of new interactive map to locate Irish addiction treatment services

A new interactive map has been launched to help people in Ireland quickly find addiction treatment services in their area. Developed by the Health Research Board (HRB) in collaboration with the Department of Health, the map provides a comprehensive overview of all publicly funded addiction treatment and family support services across the country (see Figure 1).[1]

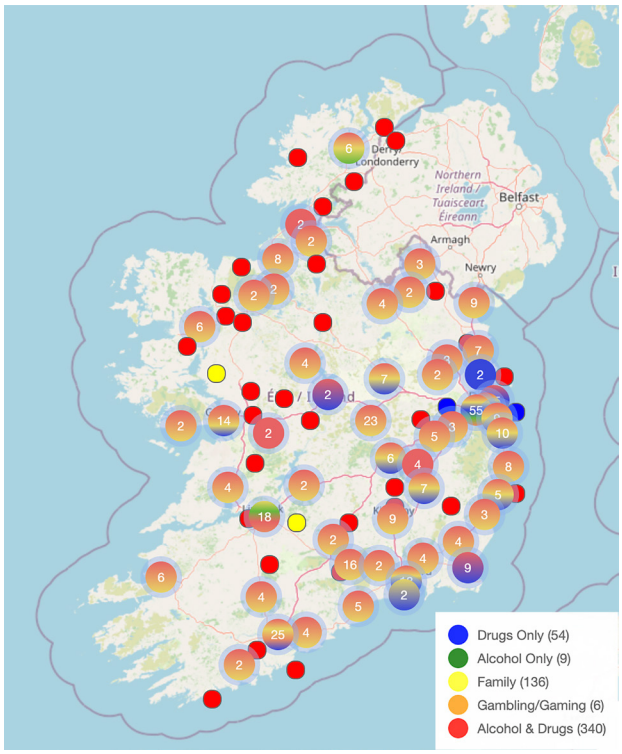

Figure 1: Interactive map of addiction treatment services in Ireland

1. The interactive map is available from the HRB National Drugs Library website: https://www.drugsandalcohol.ie/services_map

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HRB Health Research Board

Research. Evidence. Action.

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**

National Drugs Forum 2024

Emerging drug trends: monitoring, communicating and responding

Croke Park, Dublin, Thursday 14 November 2024

As patterns in drug use and markets change, so too do the techniques used for monitoring and responding to these patterns. Routine monitoring on levels of drug use, treatment demand, and harms is essential for observing trends and planning services, but the unpredictable nature of synthesised drugs requires more immediate responses and a capacity to interpret diffuse information from a wide variety of sources.

Health services and policy-makers have adapted the principles of early warning systems designed to mitigate the consequences of natural disasters, and drug early warning systems are well established in the European Union (EU), the United States of America (USA), and Australia. We have learned a lot from these large national and multinational systems, and EU member states successfully exchange information on the appearance of new drugs or unusual outbreaks. The outcomes from these initiatives are both practical and regulatory. The results is a well-coordinated system of communication and a robust mechanism with which to provide the European Commission with scientific advice on control decisions.

National early warning systems are not as well developed as the EU's system, and there are obvious challenges, such as developing the new monitoring tools on which to build such a system.

There has been progress in this regard in the past 10 years Previously experimental techniques – such as wastewater analysis, drug checking and testing, analysis of syringe residues, and online surveys – are becoming far more common, and each EU member state has at least some of the monitoring elements on which an early warning system can be built. This will involve putting in place reporting tools with the sensitivity to detect early signals. We also need to develop the analytical capacity to determine the level of urgency these signals represent and to synthesise the information emerging from a very diverse range of information resources in the health, nightlife, and security settings.

There are also technical challenges, such as the availability of standards to confirm the chemical compositions of substances. Time pressure on those working as first responders, as key workers in low-threshold services, or in emergency departments means that the opportunity to collect data and gain valuable insights into new drug phenomena is limited. Awareness of the needs of these staff will help to harness the rich knowledge they hold and their skill in extracting information in difficult circumstances. These areas need work, but the main task facing our public health services in relation to drugs is administrative and relates to communication, the diffusion of knowledge, and the coordination of services. The main challenges are in health intelligence: how do we use the knowledge that is available to us in order to protect lives?

The National Drugs Forum 2024 will be an opportunity to learn about the disparate elements that comprise our developing emerging drug trends monitoring system. It is also a chance to think through how all stakeholders can contribute to this system in order to meet the challenge of a changing drug world with confidence and determination.

New interactive map to locate Irish addiction treatment services

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The project involved extensive collaboration with over 430 Health Service Executive (HSE) and community-based services to ensure the accuracy and accessibility of the information provided.

The user-friendly tool allows individuals to search for services by address or simply zoom in on their location to view available options. Detailed information is provided for each service, including type of facility (community-based or residential), target groups (adults, young people), and specific treatments offered (counselling, etc.). Users can also filter results based on the type of addiction they are struggling with, whether alcohol, drugs or gambling, etc.

The map is based on data from the HRB's National Drug Treatment Reporting System (NDTRS). The HRB will update the map regularly to ensure that people who need treatment have access to the most up-to-date information.

Ireland is leading the way in Europe with this innovative approach to presenting addiction treatment information. The map is expected to serve as a model for presenting information to the general public, policy-makers, practitioners, and funders.

Anne Marie Carew

Policy and legislation

Drug use and current alternatives to coercive sanctions in Ireland

In July 2024, the Centre for Justice and Innovation published a report, presented by Tony Duffin, the chair of the National Drugs Strategy Strategic Implementation Group 5 (SIG-5), which aimed to map existing alternatives to coercive sanctions (ACS) for individuals found in possession of controlled drugs for personal use in Ireland.[1] The authors explored how ACS are delivered in Ireland, stakeholders' views on how these could be improved, and the potential for the expansion of ACS in the Irish context.

Strategic Implementation Group 5

The mid-term review of the National Drugs Strategy resulted in the identification of six strategic priorities that needed to be actioned and implemented.[2] Responsibility for these priorities was given to six strategic implementation groups (SIGs), who are required to report their actions to the National Oversight Group on a quarterly basis. SIG-5 is responsible for actions related to the promotion of alternatives to coercive sanctions for drug-related offences. The 2024 report addresses Action 5.4 to 'Strengthen policy and practice with regard to alternatives to coercive sanctions and share learning with EU member states' (p. 1).[1]

Drug use and current alternatives to coercive sanctions in Ireland

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Literature review

The authors carried out a 'light touch literature review', which gleaned knowledge from systematic reviews and meta-analyses within the European context. Within the Irish context, statistical trends were explored using Government data. Several themes were presented.

Alternatives to coercive sanctions

ACS have been defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as 'measures that are rehabilitative, such as treatment, education, aftercare, rehabilitation and social reintegration' (p. 6).[3] While they cover a wide range of interventions, they also vary in terms of the types of offences they deal with and the stage of the judicial process in which they are accessed (e.g. pre-arrest or post-sentencing). In Ireland, much of the public debate on ACS is focused on responding to possession of drugs for personal use. For example, such as in the Health Diversion Programme and in the Citizens' Assembly on Drugs Use recommendation that 'the State should introduce a comprehensive health-led response to possession of drugs for personal use' (p. 13). However, the ACS identified in this report have a broader scope and deal with 'minor drug offences in Ireland' (p. 1).[1] They also represent interventions that deal with people at various stages of the criminal justice system.

Rationale for using ACS

The authors put forward several reasons to explain why the criminalisation of drug possession and low-level drug offences continue to be problematic in Europe, such as increased pressure on justice systems and prisons, the failure of sanctions to prevent drug use, and the subsequent social harms produced by them.

In Ireland, drug possession for personal use is an offence under Section 3 of the Misuse of Drugs Act, 1977 and accounts for around 70% of all controlled drug crime. While this offence can result in a fine and or up to 7 years' imprisonment, in practice cases that appear before the Courts are more often dismissed or result in fines, probation, community service, or suspended sentences (p. 6). In light of this, further pressure is placed on criminal justice resources, in particular probation. The authors have acknowledged that illicit drug use continues to rise in Ireland, which is consistent with findings across Europe.

Benefits of ACS

The link between drug use and dependence and criminality has been well-documented.[5] In contrast to the use of sanctions, incarceration, and decriminalisation, it has been shown – despite limitations in how ACS studies have been conducted – that treatment, education, aftercare, rehabilitation, and social reintegration are related to less drug use and related harms.[6] This is achieved by using a multifaceted approach:

- **Individual level:** Targeting addiction and stigma.
- **Social level:** Easing public health problems along with the level of acquisitive crimes.
- **State level:** Reducing the pressure on resources (prisons and courts) within the criminal justice system.

The evidence also suggests that there is a negative association between ACS and reoffending.[6]

Types of ACS

In 2016, the European Commission identified 13 distinct ACS initiatives (see Table 1).[7]

Drug use and current alternatives to coercive sanctions in Ireland

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Table 1: Types of alternatives to coercive sanctions

Category	Description
Caution/warning/no action	Drug treatment
Diversionary measure	Probation with a treatment element
Drug addiction dissuasion committees	Community work with a treatment element
Suspension of investigation/prosecution with a treatment element	Restriction of liberty with a treatment element
Suspension of Court proceedings with a treatment element	Intermittent custody/release with a treatment element
Suspension of sentence with a treatment element	Parole/early release with a treatment element
Drug Court	

Source: Adapted from European Commission (2016, p. 16)[7]

Barriers to implementation

Based on the findings of their literature review, the authors identified several common barriers to implementation:

- Professionals implementing ACS do so at their own discretion, which is influenced by their understanding of the nature of drug use, whether a health-driven issue, a criminal one, or their attitudes towards people who take drugs.
- There is limited feedback regarding the effectiveness of ACS.
- There is a lack of awareness by prosecutors and judges regarding the ACS available. This issue was identified in the Drug Treatment Court in Ireland and by the European Commission.[7]
- Funding and legislation can limit the mandate and role of ACS.

Methods

This research involved a mixed method approach. Professionals were invited by the Department of Health to complete a survey.

The survey questions centred on the details of local initiatives and their background; agencies involved (leading/delivering/funding); how they operated; eligibility criteria; and whether programmes were evaluated.

Thirteen responses were received, of which only five were complete. Interviews were carried out with practitioners/managers working in relevant agencies across Ireland, such as the Health Service Executive (HSE) (Cork Court Referral Programme), An Garda Síochána, Dublin Drug Treatment Court, and Letterkenny CDP Start Project.

Results

The results indicated that:

- Most of the initiatives were localised, except for the Adult Caution Scheme.
- Operation timeframes varied across projects.
- The longest-running initiative was the Dublin Drug Treatment Court.
- Initiative funding came mainly from the Department of Health, Department of Justice, Local Drug and Alcohol Task Forces, and the Probation Service. However, agencies sometimes lent resources or money from fines diverted into programmes.

Drug use and current alternatives to coercive sanctions in Ireland

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- The response rate was low, and the limited interviewee awareness regarding ACS projects suggests that knowledge of current ACS practice is limited across the sector.

Caution/warning/no action

Adult Caution Scheme

The Adult Caution Scheme was established in 2005 as an alternative to crimes where prosecution was not in the public interest. In December 2020, possession of cannabis or cannabis resin was added to the scheme. It can only be used once and at the discretion of An Garda Síochána, who factor in a range of circumstances such as behaviour, guilt, victim's views, and public interest. The type, quantity, and volume of cannabis or cannabis resin are also factored into the decision.

Between December 2020 and February 2024, the number of cautions issued for the personal possession of cannabis was 5,139.[8] However, in the same period, 17,124 people were issued with a charge/summons for simple possession of cannabis or cannabis resin,[7] which suggests that the scheme is not being used consistently.[1]

Diversionary measures

Law Engagement and Assisted Recovery (LEAR) Programme

The LEAR initiative, which has been based in Dublin City since 2014 and Limerick City since 2023, targets individuals who:

- Have committed multiple offences
- Are aged 18 years and over
- Are experiencing complex and multiple needs in relation to addiction, public injecting, homelessness, rough sleeping, antisocial behaviour, begging, criminality, and mental health.

Referrals are made directly by Gardaí to a local case worker. Ongoing support includes needs assessment and signposting to appropriate services with the aim of addressing offending behaviour and reducing harm. Progress is monitored every 6 months by both the referring Garda and the case worker. Participation in the programme is voluntary.

An evaluation of the programme pilot showed that:

- 40% of clients had access to more stable accommodation.
- 26% were able to access treatment for drugs and alcohol.
- Antisocial behaviour had reduced (37%).
- The majority of participating individuals remained engaged with the programme (90%).

Drug Courts

The Drug Treatment Court (DTC) was initially established in 2001 in Dublin to deal with offenders committing offences as a result of illicit drug use. The aim is to reduce crime via treatment and rehabilitation. Two other Drug Courts have since developed: one in Louth, which also covers Meath, in 2018 and the other in Cork City in 2019. These were developed under a local accord and hence are not officially sanctioned; as a consequence, they do not have access to the same resources as the Dublin DTC. Since 2022, there have been 33 referrals to the Louth DTC, of which 13 graduated. In 2023, some 25 individuals were admitted to the programme. Up to September 2023, some 189 young cocaine users had been referred to Cork DTC. Limited data are available on programme outcomes; however, attendance for intervention screening has been high (93%), of which 11% received referrals to drug and alcohol services.

Drug treatment

The authors report on four drug treatment programmes: Meath Community Drug and Alcohol Response (MCDAR); Prime for Life (Roscommon, Galway, Mayo, Longford and Sligo); the START Project (Donegal); and the Athy Alternative Project (Kildare, Laois and Carlow).

Drug use and current alternatives to coercive sanctions in Ireland

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Table 2 provides a description of the main features of the drug treatment projects.

Table 2: Summary outline of drug treatment projects

	MCDAR	START Project	Prime for Life	Athy Alternative Project
Location	Meath	Letterkenny Community Development Project	Roscommon, Galway, Mayo, Longford and Sligo	Kildare, Laois, Carlow
Year of launch	2001	2009	2020	Not reported
Funded by	North Eastern Regional Drug and Alcohol Task Force since 2006	Northwest Regional Drug and Alcohol Task Force	Western Region Drug and Alcohol Task Force	Probation Service and Kildare and Wicklow Education and Training Board
Open to	• Individuals aged over 18 years with a dependence on any drug or alcohol	• Individuals aged over 18 • Any offence where drug dependence has been a factor • Any type of drug or alcohol • Pre-arrest or pre-court referrals, but police policy currently prevents this	• Individuals who have committed any drug-related offences, on any drug or alcohol classifications • Not limited to age group – open to children as well	• Individuals on the Community Return Scheme and Community Support Scheme who are released from prison early on condition of engaging with programme • Also works at pre-sentence stage
Number of individuals participating	150–200 a year	140 people accessed support in past year, one-to-one or in groups	80 on average every year	Not reported
Direct referrals	Probation Service (Yes) Courts (No) Gardaí (No)	Started as community-based programme for addiction; now takes referrals from Probation Service pre- and post-conviction stages and after release from prison	Probation Service (Yes) Open to referrals from Gardaí and Courts pre-sentence, but police policy currently prevents this	No information reported
Self-referrals	Yes, taken into consideration during Court proceedings and sentencing	Yes	Yes, from the community	No

Drug use and current alternatives to coercive sanctions in Ireland

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	MCDAR	START Project	Prime for Life	Athy Alternative Project
Treatment options	• CBT • Signposting to help for addiction, housing, mental health or other needs	• CBT • DBT • Signposting for addiction housing and mental health support • Can be done online via Zoom or in-person	• CBT • Signposting for specific needs • Runs 10-hour multimedia course, including skills for life and cycle of change model	• Anger management • Social and life skills • Offending behaviour and drug and alcohol awareness • Groupwork delivered in-person and remotely
Evaluation	No information currently available	No information available on programme outcomes	No information available on outcomes	No information reported

Source: Extracted from Centre for Justice Innovation (2024, pp. 13–14)1
CBT: Cognitive behavioural therapy; DBT: Dialectical behaviour therapy.

Reflections

Through their interviews with stakeholders, the authors identified five overarching themes.

1 **There are opportunities and enthusiasm to develop pre-arrest and point-of-arrest diversion offers:** They found a 'solid foundation' (p. 15) of Court and post-Court diversion into treatment programmes, but the options that focused on pre-arrest and point-of-arrest diversion for drug-related offences among adults were much more limited. ACS were found to have broad support among the Probation Service, court workers, some of the judiciary, the drug and alcohol treatment providers and their networks. However, attitudes among An Garda Síochána towards ACS were more varied.

2 **Funding is available from various sources but can lack consistency:** While existing ACS were managed with funding from a variety of sources, it was suggested that increased, specific management of HSE funding for each ACS activity may help to provide better national awareness of what is being delivered and the impact it is having.

3 **There are gaps around learning and evaluation:** Given that existing ACS are being funded and managed at the local level and are often driven by a small number of stakeholders, there has been little opportunity for learning from and evaluation of the various interventions and the impact they are having.

4 **There is a lack of awareness around some existing projects:** Projects tended to be local and not all stakeholders working in the area were aware of the ACS as an option in their locality.

5 **There is a promising environment for change:** Given the broad support of ACS from stakeholders and the recommendations of the Citizens' Assembly on Drugs Use, the authors argue that this has created an environment amenable to the expansion of ACS and particularly the availability of pre-arrest and point-of-arrest diversion.

Conclusion

In the report foreword, Tony Duffin, chair of SIG-5, stated that 'looking ahead it is important that we deliver streamlined processes to ensure alternatives to coercive sanctions are accessible, cost-effective, and efficient, offering individuals every chance to thrive and avoid the negative impact of criminal penalties' (p. 1).[1]

Drug use and current alternatives to coercive sanctions in Ireland

continued

Moreover, in the executive summary, he concluded that:

> *The findings of this report lead us to believe that at present Ireland is at the precipice of transforming how its justice system responds to drug use in a more effective and humane way. It has shown how local initiatives have identified a need for ACS and have begun to implement them throughout the country in the absence of a national ACS for possession of drugs for personal use. The innovative work undertaken across the system to support individuals with their drug use is laudable, but it is missing opportunities earlier to prevent offending and re-offending and improve health outcomes for its citizens. (p. 3)*[1]

Ciara H Guiney and Lucy Dillon

1 Centre for Justice Innovation (2024) *Drug use and current alternatives to coercive sanctions in Ireland: Mapping the existing alternatives to coercive sanctions for people found in possession of controlled drugs for personal use.* Dublin: National Drugs Strategy Strategic Implementation Group 5 (SIG-5). Available from: https://www.drugsandalcohol.ie/41354/

2 Drugs Policy and Social Inclusion Unit (2021) *Mid-term review of the national drugs strategy, Reducing Harm, Supporting Recovery and strategic priorities 2021–2025.* Dublin: Department *of Health*. Available from: https://www.drugsandalcohol.ie/35183/

3 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2015) *Alternatives to punishment for drug-using offenders.* Luxembourg: Publications Office of the European Union. Available from: https://www.drugsandalcohol.ie/24320/

4 The Citizens' Assembly (2024) *Report of the Citizens' Assembly on Drugs Use, Volume 1.* Dublin: The Citizens' Assembly. Available from: https://www.drugsandalcohol.ie/40393/

5 Rooney L (2021) *Informing & supporting change: drug and alcohol misuse among people on probation supervision in Ireland.* Dublin: The Probation Service. Available from: https://www.drugsandalcohol.ie/35133/

6 Tomaz V, Moreira D and Cruz OS (2023) Criminal reactions to drug-using offenders: a systematic review of the effect of treatment and/or punishment on reduction of drug use and/or criminal recidivism. *Front Psychiatry,* 14: 1–19. Available from: https://doi.org/10.3389/fpsyt.2023.935755

7 Kruithof K, Davies M, Disley E, Strang L and Ito K (2016) *Study on alternatives to coercive sanctions as response to drug law offences and drug-related crimes: final report.* Brussels: European Commission. Available from: https://op.europa.eu/en/publication-detail/-/publication/6e9f22b4-aa5a-11e6-aab7-01aa75ed71a1

8 McEntee H (2024) *Parliamentary Debates Dáil Éireann.* 22 Feb 2024. Vol. 1050, No. 2: Question 37 – Substance Misuse. Available from: https://www.drugsandalcohol.ie/40543

Review of drugs and alcohol work sector of British–Irish Council, 2021–2024

A ministerial meeting of the drugs and alcohol work sector of the British–Irish Council (BIC) was held in Dublin on 26 January 2024. The Irish Government is the lead administration for this strand of work.

The meeting was chaired by Minister for Public Health, Well-being and the National Drugs Strategy, Hildegarde Naughton TD. It was also attended by ministers from Scotland, Wales, the Isle of Man, and Guernsey.[1]

British–Irish Council

As described in issue 72 of *Drugnet Ireland*,[2] BIC was established in 1999 as part of the Good Friday Agreement of 1998 in order to further promote positive, practical relationships among the peoples of the islands as well as to provide a forum for consultation and cooperation. The formal purpose of BIC, as outlined in Strand 3 of the Agreement, is as follows:[3]

> *To promote the harmonious and mutually beneficial development of the totality of relationships among the peoples of these islands... The BIC will exchange information, discuss, consult and use best endeavours to reach agreement on co-operation on matters of mutual interest within the competence of the relevant Administrations.*[4]

Work sector activity report

Between 2021 and 2024, the group held a series of events and visits, worked with other relevant BIC work sectors, and consulted with external stakeholders and third-sector organisations to provide a broader perspective for its work across five themes. It provided participants with the opportunity to share emerging good practice and knowledge between those facing common challenges across the different jurisdictions.

Central to the January meeting was a report on the work sector's activity over this period.[5] It is a descriptive report structured around the five topics that were agreed as priorities for the group's work.

1. **Lessons from COVID-19 on the design and delivery of drug and alcohol services:** The group found that many service innovations and improvements that came from the policy and drug service response to the COVID-19 pandemic had since been mainstreamed. These included the provision of additional resources, improved capacity, and better ways of working. The work sector will continue to share learnings on these approaches and innovations as they continue to be implemented.
2. **Reduction to risk of drug-related deaths:** Information has been shared within the group about the underlying factors identified in drug deaths and innovative responses to address them. Responses included monitoring drug consumption trends, harm reduction measures, and treatment delivery.
3. **Reduction of alcohol-related harms through the use of financial mechanisms:** The group recognised that financial mechanisms can be used as policy levers to reduce alcohol consumption. They explored the evidence surrounding these mechanisms in their ability to reduce alcohol-related harms, with a focus on the use of minimum unit pricing (MUP) and the experiences of BIC member administrations in implementing it as a policy. A workshop held on the topic concluded that 'effective MUP policy is important to reducing alcohol-related harms but needs to sit alongside a comprehensive alcohol policy with a holistic approach to treatment' (p. 7).[5]

Review of drugs and alcohol work sector of British–Irish Council

continued

4 **Meeting the health and social needs of people who are homeless and use drugs and/or alcohol:** A central output of the work in this area was a two-day symposium held in Dublin in May 2022, in collaboration with the BIC Housing Work Sector. It brought stakeholders together to look at effective approaches to supporting people who use drugs and are homeless, recognising that many will have complex needs that require a joined-up approach to policy and service delivery between housing and health services.

5 **Engagement with the voluntary and community sectors to consider their role in the provision of drug and alcohol services and in the development and monitoring of policy:** The group's work in this area involved meeting and visiting community and voluntary organisations working in the field (e.g. in London, Dublin and Glasgow). This contributed to an informative discussion on 'the development of services that have a broader remit, incorporating a whole system approach which address the wider determinants of health such as inequalities, deprivation, housing and employment' (p. 10).[5]

Future priorities

At the January meeting, five topics were agreed as priorities for the group's work moving forward:

- Involvement of people with lived experience in drugs services
- Drug use and drug services for people in prison
- Health-led approaches for people in possession of drugs for personal use
- Community action on alcohol (collaboration with the European Framework for Action on Alcohol)[6]
- Peer reviews on topical drug and alcohol trends.

Deliberative democracy and drugs policy

The chair of Ireland's Citizens' Assembly on Drugs Use, Paul Reid, made a presentation to the group. He described the structure and work of the Assembly and illustrated how it could be used as a model for deliberative democracy and drugs policy.

Lucy Dillon

1 British–Irish Council (2024) *Drugs and Alcohol Ministerial meeting, Dublin, 26 January 2024 communiqué*. Edinburgh: British–Irish Council. Available from: https://www.drugsandalcohol.ie/40402/

2 Dillon L (2020) *British–Irish Council in Dublin. Drugnet Ireland*, 72 (Winter): 5. Available from: https://www.drugsandalcohol.ie/31712/

3 More details on the work of BIC is available from its website: https://www.britishirishcouncil.org/

4 A copy of the Good Friday Agreement is available at: https://www.dfa.ie/media/dfa/alldfawebsitemedia/ourrolesandpolicies/northernireland/good-friday-agreement.pdf

5 British–Irish Council (2024) *Drugs and Alcohol Work Sector: report on work sector activity 2021–2024*. Edinburgh: British–Irish Council. Available from: https://www.drugsandalcohol.ie/40402/

6 World Health Organization (WHO) (2022) *European framework for action on alcohol 2022–2025*. Tel Aviv: WHO European Region. Available from: https://iris.who.int/bitstream/handle/10665/361662/72wd12e-Alcohol-220604.pdf

Oireachtas Joint Committee on Drugs Use

In March 2024, the Joint Committee on Drugs Use was established by the Irish Government to consider the recommendations in the report of the Citizens' Assembly on Drugs Use.[1]

Oireachtas Committees

In Ireland, there are mechanisms that Government can use to inform the policy-making process. Oireachtas (Parliamentary) committees advise the Oireachtas on a range of specific areas, including drug policy.

They also scrutinise Government expenditure and debate proposed legislation. Where appropriate, they publish reports on specific issues, which reflect the views of the committee rather than the relevant minister or Government of the day as such.[2]

Committee brief

The Joint Committee on Drugs Use was set up by the Government to specifically consider the 36 recommendations in the report of the Citizens' Assembly on Drugs Use and to make a reasoned response to each recommendation.[1] Its terms of reference were agreed in February 2024 and the committee held its first meeting on 13 June 2024. Within its terms of reference is a requirement that the committee reports to Government within 7 months of its first meeting.[3]

Committee membership

The committee includes members from across the spectrum of political parties (not just Government parties). The first chair of the committee was Michael McNamara TD, an Independent Dáil Deputy for Clare, but a member of the European Parliament since July 2024. He has spoken in the past about the issue of drugs, supporting legalisation and regulation.

On his website, he states that 'drugs need to be legalised and possession decriminalised by the Dáil to take this lucrative trade out of the hands of brutal thugs without delay'.[4] In a Dáil debate on drugs policy in November 2022, he argued the following:

> *They are evil and the trade is very much in their hands, and they are making money out of it, but the answer is not to continue to chase them, it is to take the trade out of their hands, to legalise drugs and to deal with the fact that there is a huge and growing market for drugs. That is a health issue, and it must be dealt with in the same way we deal with the appetite and demand for every other substance – cigarettes, alcohol, etc., instead of fighting a losing war, which we are very clearly losing, despite the best efforts of the Garda.*[5]

The other members of the committee reflect cross-party membership, including Independents, as well as members of the Senate (Seanad Éireann). Where Deputy McNamara could not attend meetings of the Committee up to the summer recess, Senator Lynn Ruane (Independent) stood in as the chair.

Committee activity

Prior to the Oireachtas summer recess (11 July 2024), the committee had met six times and received presentations from members of Government Departments and other State bodies, as well as representatives of other organisations and academic institutions with an interest in the field. Their meetings are public and broadcast live, with recordings and transcripts of the meetings available publicly. Four of the six meetings had 'decriminalisation, depenalisation, diversion and legalisation of drugs' as the main topic under discussion.[6]

Oireachtas Joint Committee on Drugs Use

continued

Lucy Dillon

1 The Citizens' Assembly (2024) *Report of the Citizens' Assembly on Drugs Use*. vol. 1. Dublin: The Citizens' Assembly. Available from: https://www.drugsandalcohol.ie/40393/

2 For further information on Oireachtas committees and how they work, visit: https://www.oireachtas.ie/en/committees/

3 For the committee terms of reference, visit: https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/committee_on_standing_orders_and_dail_reform/reports/2024/2024-02-28_orders-of-reference-for-special-committee-on-drugs-use_en.pdf

4 McNamara M (2022) *Legalising drug use in Ireland*. Available from: https://michaelmcnamaratd.com/2022/11/30/legalising-drug-use-in-ireland/

5 McNamara M (2022) *Parliamentary Dáil Debates*. 30 Nov 2022. Vol. 1030, No. 3. Available from: https://www.oireachtas.ie/en/debates/debate/dail/2022-11-30/8/#spk_41

6 To view a video or read a transcript of the committee meetings, visit: https://www.oireachtas.ie/en/committees/33/drugs-use/debates/

Young Ireland: national policy framework for children and young people

In November 2023, *Young Ireland: national policy framework for children and young people* was launched by the Department of Children, Equality, Disability, Integration and Youth (DCEDIY).[1] It sets out the policy direction and key priorities in respect of children and young people (aged 0–24 years) in Ireland across all Government Departments and State agencies to the end of 2028.

Background

Young Ireland is the successor strategy to *Better Outcomes, Brighter Futures: the national policy framework for children & young people 2014–2020*, which was Ireland's first national policy framework for children and young people.[2] Overall, *Young Ireland* reflects a continuation in its aim, focus, and approach when compared with its predecessor.

It is grounded in the United Nations (UN) Convention on the Rights of the Child, as ratified by Ireland in 1992.

Following an oral presentation to the UN Committee on the Rights of the Child (UNCRC) in Geneva in 2023, a set of concluding observations was published on Ireland's compliance with the Convention. While Ireland was found to have made progress in some areas, it was also criticised under several topic areas. For example, in relation to non-discrimination, addressing violence, mental health, standards of living, education, and child justice. The authors of *Young Ireland* note that the framework was developed in part as a response to the UNCRC's observations. It is also informed by the Agenda for Sustainable Development as well as other national and international strategies.

National policy framework for children and young people

continued

Vision and framework

The vision of *Young Ireland* is of 'an Ireland which fully respects and realises the rights of children and young people' (p. 8).[1]

As laid out in a summary of the framework, it:

- Sets out current issues impacting children and young people identified by them, as demonstrated by the Children and Young People's Indicator Set[4] and as highlighted by the UNCRC in 2023[3]
- Sets out a programme of work to create an enabling environment to ensure that children and young people are a central part of everyone's agenda
- Announces spotlight programmes to focus on the most significant challenges for children and young people, with resources from across Government
- Re-establishes governance structures, where the State will work with civil society partners to provide renewed leadership and impetus to realise existing policy commitments, such as *First 5;* Ireland's European Child Guarantee National Action Plan; the Child Poverty and Well-being Programme Office; and other major policy initiatives across Government impacting children and young people
- Identifies the priority areas requiring coordinated action across Government
- Identifies a number of complementary actions to address issues that were identified during the development of the framework.

Focus on vulnerable young people

While the strategy is concerned with all children and young people, it has a particular focus on those who face additional challenges, including:

> *Those with a disability; with mental health challenges; living in or at risk of poverty including homelessness; who are members of the Traveller or Roma communities; who are members of the LGBTI+ community; who have suffered abuse or neglect; seeking international protection; from minority ethnic backgrounds; migrant children and young people; living in a single parent household; living in Care or Aftercare; who are young carers; living in a household with substance misuse; or with a family member in prison." (p. 8).*[1]

Spotlights

To meet the needs of children and young people who are more vulnerable to poor outcomes, *Young Ireland* identifies an initial set of three 'spotlights'. Spotlights are areas which require action across Government and concentrate on these pressing challenges in a focused, time-bound way. Hence, there will be 'a concerted effort over a specified period of time to generate the necessary momentum for change' (p. 16).[1] While it is envisaged that more spotlights will be identified in the course of the strategy, the data strongly indicate that the first three should be: child and youth poverty, mental health and well-being for children and young people, and disability services. Child poverty will be the first spotlight for the strategy – it is being delivered through the Child Poverty and Well-being Programme Office in the Department of the Taoiseach, which will 'enhance accountability for actions to address child poverty and well-being, and bring strategic focus to a select number of priority commitments to accelerate implementation' (p. 16).[1] Following this spotlight, the Department of Health will lead on the mental health and well-being spotlight, followed by one on disability services.

National policy framework for children and young people

continued

Measuring success

The five national outcomes identified for *Young Ireland* are the same as those of *Better Outcomes, Brighter Futures*. They are that all children and young people will:

- Be active and healthy
- Be achieving in learning and development
- Be safe and protected from harm
- Have economic security and opportunity
- Be connected, respected and contributing to their world.

These outcomes will be tracked over the course of the strategy using a Children and Young People's Indicator Set, developed by DCEDIY. It includes a set of indicators for each outcome. The indicators use data from a range of sources, including administrative surveys and Census data.[4]

Young Ireland and the national drugs strategy

Young Ireland is aligned with Ireland's national drugs strategy and is specifically identified under the outcome of 'safe and protected from harm', in which it cites the national drugs strategy, *Reducing Harm, Supporting Recovery*, as one of the existing policies and strategies that complements its work.[5]

Lucy Dillon

1 Department of Children, Equality, Disability, Integration and Youth (2023) *Young Ireland: national policy framework for children and young people 2023–2028*. Dublin: Government of Ireland. Available from: https://www.drugsandalcohol.ie/39966/

2 Department of Children and Youth Affairs (2014) *Better Outcomes, Brighter Futures: the national policy framework for children & young people 2014–2020*. Dublin: Stationery Office. Available from: https://www.drugsandalcohol.ie/21773/

3 United Nations Committee on the Rights of the Child (2023) *Concluding observations on the combined fifth and sixth periodic reports of Ireland*. CRC/C/IRL/CO/5-6. Geneva: UN Committee on the Rights of the Child. Available from: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/SessionDetails1.aspx?SessionID=2600&Lang=en

4 For further information on the indicator set, visit: https://www.gov.ie/en/publication/03f4b-children-and-young-peoples-indicator-set/

5 Department of Health (2017) *Reducing Harm, Supporting Recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. Available from: https://www.drugsandalcohol.ie/27603/

Road Traffic Act 2024

The Road Traffic Act 2024 was enacted on 17 April 2024.[1] The purpose of the Act is to overcome anomalies evident in the existing legislation. It provides for changes to the penalty points regime (Part 2), speed limits (Part 3), and mandatory roadside testing of drivers involved in serious collisions for intoxicants, which will now include drug testing (Part 4). This article will focus on Part 4, which provides for several amendments to the Road Traffic Act 2010.

Section 12 of the Road Traffic Act 2024 amends Section 9 of the Road Traffic Act 2010.[2] Section 9 of the 2010 Act provided for four circumstances where a member of An Garda Síochána can request breath specimens to test for drugs and alcohol if they are of the opinion that the person:

a) Has consumed an intoxicant

b) Is committing or has committed an offence under the Road Traffic Acts 1961 to 2011

c) Is or has been, with the vehicle, involved in a collision, or

d) Is or has been, with the vehicle, involved in a collision where someone has died, has an injury, or requires medical attention at the scene or needs to go to hospital.

This meant that a Garda 'shall' test an individual's breath for alcohol in situations (a) and (d) and 'may' do so in situations (b) and (c). However, in relation to drugs, the word 'may' is used for all circumstances. In situations (a) and (b), there was a requirement to test for alcohol but not for drugs.

The new Act amends Section 9 so that the situations in which a Garda shall test for drugs and alcohol are now the same.

Sections 12 and 13 of the Road Traffic Act 2024 amend Sections 9 and 10 of the Road Traffic Act 2010 to include the insertion of subsections (2C) and (4A) after subsections (2A) and (4), respectively.

Under both of these subsections, where a Garda requires an oral fluid specimen from a person's mouth, the individual is required to remain at the vehicle or nearby for at least 30 minutes after testing until the testing apparatus shows the presence or absence of drugs in the specimen.

Sections 14 and 15 of the Road Traffic Act 2024 amend Sections 22 and 23 of the 2010 Act. These amendments were wording changes that take account of the changes introduced under Sections 12 and 13 of the Road Traffic Act 2024.

Commencement

Provisions for Part 4 of the Road Traffic Act 2024 commenced on 31 May 2024.[3] After signing the commencement order, Minister Chambers stated that:

> *The signing of the 'mandatory drug testing' provisions into law is an important milestone in our response to the trends we are witnessing on our roads. Driving under the influence is one of the four main causes of road fatalities and it is simply unacceptable.*
>
> *Ensuring that enforcement by An Garda Síochána is underpinned by robust road traffic legislation is a priority for me and my Department. Government is committed to doing all it can to reverse the really alarming trends we have seen in recent times, where fatalities have been rising year-on-year. One life lost is one too many on our roads. I am committed to commencing the remaining provisions of the Act in the coming period, which will further enhance our response to the trend.*[3]

In order to ensure that Gardaí have adequate roadside drug tests, the Department of Transport has sanctioned the acquisition of 10,000 additional DrugWipe test kits.

Road Traffic Act 2024

continued

Ciara H Guiney

1 Road Traffic Act 2024, Ireland.

2 Road Traffic Act 2010 Revised, Ireland.

3 Department of Transport. Minister Chambers signs mandatory roadside drug testing provisions into law [Press Release]. 29 May 2024. Available from: https://www.drugsandalcohol.ie/41129/

Irish delegation report from 67th session of United Nations Commission on Narcotic Drugs, 2024

An Irish delegation attended the 67th session of the United Nations Commission on Narcotic Drugs (CND)[1] in Vienna on 14–22 March 2024. The delegation consisted of:

- Jim Walsh, Brian Dowling and Richie Stafford of the Department of Health
- Lisa Fay of the Department of Justice
- Detective Superintendent Sé McCormack of An Garda Síochána
- Ambassador Eoin O'Leary and officials from the Irish Permanent Representation to the United Nations (UN).

CND meets annually and adopts a range of decisions and resolutions.[2] Intersessional meetings are convened throughout the year. Towards the end of each year, CND meets at a reconvened session to consider budgetary and administrative matters as the governing body of the UN drugs programme.

CND reviews and analyses the global drug situation, considering supply and demand reduction, and takes action through resolutions and decisions. Participants at the CND session include national delegations, officials from UN agencies, and civil society.

The CND session is divided into two segments: the High-Level Segment and the Regular Segment.

High-Level Segment

The High-Level Segment, which took place on 14–15 March, was attended by Jim Walsh and Ambassador O'Leary. The segment was tasked with conducting the 2024 Mid-Term Review of the Ministerial Declaration in 2019. The focus of the review was on taking stock of the implementation of all existing international drug policy commitments and the work to accelerate the implementation of the commitments from 2024 to 2029.

The segment also consisted of a General Debate and two multi-stakeholder roundtables on the topics of 'Taking Stock: Work Undertaken since 2019' and 'The Way Forward: The Road to 2029'.

Pledge4Action

Countries attending the segment were invited by the CND chair, Philbert Abaka Johnson, to submit a Pledge4Action. Approximately 66 countries and regions submitted a pledge, including the EU regional delegation.

UNCND Session

continued

Ireland submitted a pledge committing the Irish Government to carefully consider and respond with urgency to the recommendations of the Citizens' Assembly on Drugs Use for reform of the legislative, policy, and operational approach to drug use, and to indicate the timeframe for implementing the recommendations which it accepts. The wording of the pledge is as follows.

> *Acknowledging the decision of the Irish Parliament to establish a citizens assembly to consider the harmful impacts of illicit drugs on individuals, families, communities and wider society;*
>
> *Noting the assembly operated according to the principles and mechanisms of deliberative democracy and considered a diverse range of perspectives, including the perspective of people with lived experience of drug use;*
>
> *The Irish Government commits to carefully consider and respond with urgency to the assembly's recommendations for reform of the legislative, policy and operational approach to drug use, and to indicate the timeframe for implementing those recommendations which it accepts.*

Figure 1: Pledge box at the 67th session of the Commission on Narcotic Drugs

Regular Segment

The Regular Segment of the 67th session of CND took place on 18–22 March 2024. It dealt with administrative aspects of CND, along with the implementation of agreed policy positions and enhanced cooperation between member states to counter the world drug problem. Four resolutions were proposed to the Committee of the Whole for adoption by CND:

- L.2 – Commemoration of the 10th anniversary of the United Nations Guiding Principles on Alternative Development: effective implementation and future perspectives (sponsored by Thailand, Germany and Peru).
- L.3 – Promoting rehabilitation and recovery management programmes as part of the comprehensive treatment of drug use disorders (sponsored by Chile).
- L.4 – Improving the access to and availability of controlled substances for medical purposes, including for the treatment of children in pain, through the promotion of awareness-raising, training and data collection (sponsored by Belgium).
- L.5 – Preventing and responding to drug overdose through scientific evidence-based prevention, treatment, harm reduction and recovery support services in accordance with domestic law and circumstances (sponsored by USA).

In keeping with the 'Vienna spirit', three of the proposed resolutions were adopted by consensus. However, L.5 proved to be more contentious, with a small number of nations opposing the inclusion of the phrase 'harm reduction'. This resolution was passed to the Plenary, where it was voted on among CND members and passed by a majority (38 nations in favour, two against and six abstentions). Throughout the week, the Irish delegation worked closely with fellow EU member states, coordinated by the European External Action Service and the Belgian delegation (as Belgium held the presidency of the Council of the EU at the time) to advance the above resolutions.

UNCND Session

continued

Various bilateral meetings were held with other national delegations during the 67th session. In addition, an extensive programme of side events was organised: more than 170 side events and over 30 exhibitions took place on various aspects of addressing and countering the world drug problem. These events provided an important opportunity for national delegations and civil society groups to showcase innovative responses and create networking opportunities to enhance learning and collaboration.

Richie Stafford

1 CND was established by the Economic and Social Council (ECOSOC) Resolution 9(I) in 1946, to assist ECOSOC in supervising the application of the international drug control treaties. In 1991, the General Assembly expanded the mandate of CND to function as the governing body of the United Nations Office on Drugs and Crime (UNODC). CND's agenda has two distinct segments: a normative segment for discharging treaty-based and normative functions as well as an operational segment for exercising its role as the governing body of UNODC. CND has 53 member states that are elected by ECOSOC. It is chaired by a bureau, including one member per Regional Group. CND actively contributes to the implementation of the 2030 Sustainable Development Agenda, as sustainable development and CND mandates are interrelated and mutually reinforcing.

2 For further information on the 67th session, visit: https://www.unodc.org/unodc/en/commissions/CND/session/67_Session_2024/67CND_Main.html

Recent research

Drug prevention training in Ireland

A feature of an effective drug prevention system is the training of stakeholders.[1] Progress in this area in Ireland can be seen through the implementation of the European Prevention Curriculum (EUPC) training programme, albeit to limited numbers to date.

What is the EUPC?

The EUPC is a training programme whose primary goal is 'to reduce the health, social and economic problems associated with substance use by building international prevention capacity through the expansion of the European professional prevention workforce' (p. 10).[2]

It originated as an American training programme, the Universal Prevention Curriculum, and underwent a rigorous adaptation process to ensure its suitability for the European context.

The EUPC provides training for decision-makers, opinion-makers, and policy-makers on how to prioritise evidence-based interventions and policies and how to advocate for them. Progress is currently being made to expand the EUPC to train frontline workers.

Drug prevention training in Ireland

continued

EUPC in Ireland

Prevention is one of the six strategic priorities identified in the mid-term review of Ireland's national drugs strategy, in which specific mention is made of the EUPC.[3] The priority is:

To strengthen the prevention of drug and alcohol use and the associated harms among children and young people: This will cover a variety of settings (school, community, and family) and will focus on increasing resilience and strengthening life skills and healthy life choices. Activity under this priority will be informed by the EUPC and the UNODC/WHO International Standards on Drug Use Prevention.[2,1,3]

The EUPC has featured in two contexts in Ireland since the adoption of this strategic priority:

1 The Prevention and Education Funding Programme of the Department of Health is supporting five projects, each of which must adhere to international prevention standards.[4] Staff working on the projects were required to undertake the EUPC training, which was delivered in May 2024. The Department of Health has actively supported two staff members to take part in EUPC training courses to the level of being qualified to deliver this training.[5]

2 The EUPC is evolving. Clondalkin Drug and Alcohol Task Force (CDATF) was the Irish partner in the European project, Frontline Politeia, which completed its work in December 2023. Although the EUPC training originally focused on training decision-makers, opinion-makers, and policy-makers, Frontline Politeia aimed to develop and implement the EUPC for frontline prevention workers, including teachers, police, and social workers. Based on the EUPC and international standards, the project team developed a two-day in-person drug prevention training programme, as well as an online learning path with six interactive e-learning modules. CDATF was involved in various stages of the project, including delivering the adapted EUPC training to frontline workers in Ireland. Based on their learnings, CDATF contributed to the further development of the training materials and activities.

Concluding comment

Training stakeholders in prevention will lead to better funding decisions, improved implementation, and should in turn result in more positive outcomes for participants. The EUPC is heavily supported by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and it is a positive step for it to be delivered at a national level.

Lucy Dillon

1 United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO) (2018) *International standards on drug use prevention.* 2nd edn. Vienna: UNODC. Available from: https://www.drugsandalcohol.ie/30048/

2 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019) *European prevention curriculum: a handbook for decision-makers, opinion-makers and policy-makers in science-based prevention of substance use.* Luxembourg: Publications Office of the European Union. Available from: https://www.drugsandalcohol.ie/31119/

3 Drugs Policy and Social Inclusion Unit (2021) *Mid-term review of the national drugs strategy, Reducing Harm, Supporting Recovery and strategic priorities 2021–2025.* Dublin: Department of Health. Available from: https://www.drugsandalcohol.ie/35183/

4 Department of Health (2023) *Press release: Minister Naughton announces successful projects for €1.5 million drug prevention and education funding scheme.* Dublin: Department of Health. Available from: https://www.gov.ie/en/press-release/92172-minister-naughton-announces-successful-projects-for-15-million-drug-prevention-and-education-funding-scheme/

5 For further information on EUPC training in Ireland, email Richie Stafford: Richie_Stafford@health.gov.ie

Review of Prevention Systems (RePS)

Improving the quality of drug prevention interventions and systems internationally is a focus of the United Nations Office on Drugs and Crime (UNODC). Building on its International Standards on Drug Use Prevention, the UNODC has developed a tool for countries to assess their drug prevention systems and interventions in line with the standards.[1,2] The *Review of national prevention systems based on the UNODC/WHO International Standards on Drug Use Prevention: final report of the pilot in Norway* was published in September 2023 and a webinar on the project findings held on 19 April 2024.[2,3]

Background to Review of Prevention Systems

In 2018, the UNODC in collaboration with the World Health Organization (WHO) published the International Standards on Drug Use Prevention.[1] The standards present an overview of the international evidence for prevention interventions and policies that promote the health and well-being of children, young people, adults, families, and communities. They also identify the characteristics of an effective national drug prevention system, which has the overarching goal to support the healthy and safe development of individuals. The authors of the standards describe such a system as delivering 'an integrated range of interventions and policies based on scientific evidence, taking place in multiple settings and targeting relevant ages and levels of risk' (p. 41).[1] It would have strategies that have 'a mix of environmental and developmental components, with a minor component focusing on information' (p. 41).[1] To be effective, the system needs to be underpinned by strong structural foundations.[1,4]

Grounded in these standards, the Review of Prevention Systems (RePS) is a tool developed by the UNODC to assess 'the extent to which the drug prevention system of a country or sub-national entity (e.g. a municipality) is in line with the Standards on Drug Use Prevention with a view to identifying areas of strength and weakness to allow improvement' (p. 1).[2] It was decided to pilot the tool in Norway.

Implementing RePS

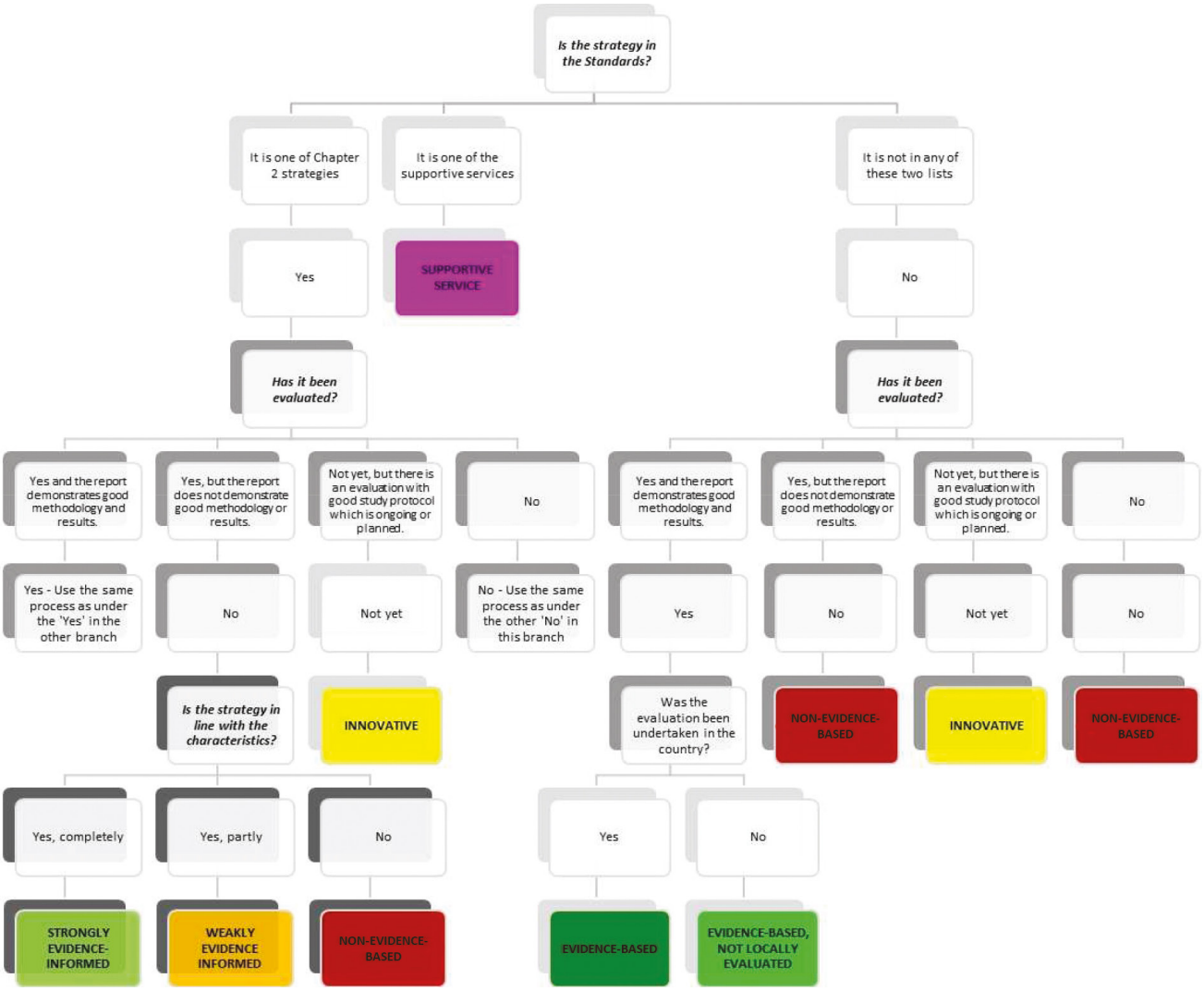
The RePS tool is divided into two main components: interventions and prevention system. Each involves the collection and analysis of data from a variety of stakeholders working in drug prevention in the country/area of interest.

Component 1: Interventions

The first component focuses on the quality of implemented interventions. In the pilot, the Norwegian team used an online questionnaire to gather data, via a network of colleagues, from practitioners implementing drug prevention interventions across the country. The data gathered were screened to ensure that only appropriate interventions were included and there was adequate information provided upon which to make a quality assessment. Out of 187 entries, 130 were included in the final analysis. These were categorised according to age of target group, their level of risk, the setting of the implementation (family, school, workplace, health setting, or community), and geographical region. Each intervention was assessed for the extent to which it was evidence based, on the basis of the Standards, and according to a methodology illustrated in Figure 1. Interventions were labelled as 'evidence-based', 'non evidence-based', 'strongly evidence informed', and 'weakly evidence informed'. Interventions that had a clear theoretical basis but no study yet carried out were labelled as 'innovative'.

Review of Prevention Systems

continued



Source: UNODC and KORUS Oslo (2023, p. 9)[2]

Figure 1: Overview of the assessment process

Component 2: Prevention system

The second component assesses the quality of the prevention system as a whole. It identifies the strengths and weaknesses in the system. In Norway, it was based on data collected for the first component and from a questionnaire aimed at those with the mandate to coordinate and manage prevention at the national level. The methodology used describes a set of six elements (and 17 corresponding criteria) that need to be met for a system to be considered supportive of evidence-based practice.

The six elements are:

1. A range of interventions and policies based on evidence
2. Supportive policy and regulatory frameworks
3. Evidence-based planning and use of research
4. Coordination among different sectors and levels
5. Strong delivery system
6. Sustainability.

Review of Prevention Systems

continued

An assessment is made as to whether each of the criteria corresponding to these elements were met fully, partially, or not at all, as well as the option to say there was insufficient information to make an assessment.

Lessons from the pilot in Norway

The overall message from the report is that the pilot of this tool in Norway was a success. While the report does not unpack the strengths and weaknesses of the methodology in detail, there were some limitations and features identified that would have contributed to its success, such as:

- The team leading the pilot was well-connected with those working in the sector in Norway. Their existing network facilitated the collection of data for both components, including where inadequate information was initially submitted and contacts needed to be followed up.
- The team had the appropriate skills to be able to assess the quality of the interventions and the system overall.
- It was unclear from the report the level of resources required to carry out the review. Data gathering could be labour-intensive.
- A limitation identified in the report was that the unit of analysis was a single intervention. Therefore, while two separate interventions may be delivered to the same target group, if they are assessed in isolation they may not be considered evidence-based according to the Standards (e.g. an information-only intervention).
- Another limitation identified was that it was not possible to analyse the coverage of the interventions in terms of population.
- The team also could not include analysis of the requirement of training and its existence to ensure fidelity of implementation. Further explanation of why these could not be included was not provided.

The findings of this pilot were positive for the range of interventions and the prevention system as a whole in the case of Norway. Among the findings were that there was a need for more evaluations of interventions; non-evidence-based interventions needed to be replaced; and more support was needed for those found to be effective.

Concluding comments

Overall, the output from this review would suggest that RePS could be a useful tool to explore the range of prevention interventions in an area/country and the system underpinning them.

Given the potential resources required to carry out a review, it would be important that stakeholders are committed to the process, support data collection, and have the resources to act on any findings and recommendations made. The findings would need to be linked into a strategy to support elements of the system and interventions that are working well and address those that are not. Given that one limitation was that the coverage of interventions could not be assessed, care would be needed not to suggest that there is more coverage through a particular intervention than is the case in reality. For example, in the Irish context, the intervention Know the Score is in theory available nationally; however, coverage is likely to be much more limited.

Lucy Dillon

1 United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO) (2018) *International standards on drug use prevention*. 2nd edn. Vienna: UNODC. Available from: https://www.drugsandalcohol.ie/30048/

2 United Nations Office on Drugs and Crime (UNODC) and KORUS Oslo (2023) *Review of national prevention systems based on the UNODC/WHO international standards on drug use prevention: final report of the pilot in Norway.* Vienna: UNODC. Available from: https://www.drugsandalcohol.ie/41014/

Review of Prevention Systems

continued

3 International Society of Substance Use Professionals (ISSUP) (2024) *Accelerating drug use prevention systems in drug policy: new initiatives* [webinar]. Available from: https://youtu.be/5TDF3p4-Mho [RePS report at 0:45:20]

4 Dillon L (2019) Updated international standards on drug use prevention. *Drugnet Ireland*, 69 (Spring): 16–17. Available from: https://www.drugsandalcohol.ie/30639/

Review on evidence on place-based responses to drug-related threats in communities

In July 2024, the Health Research Board (HRB) published *Integrative review on place-based and other geographically defined responses to drug-related threats in communities,*[1] the ninth report in the Drug and Alcohol Evidence Review series. On behalf of the Department of Health, the HRB commissioned this report to systematically review and synthesise the international evidence on this topic. Place-based initiatives emerged originally in the field of health, guided by new ideas relating to the social determinants of health, the role of the socioecological context, implementation science, and the importance of community empowerment.

Although there are considerable variations, it is possible to identify an underlying model which focuses on providing universal, structural interventions that seek to improve health and well-being by modifying the social context in which health-related behaviour occurs.

The key findings of the review are set out below under the five research questions.

Key findings

Research question 1

How is the association between the characteristics of places and drug-related threats understood in the literature?

The relationship between neighbourhood characteristics and drug-related threats is typically theorised in the literature using the risk and protective factor framework. Drawing on local data and direct knowledge of the local context, community coalitions are expected to identify elevated risk and depressed protective factors. This information can then be used to guide the choice of intervention and to set targets for community actions. For example, community coalitions in Communities That Care (CTC) are expected to select 'effective preventive interventions to change locally identified elevated risk and suppressed protective factors'.[2] The authors argue that this approach has limitations in that the conceptualisation of risk and protective factors in terms of individual-level characteristics can reduce the visibility of factors such as stigmatisation, systemic racism, social isolation, community disorganisation, local problems, and economic hardship and organised crime.

Review on place-based responses to drug-related threats in communities

continued

Research question 2

What criteria are used by policy-makers and funders to select locations for place-based initiatives?

The criteria used to select locations vary according to the intervention being implemented. In the case of PROmoting School-university-community Partnerships to Enhance Resilience (PROSPER), eligibility requirements included having 1,300–5,200 students enrolled at local schools and having stakeholder agreement to random assignment, as well as a willingness and capacity to support implementation if assigned to the intervention condition. In the case of CTC, communities chosen were small- to moderate-sized incorporated towns with their own governmental, educational, and law enforcement structures, ranging from 1,500 to 50,000 residents.[2] To be included in the CTC trial in Germany, communities had to have at least one secondary school and a willingness to sign a cooperative agreement for study participation with the principal investigator. A Dutch quasi-experimental study tested the effectiveness of CTC in 10 cities with an average population of about 65,500.[3]

Target communities for the HEALing Communities Study (HCS) include counties, towns, and city districts located in states burdened with above-average rates of opioid overdose morbidity and mortality.

The three largest trials that have been implemented thus far to evaluate place-based initiatives have used weak forms of spatial targeting, while the Icelandic Prevention Model (IPM) is not associated with spatial targeting. Although not discussed in detail in the literature, it would appear that the designers of trials selected locations where a positive programme effect could be identified.

Research question 3

What place-based initiatives designed to tackle drug-related threats to communities show signs of promise?

PROSPER and CTC are the only place-based initiatives that have been shown to have a significant impact on drug-related harms, following well-designed controlled trials. Both programmes targeted young adolescents and focused primarily on smoking and drinking alcohol, but they nevertheless had an impact on drug use that persisted over time and was detectable for most of the high school years. There is robust empirical evidence that both programmes were effective in reducing drug use among adolescents in small rural towns. Furthermore, an evaluation of the roll-out of CTC in Pennsylvania in the United States reported significant effects in relation to past 30-day and lifetime marijuana use as well as lifetime use of any drug. The effects were stronger for CTC districts which implemented evidence-based programmes. One of the strengths of PROSPER and CTC is that they have continued to collect data on participants even as they complete high school, attend college, and enter the labour market.

The evidence that has been published regarding the effectiveness of the IPM is largely observational but has convinced many policy-makers and practitioners of its value.

This is partly because data from Iceland on substance use among young people compare favourably with data from other countries, although it is not clear what role the IPM played in this and what influence factors such as national policies and other specificities (e.g. low population density, relative affluence, etc.) may have had.

HCS is a good example of a programme which is expected to produce significant improvements in drug-related harms in the target communities but has not yet demonstrated effectiveness. As this programme is situated at the frontier of research and practice-related innovations in place-based initiatives, it is arguably the most promising study of all.

Review on place-based responses to drug-related threats in communities

continued

The resources allocated to studying HCS will ensure that dozens of publications will appear over the next few years analysing all aspects of this programme. HCS thus offers an excellent opportunity to assess the potential of place-based initiatives to reduce drug-related harms. The least promising initiatives are Pulling Levers and Second Chance or Else (SCORE), and their failure to produce positive effects is arguably related to their inability to engage with local communities. There is evidence now from several projects that repressive place-based initiatives headed by law enforcement agencies are unlikely to yield positive impacts.

Research question 4

What indicators have been developed to measure the impact of these interventions?

In CTC and PROSPER, impacts were measured in different ways: (1) by assessing the nature of the interventions they promoted (e.g. number of evidence-based programmes adopted); (2) fidelity of implementation; and (3) by quantifying substance use over the past month or year (or over the respondent's lifetime). The primary aim of HCS is to reduce opioid overdose deaths, while the secondary outcomes of interest include reducing overdose events, opioid misuse and injection drug use; medications for opioid use disorder (MOUD) and behavioural treatment; treatment retention; people receiving recovery support and access to naloxone; and targeting other health conditions, including hepatitis C, HIV, and endocarditis.

Brown *et al.* use longitudinal cross-lagged panel models to explore the relationship between community coalitions and programme outcomes.[4] They highlight the following qualities as relevant to the success of place-based initiatives: collaborative processes (how coalition members interact as a team), coalition capacities (including the attitudes, knowledge, and skills of the coalition members and paid coordinator), and coalition activities (how coalitions direct their energy).

All these features of coalitions predicted their capacity to implement preventive programmes. Bašić concluded,[5] based on findings from interviews with community leaders in Croatia, that building community readiness is an essential step before implementing place-based initiatives, and this concept can be measured using a local version of a survey questionnaire originally used in the USA.

Research question 5

Could these place-based initiatives and indicators be used in Ireland?

It is important to be aware of differences in national context, social structure, and neighbourhood characteristics when considering transferring initiatives from one country to another. There may be specific features of the national or regional context which are essential to the success of an initiative in its original form. An evidence-based programme or a place-based initiative that has been found effective in one country may not be equally effective in another. However, there may not be the time and resources to develop a completely new framework and to test it, along with locally specific interventions. It might make sense, in this case, to use an existing model, even if this decision brings with it certain risks, while being sure to set aside a budget to evaluate the initiative in its new context.

The starting point for a debate about the usefulness and applicability of place-based initiatives in Ireland should arguably be the Irish context itself: what kinds of drug-related harms are observed at local level and how could new approaches contribute to improving conditions? What resources and knowledge are already present and how can these be mobilised to tackle risk factors and to strengthen protective factors? Most place-based programmes share common frameworks which can help with choosing, designing, and implementing an intervention. But it is difficult to answer the question whether an intervention will work in a local context.

Review on place-based responses to drug-related threats in communities

continued

In order to be effective, interventions must be well-suited to the local context and capable of producing the desired impacts. There is thus a role for researchers to work with community coalitions in order to evaluate existing interventions, identify obstacles, and explore alternative approaches. Because innovation is central to place-based initiatives, community coalitions may come up with new ideas about how to intervene and tackle drug-related harms, and innovations should be expected and welcomed at the intervention level. From this perspective, it is the community coalition which must decide whether an existing intervention or survey questionnaire meets its needs, or whether a new tool or programme should be developed. If a robust monitoring framework is in place, the coalition can assume responsibility for this choice, in the knowledge that all impacts will be assessed in an impartial way.

Local and Regional Drug and Alcohol Task Forces in Ireland have a few similarities with place-based initiatives. The task forces are expected to bring together organisations and individuals from the statutory, community, and voluntary sectors to develop an integrated locally based response to problem drug use. They address these challenges by identifying local needs and promoting the development of projects which can satisfy these. They work cross-sectorally and inter-institutionally with the aim of ensuring that local responses are coherent, integrated, and effective.

It should be possible to assess the capacity of the task forces from this perspective, beyond a formal description to ascertain whether there is effective local ownership of the task forces and the level of community engagement that place-based initiatives need for innovation.

It is also necessary to measure the impact that the task forces have at local level. This represents a significant challenge, as their introduction was not accompanied by a framework for data collection and statistical assessment. This underlines the importance of measuring, monitoring, and evaluating place-based initiatives to ensure accountability.

Brian Galvin

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2 Oesterle S, Hawkins JD, Kuklinski MR, Fagan AA, Fleming C, Rhew IC, *et al.* (2015) Effects of Communities That Care on males' and females' drug use and delinquency 9 years after baseline in a community-randomized trial. *Am J Community Psychol*, 56(3–4): 217–228.

3 Steketee M, Oesterle S, Jonkman H, Hawkins JD, Haggerty KP and Aussems C (2013) Transforming prevention systems in the United States and the Netherlands using Communities That Care. *Eur J Crim Policy Res*, 19(2): 99–116.

4 Brown LD, Feinberg ME, Shapiro VB and Greenberg MT (2015) Reciprocal relations between coalition functioning and the provision of implementation support. *Prevention Science*, 16(1): 101–109.

5 Bašić J (2015) Community mobilization and readiness: planning flaws which challenge effective implementation of 'Communities That Care' (CTC) prevention system. *Subst Use Misuse*, 50(8–9): 1083–1088.

Recreational and sexualised drug use among men who have sex with men

Background and methods

The overall prevalence of recreational drug use (RDU) has risen in Ireland from 5.6% in 2002/2003 to 7.4% in 2019/2020; and males report a higher prevalence of RDU in comparison to females (12.3% and 5.7%, respectively).[1] International evidence suggests that gay, bisexual, and other men who have sex with men (gbMSM) have a higher prevalence of drug use versus age-comparable non-gbMSM.[2] Previously cited reasons for this drug use disparity may include 'minority stress', as well as the perceived 'normalisation' of drug use within the gbMSM community, including sexualised drug use (SDU).[3,4,5] However, in Ireland, there is a paucity of literature regarding the prevalence of drug use and its determinants among gbMSM.

A 2023 study[2] quantified the prevalence of RDU and SDU among gbMSM in Ireland using data from the European Men-Who-Have-Sex-With-Men Internet Survey (EMIS-2017), an online, anonymous, internationally promoted questionnaire. In this research, published in the journal *PLOS One*, multivariable-adjusted logistic regression explored factors associated with RDU and SDU. The main findings from this study are discussed below.

Results

Among gbMSM without HIV (n=1898), some 40.9% and 13.1% engaged in RDU and SDU in the previous year, respectively. Among HIV diagnosed-positive gbMSM (n=141), the past-year respective prevalence estimates were 51.8% and 26.2%. Increased odds of RDU were observed among gbMSM who were younger (OR=2.96; 95% CI: 2.05–4.28), lived in Dublin (OR=1.47; 95% CI: 1.17–1.83), and engaged in condomless anal intercourse (CAI) in the previous year (1–2 partners: OR=1.79; 95% CI: 1.34–2.38, 6+ partners: OR=1.79; 95% CI: 1.18–2.71). Greater odds of SDU were identified among those who lived in Dublin (OR=1.50; 95% CI: 1.07–2.10) and engaged in CAI (1–2 partners: OR=3.16, 95% CI: 2.05–4.88, 3–5 partners: OR=2.50; 95% CI: 1.47–4.26, and 6+ partners: OR=3.79; 95% CI: 2.23–6.43).

Conclusions

The authors noted that gbMSM in Ireland reported a high prevalence of RDU and SDU, and that this was particularly true for men who were living in Dublin, presented for HIV testing, engaged in more CAI encounters, and among those who reported a recent diagnosis of a bacterial sexually transmitted infection. They suggest that messaging should be tailored to subgroups of gbMSM who are likely to be at increased odds of drug-related harms, and that findings from the study may serve as a guideline to relevant partner organisations who work to promote the overall health and well-being of gbMSM nationally.

Seán Millar

1 Mongan D, Millar SR and Galvin B (2021) *The 2019–20 Irish National Drug and Alcohol Survey: main findings*. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/34287/

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3 Meyer IH (2003) Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull*, 129(5): 674–697.

Recreational and sexualised drug use among men who have sex with men

continued

4 Hughes TL and Eliason M (2002) Substance use and abuse in lesbian, gay, bisexual and transgender populations. *J Prim Prev*, 22(3): 263–298.

5 Amundsen E, Haugstvedt Å, Skogen V and Berg RC (2022) Health characteristics associated with chemsex among men who have sex with men: results from a cross-sectional clinic survey in Norway. *PLOS One*, 17(10): e0275618.

Prevalence and current situation

Criminal Justice (Engagement of Children in Criminal Activity) Act 2024

The Criminal Justice (Engagement of Children in Criminal Activity) Act 2024 was enacted on 11 March 2024.[1] The purpose of the Act is to provide for offences relating to the engagement of a child in criminal activity. Section 2 of the Act addresses engagement of children in criminal activity, while Section 3 makes amendments to the Schedule of the Bail Act, 1997.

Section 2

- Under Section 2(1) of the Act, an adult who 'compels, coerces or directs … or deceives the child' for the purpose of engaging them in criminal behaviour shall be guilty of an offence (p. 1).
- Under Section 2(2) of the Act, an adult who 'induces or invites, or aids, abets, counsels or procures the child' for the purpose of engaging them in criminal behaviour shall be guilty of an offence (p. 2).
- Under Section 2(3) of the Act, an adult can be convicted of an offence regardless of whether the child:
  - Engaged in the criminal activity
  - Intended to engage in the criminal activity
  - Has been prosecuted or found guilty of the offence of criminal activity.
- Under Section 2(4), any person found guilty of this offence will be liable:
  - On summary conviction to a Class A fine or imprisonment for up to 12 months or less, or both
  - On conviction on indictment to a fine or imprisonment for a term up to five years, or both.

Section 3

Under Section 3, the Schedule of the Bail Act, 1997 was amended to include an insertion after paragraph 44:

'Offences under the Criminal Justice (Engagement of Children in Criminal Activity) Act 2024

45. An offence under the Criminal Justice (Engagement of Children in Criminal Activity) Act 2024.'

Criminal Justice Act 2024

continued

Conclusion

The passage of this legislation was welcomed by Minister for Justice Helen McEntee TD and Minister of State for Law Reform James Browne TD.[2] It fulfils two Programme for Government commitments, which are (a) to provide legislation to prevent children from being coerced into the selling and supplying of drugs and addresses the issue of grooming children to partake in criminality, and (b) to criminalise adults who are responsible for grooming children to do so.

It also fulfils objectives in the Youth Justice Strategy 2021–2027.[3]

Minister Browne stated that it 'falls on us to protect the children of Ireland' and it was only right to make 'punishable the harm caused to children by drawing them into a life of crime' (p. 2).[2] He went on to say that the legislation will make it 'possible to prosecute the adult for both the crime that is committed by the child and for the harm done to the child' (p. 2).[2] He also believed that this is a 'huge step in the right direction' (p. 2).[2]

Minister McEntee acknowledged Minister Browne's work in developing and steering the legislation through the Oireachtas along with the extension to the Greentown Programme.[4]

She believed that 'it marks another step as we strive to deliver on our commitment to criminalise those who target some of the most vulnerable in our society, our children and young people, in order to commit offences' (p. 3).[2] She added that:

> *This legislation will be an effective tool for tackling organised crime. It will also protect children from the harmful effects of crime on their lives, their families' lives and futures as citizens who are properly equipped to benefit fully from all that society has to offer (p. 3).*[2]

Ciara H Guiney

1 Criminal Justice (Engagement of Children in Criminal Activity) Act 2024. Available from: https://www.irishstatutebook.ie/eli/2024/act/8/enacted/en/pdf

2 Department of Justice (2024) *Press release: Minister McEntee and Minister Browne welcome passage of legislation to combat grooming of children for the purposes of crime*. Available from: https://www.drugsandalcohol.ie/40602/

3 Department of Justice (2021) *Youth justice strategy 2021–2027*. Dublin: Department of Justice. Available from: https://www.drugsandalcohol.ie/34061/

4 Department of Justice (2024) *Press release: Minister McEntee extends Greentown Programme for further three years*. Dublin: Department of Justice. Available from: https://www.drugsandalcohol.ie/40398/

Drug treatment demand in Ireland, 2023

Published in June 2024, the latest report from the National Drug Treatment Reporting System (NDTRS) presents data on treated problem drug use (excluding alcohol) for the year 2023, as well as trends for the seven-year period from 2017 to 2023.[1]

Key findings, 2023

In 2023, some 13,104 cases were treated for problem drug use. This is the highest annual number of cases recorded by the NDTRS to date, and an increase of more than a thousand cases compared with the previous year.

Much of this increase was driven by demand for treatment for cocaine use, particularly treatment for females. Cocaine was the most common drug reported among new cases entering drug treatment, accounting for almost one-half of new treatment demand. Cocaine was also the most common problem drug generating treatment demand for those aged 20–39 years. Until 2023, opioids had been the main problem drug for cases aged 35 years and over.

Main problem drug by age

age started treatment

More than one-half (57.9%) of cases had been treated previously, and opioids were the most common problem drug among this group. Almost four in 10 (36.6%) of cases were never treated before. In contrast, the proportion of new cases reporting cannabis or opioids as their main problem drug has decreased. Over seven in 10 (71.5%) cases were treated in outpatient facilities.

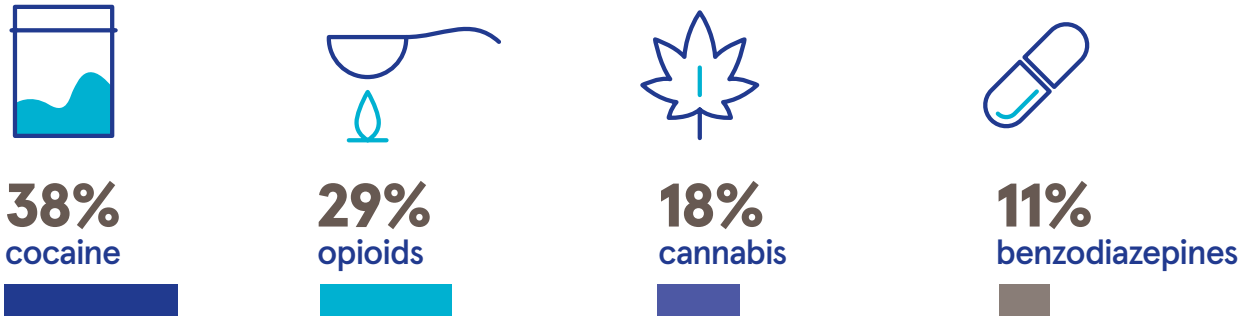
Main problem drugs generating treatment demand

Cocaine was the most common main problem drug reported in 2023, accounting for one in three (37.6%) of cases. Opioids, mainly heroin, were the second most common main problem drug reported in 2023, accounting for 29.3% of cases. Cannabis was the third most common reported main problem drug, while benzodiazepines was the fourth most common main problem drug reported for the year.

Drug treatment demand in Ireland, 2023

continued

Main problem drug



Cocaine

In 2023, some 4,923 cases entered treatment for cocaine. The majority of these (75.6%) required treatment for powder cocaine, with the remainder (24.4%) for crack cocaine. The treatment demand for powder cocaine increased by 16.8% (n=536) from the previous year, while the treatment demand for crack cocaine increased by 33.7% (n=303). Proportionally, females were more likely to require treatment for crack cocaine than powder cocaine (46.2% vs 22.4%). Powder cocaine users were more likely to be employed (40.5%) than crack cocaine users (6.5%). The median age entering treatment was lower for those seeking treatment for powder cocaine than crack (31 years vs 39 years).

Over the period 2017–2023, there was a 228.2% increase in the number of cases where cocaine was the main problem drug. Powder cocaine increased by 197.1% over the period and crack cocaine increased by 594.2%. Between 2017 and 2023, there was a 388.4% increase among females who sought drug treatment for cocaine, from 284 cases in 2017 to 1,387 cases in 2023. Cocaine is the most common drug reported among new cases entering drug treatment, with rates rising significantly over the past 7 years. There is also a steady increase in the number of cocaine cases returning for treatment.

Polydrug use

Polydrug use was common and reported by almost six in 10 cases (59%). The most common additional drug was cannabis (39%), followed by cocaine and alcohol (both 36%), and benzodiazepines (31%). Cocaine has moved up the rankings compared with previous years.

Injecting and sharing

One in five cases reported that they had ever injected (20.3%). The absolute number of cases who had ever injected increased over time (2021: 2,264; 2022: 2,492; 2023: 2,659), despite their proportion decreasing year-on-year, from 29.7% in 2017 to 20.3% in 2023. Among new cases, the proportion that reported ever injecting decreased over the period from 11.0% in 2017 to 4.0% in 2023. However, among previously treated cases the numbers reporting ever injecting have increased since 2020.

There was a decrease in the proportion of cases who inject opioids as the main problem drug, from 92.5% in 2017 to 76.5% in 2023, while there was an increase in cases injecting cocaine. Polydrug injecting over the same period also increased. Among cases who had injected, 39.8% had shared needles and syringes.

Drug treatment demand in Ireland, 2023

continued

Parental status

In 2023, almost one-half of cases (49.9%, n=6535) in drug treatment were parents who had children.

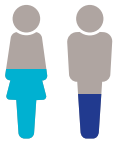
Females entering drug treatment were more likely to have dependent children and to live with children than males.

Eight in 10 of all parents (83.6%, n=5463) were known to have children aged 17 years or younger. More than three in five (62.9%) cases with younger children were males, while almost two in five cases were females (37.1%).

50%
of treated cases were
parents who had children

Cases with children aged 17 years or younger

40%
of cases lived with children



52% females
33% males

Treatment outcomes

While treatment duration varied by intervention type, one-half of cases exiting treatment in 2023 attended for 81 days or longer. Nearly one-third (29.5%) of cases successfully completed treatment, and 12.2% were referred to other drug and alcohol services for continued support. However, 31.8% of cases did not return for subsequent appointments and 14.0% refused further treatment sessions. At the point of exiting treatment, one in nine cases (11.7%) had either engaged or achieved substantial progress towards their priority care plan goals. However, 6.0% had disengaged from their care plan, if such existed. Most cases (76.3%) did not report having family members or significant others involved in their treatment.

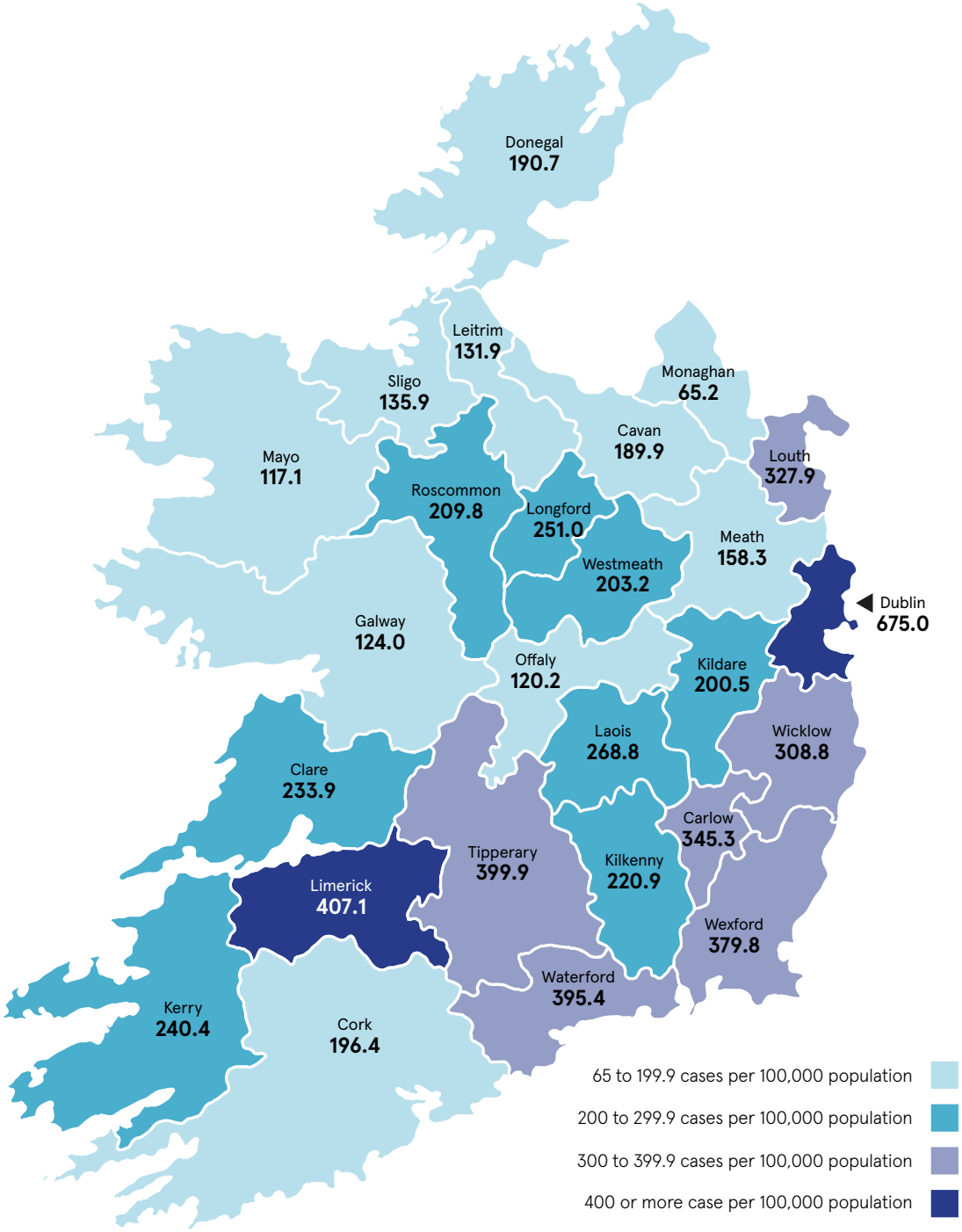
Geographical prevalence of drug treatment demand

Annual prevalence rates of treated problem drug use were calculated per 100,000 of population aged 15–64 years based on Census figures from the Central Statistics Office (CSO).[2] Overall prevalence, which includes new cases and those cases returning to treatment, increased from 278.6 per 100,000 in 2017 to 372.9 per 100,000 in 2023. The prevalence of cases was examined by county of residence in 2023 and is presented in Figure 1.

Drug treatment demand in Ireland, 2023

continued

Figure 1: Prevalence of drug treatment cases, 2023, by county of residence



Tiina Lynch

1. Lynch, T, Condron, I, Lyons S and Carew AM (2024) *National Drug Treatment Reporting System: 2023 Drug treatment demand*. HRB StatLink Series 18. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/40981/

2. Population data are taken from the CSO, available from: https://www.cso.ie/en/releasesandpublications/ep/p-pme/populationandmigrationestimatesapril2023/

An exploration of organizational climate in community-based opiate prescribing services; a mixed methods study

A recent study by Kelly *et al.*[1] aimed to understand how different factors within community-based opiate-prescribing services affect the overall work environment. The study examines how clear each organisation's goals are, how well the team works together, how much freedom staff have, and how open each organisation is to change. The goal was to identify what makes a good work environment in these services and how to improve it.

The mixed-methods study was conducted across 12 publicly funded community-based opiate-prescribing services in Ireland. Data were collected simultaneously through surveys and interviews with frontline staff. The surveys gathered information about the work environment from 132 staff members, while in-depth interviews were conducted with 12 participants in order to explore the issues in greater detail.

The authors analysed the survey data using statistical methods (multivariate linear regression modelling) in order to see how different factors were related, and they investigated the interview data using an abductive approach in order to explore the reasons behind these relationships.

Key findings

The study found that the organisational climate in community-based opiate-prescribing services is influenced by a complex interplay of factors, including the following:

- **Resources** were identified as crucial for a positive organisational climate. Adequate physical infrastructure, training, staffing, and opportunities for professional growth were associated with better outcomes. However, programmes with higher patient needs often had poorer organisational climates.
- **Organisational factors** such as leadership, supervision, staff relationships, and collective training were also important for a positive organisational climate and were often impacted by resource availability.
- **Programme practices** and how resources are utilised within organisations played a significant role in shaping the overall work environment, both positively and negatively.
- **Other challenges** such as rigid hierarchies, bureaucratic processes, differing philosophical views on addiction, and high staff turnover negatively impacted on organisational climate, and were often linked to resource shortages.

The authors highlight that effective opiate-prescribing services depend on a variety of factors, many of which can be improved without additional resources. The authors also highlight that a comprehensive approach is needed in order to address the complex challenges faced by these services, focusing on both client recovery and staff well-being within a supportive system. The authors note that understanding staff perspectives is crucial for service enhancement, and a combined approach of quantitative and qualitative research can provide valuable insights into addressing organisational challenges and implementing sustainable improvements.

Anne Marie Carew

1 Kelly P, Searby A, Goodwin J. An exploration of organizational climate in community-based opiate prescribing services; a mixed methods study. *J Subst Use Addict Treat*. 2024;162:209362. Available from: https://www.jsatjournal.com/article/S2949-8759(24)00074-2/fulltext

Deaths among people who were homeless at time of death in Ireland, 2020

The Health Research Board (HRB) has published its second report on deaths among people who were homeless at the time of death.[1] The report describes deaths that occurred in 2020 and contains updated figures for deaths in 2019.[2] The report follows on from research originally commissioned by the Department of Health, which examined deaths in 2019 among people who were homeless.[3]

Background

The HRB collects data on all deaths among people who were homeless at the time of death in order to better understand and prevent premature death among people who are homeless. The data are extracted from closed coronial files nationwide using the methodology of the National Drug-Related Deaths Index (NDRDI), even if the deaths do not meet the standard NDRDI inclusion criteria.[4] The NDRDI validates these data with the Dublin Regional Homeless Executive through its Pathway Accommodation and Support System (PASS).

For this research, deaths are classified as follows:

- **Poisoning:** a death directly due to the toxic effects of one or more substances (drugs and/or alcohol) on the body, as indicated on the coroner's certificate.
- **Non-poisoning:** deaths due to all other causes, either medical or traumatic, irrespective of whether drugs or alcohol were directly implicated in the death.

The deceased were considered as homeless if living in any of the following circumstances at the time of death:

- Homeless – without accommodation (sleeping rough)
- Homeless – temporary or crisis accommodation
- Homeless – severely substandard or highly insecure accommodation
- Homeless – unknown (no further details were available)

These criteria reflect international classifications[4,5] that were adapted to reflect the types of accommodation available to people who are homeless in Ireland.

This study examined the number of deaths, cause of death, and characteristics of those who were homeless and died in 2020, where the investigation of the death was complete.

Key findings

The NDRDI recorded 121 deaths among people who were homeless and who died in Ireland in 2020, 69 due to poisoning and 52 due to non-poisoning (see Table 1). Most of these deaths (n=83) were among people who were homeless and in temporary or crisis accommodation; the majority (n=52) of these were poisoning deaths. There were also 23 deaths among people who were sleeping rough.

Over one-half (56%) of those who died were homeless in Dublin. Almost one in two (48%) deaths occurred in temporary or crisis accommodation, while one in three (36%) were in a public place or derelict building and one in 10 (10%) in private dwellings.

Deaths among people who were homeless

continued

Table 1: Total deaths among people who were homeless, by category of homelessness and type of death

	Sleeping rough (n)(%)	Temporary or crisis accommodation (n)(%)	Other categories of homelessness* (n)(%)	Total
Poisoning deaths	12 (9.9)	52 (43.0)	~	69 (57.0)
Non-poisoning deaths	11 (9.1)	31 (25.6)	10 (8.3)	52 (43.0)
Total	23 (19.0)	83 (68.6)	15 (12.4)	121 (100)

* Includes substandard or insecure homelessness, and unknown types of homelessness.
~ Values suppressed due to small numbers.

Characteristics of the deceased

- The deaths were of 95 males and 26 females. One-half of males were aged 42 years or under, while one-half of females were aged no more than 36.5 years.
- Nineteen of the deceased (13 males vs 6 females) had a history of imprisonment.

Substance use history

- Most of the deceased (91%) had a history of substance use, many (45%) with alcohol dependency.
- Heroin (61%), cocaine (56%), and benzodiazepines (36%) were the most common drugs used, and most people who used drugs (88%) used more than one.
- One in four (26%) had ever injected drugs (27% males vs 23% females). Fifteen per cent of males were injecting at the time of death.

Comorbidities

- Hepatitis C was recorded for 16 (13%) deaths, while epilepsy was recorded for 10 (8%).
- Almost one-half (46%) of the deceased had ever accessed substance use treatment.
- One in five (21%) of the deceased were receiving opioid agonist treatment, mainly methadone, at the time of death (17% males vs 35% females).
- Almost one-half (46%) of the deceased had a known history of mental health issues.

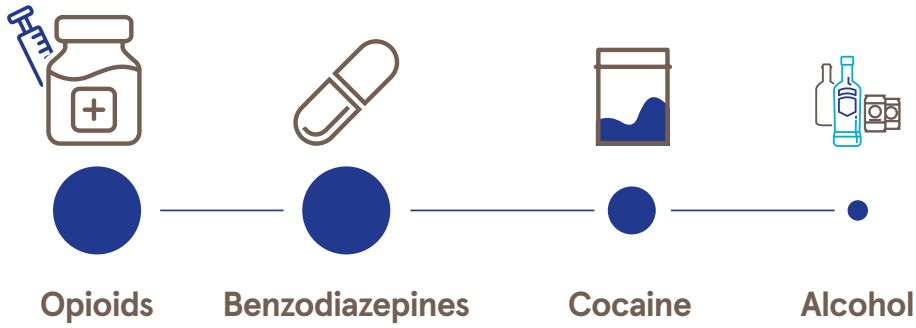
Poisoning deaths

- Of the 69 poisoning deaths, 51 were among males and 18 among females.
- The median age at death was 39 years for males and 34.5 years for females.
- The most common drugs implicated in poisoning deaths were opioids, benzodiazepines, and cocaine.
- Alprazolam was implicated in 34 poisoning deaths, while pregabalin was implicated in 16.
- Polysubstance poisoning was a common factor in the deaths of both males (82%) and females (78%).
- One-half (54%) of those whose death involved opioids had previously received substance use treatment and almost two in five (39%) were in treatment when they died.
- A high proportion of deaths involving opioids (69%) occurred in temporary or crisis accommodation, and one in three (33%) of the deceased were with other people at the time of death.

Deaths among people who were homeless

continued

Most common drugs implicated in poisoning deaths



Non-poisoning deaths

- Of the 52 non-poisoning deaths, the majority (n=44, 85%) were of males.
- One-half of those who died were aged 46.5 years or under.
- One in four non-poisoning deaths were due to hanging, and at least one-half (54%) of the deceased had a history of mental health issues.
- Of those who used drugs, the main substances used were heroin, cocaine, cannabis, and benzodiazepines.
- One in four non-poisoning deaths were due to cardiovascular conditions; most were males; and 62% had either alcohol dependency or alcohol implicated in their death.

Deaths among people with no recorded history of substance use

- Eleven (9%) deaths were among people who had no recorded history of drug or alcohol use.
- These were mostly males; one-half had traumatic deaths due to hanging or drowning; and over one-half (55%) had a known history of mental health issues.

Conclusion

The findings of the study can inform policy and measures to prevent premature deaths among people who are homeless in Ireland. The HRB will continue to collect and report these important data.

Cathy Kelleher

1 Kelleher C, Keegan E and Lyons S (2024) *Deaths among people who were homeless at time of death in Ireland, 2020*. HRB StatLink Series 16. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/40328/

2 Annual data are routinely updated when new coronial information becomes available. As such, the 2019 figure for deaths among people who were homeless was revised upwards to 92 deaths.

3 Lynn E, Devin J, Craig S and Lyons S (2023) *Deaths among people who were homeless at time of death in Ireland, 2019*. HRB StatLink Series 11. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/38793/

4 Busch-Geertsema V, Culhane D and Fitzpatrick S (2016) Developing a global framework for conceptualising and measuring homelessness. *Habitat Int*, 55: 124–132.

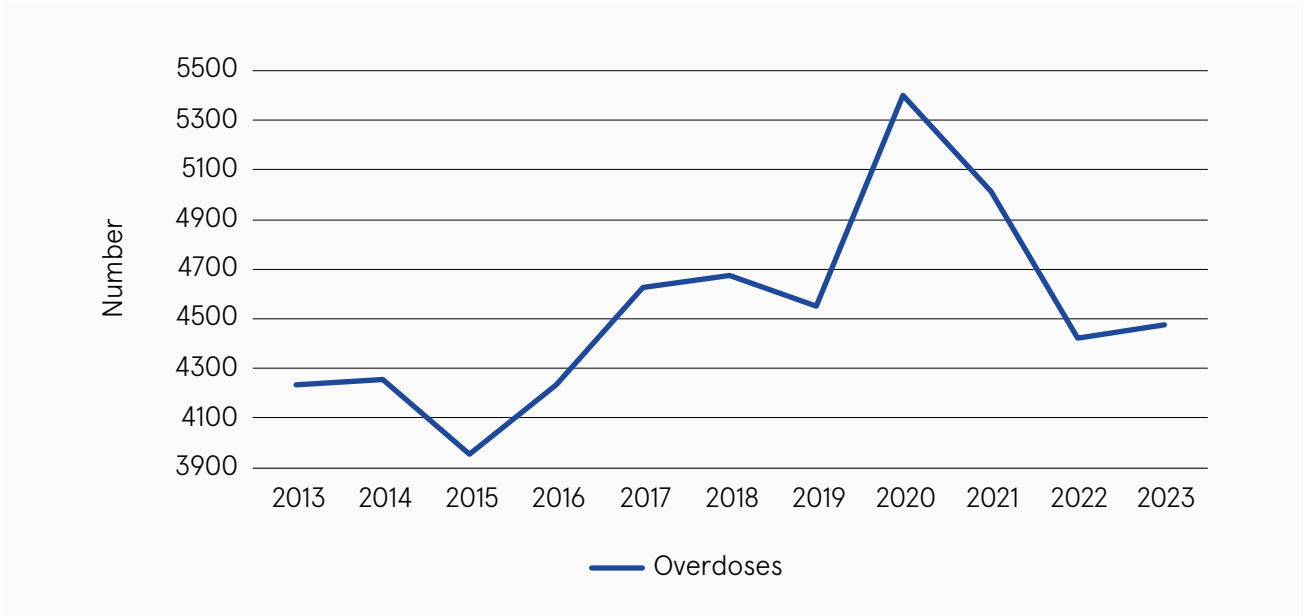
5 Edgar B (2012) The ETHOS definition and classification of homelessness and housing exclusion. *Eur J Homelessness*, 6(2): 219–225.

Non-fatal drug-related hospital admissions in Ireland, 2023

The HIPE (Hospital In-Patient Enquiry) scheme is a computer-based health information system, managed by the Economic and Social Research Institute (ESRI) in association with the Department of Health and the Health Service Executive. It collects demographic, medical, and administrative data on all admissions, discharges, and deaths from acute general hospitals in Ireland. Each HIPE discharge record represents one episode of care; each discharge of a patient, whether from the same or a different hospital, with the same or a different diagnosis, gives rise to a separate HIPE record. The scheme therefore facilitates analysis of hospital activity rather than of the incidence of disease. HIPE does not record information on individuals who attend emergency departments but are not admitted as inpatients. Monitoring of drug-related acute emergencies in the Irish context refers to all admissions for non-fatal overdoses to acute general hospitals in Ireland.

Drug-related emergencies – non-fatal overdoses

Data extracted from the HIPE scheme were analysed to determine trends in non-fatal overdoses in patients discharged from Irish hospitals in 2023.[1] There were 4,523 overdose cases in 2023, of which 47 died in hospital. Only discharged cases are included in this analysis (n=4476). There was a noticeable increase in overdose cases during the years of the COVID-19 pandemic, with the number of discharged overdose cases in 2020 being the highest recorded in 12 years. Since the end of the pandemic, overdose cases have decreased, with the number of discharged overdose cases in 2022 being the lowest recorded since 2017 (see Figure 1).



Source: HIPE, Healthcare Pricing Office, 2024

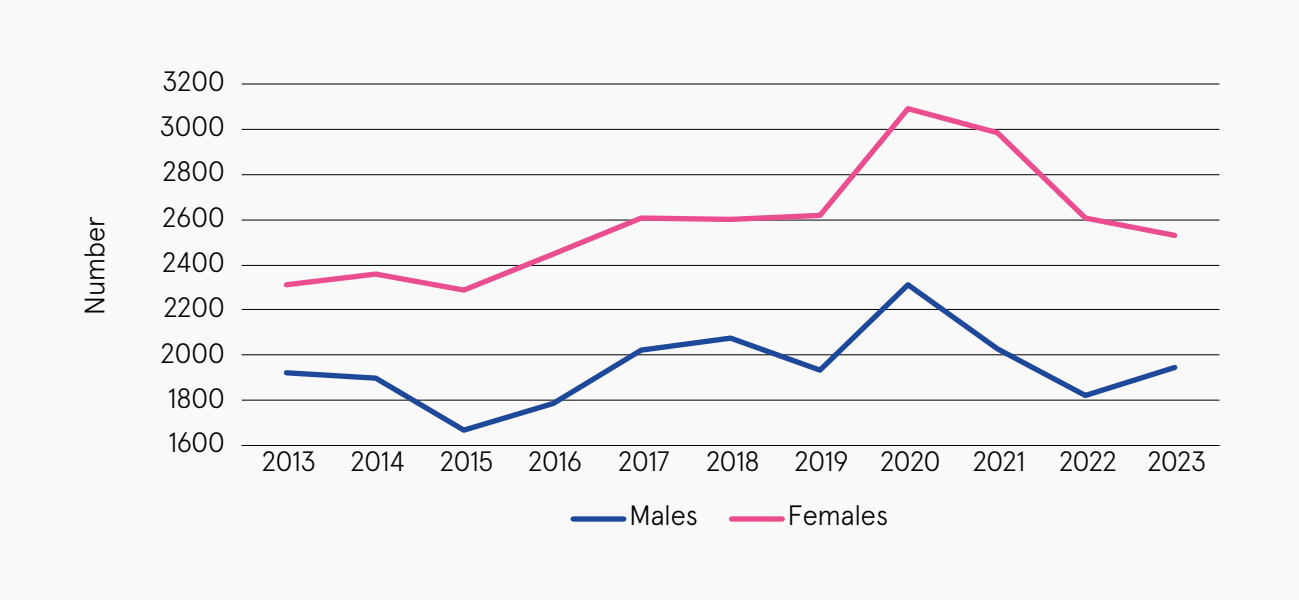
Figure 1: Number of non-fatal overdose cases admitted to Irish hospitals, by year, 2013–2023

Non-fatal drug-related hospital admissions

continued

Sex of overdose cases

Between 2013 and 2023, there were more overdose cases among women than men, with women accounting for 2,528 (56.5%) of all non-fatal overdose cases in 2023 (see Figure 2).



Source: HIPE, Healthcare Pricing Office, 2024

Figure 2: Number of non-fatal overdose cases admitted to Irish hospitals, by year and sex, 2013–2023

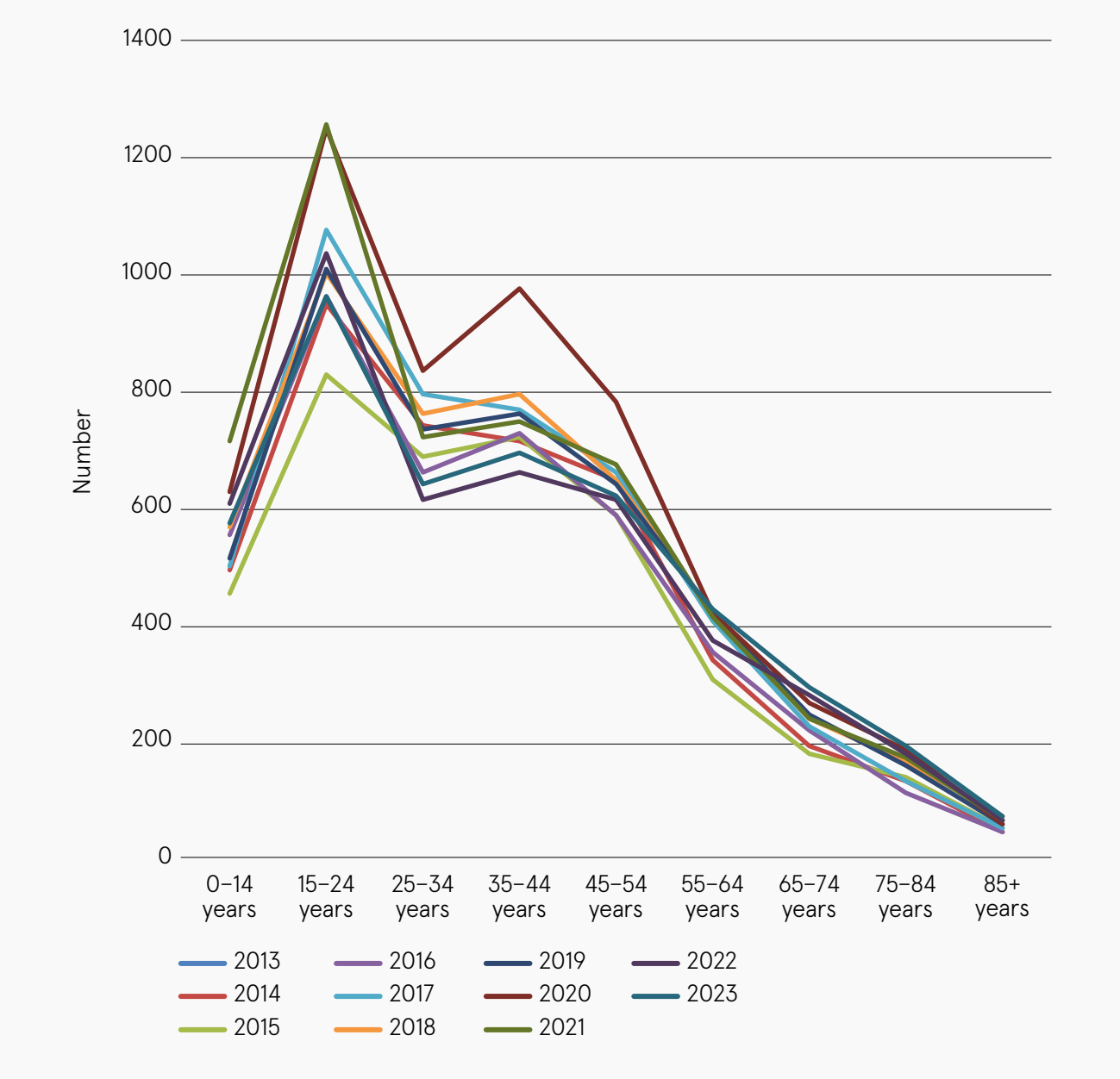
Age group

Between 2015 and 2020, there was a general increase in the number of non-fatal overdose cases in all age groups.

As noted in previous years, the incidence of overdose cases in 2023 peaked in the 15-24 years age group (see Figure 3). In 2023, some 34.3% of cases were under 25 years of age.

Non-fatal drug-related hospital admissions

continued



Source: HIPE, Healthcare Pricing Office, 2024

Figure 3: Non-fatal overdose cases admitted to Irish hospitals, by year and age group, 2013–2023

Toxicology of drug-related acute emergencies

Table 1 presents the positive findings per category of drugs and other substances involved in all cases of overdose in 2023. Non-opioid analgesics were present in 1,541 cases. Paracetamol is included in this drug category and was present in 1,323 of cases in 2023.

Benzodiazepines and psychotropic agents were taken in 832 and 1,059 of cases, respectively. There was evidence of alcohol consumption in 260 of cases in 2023. Cases involving alcohol are included in this analysis only when alcohol was used in conjunction with another substance.

Non-fatal drug-related hospital admissions

continued

Table 1: Categories of drugs involved in non-fatal overdose cases admitted to Irish hospitals, 2023

Drug category	2023
Non-opioid analgesics	1541
Paracetamol (4-Aminophenol derivatives)	1323
Benzodiazepines	832
Psychotropic agents	1059
Antiepilepic/sedative/antiparkinson agents	1927
Narcotics and hallucinogens	1016
Alcohol*	260
Systemic and haematological agents	196
Cardiovascular agents	183
Autonomic nervous system	137
Anaesthetics	70
Hormones	149
Systemic antibiotics	59
Gastrointestinal agents	91
Other chemicals and noxious substances	307
Diuretics	44
Muscle and respiratory agents	26
Topical agents	46
Anti-infectives/antiparasitics	31
Other gases and vapours	36
Other and unspecified drugs	1006

Source: HIPE, Healthcare Pricing Office, 2024

Note: The sum of positive findings is greater than the total number of cases, as some cases involved more than one drug or substance.

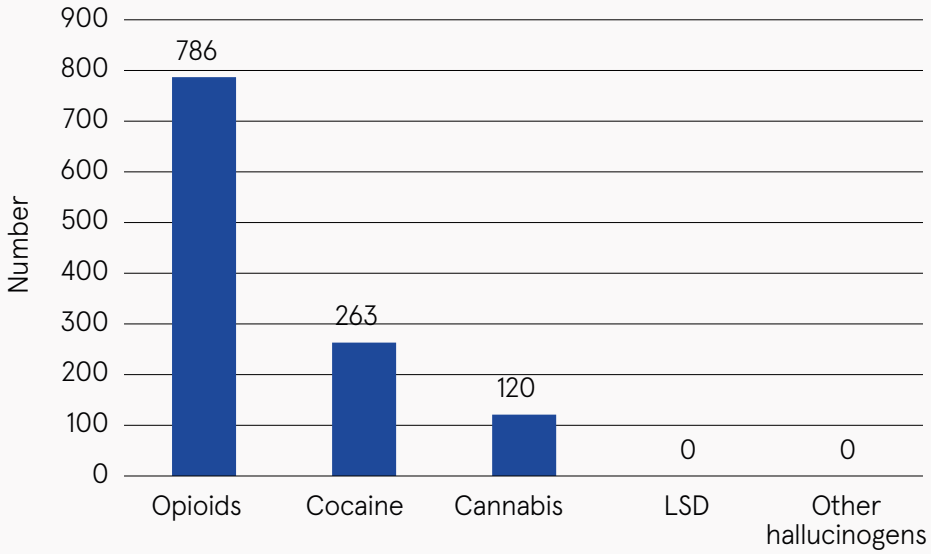
* Alcohol was only included for cases where any code from any of the other drug categories in this table was also reported.

Overdoses involving narcotics or hallucinogens

Figure 4 shows positive findings of illicit substances among overdose cases in 2023. Opioids were used in 17.6% (n=786) of cases; cocaine in 5.9% (n=263) of cases; and cannabis in 2.7% (n=120) of cases in 2023. No overdose cases (or five or fewer) involving LSD or other hallucinogens were recorded.

Non-fatal drug-related hospital admissions

continued

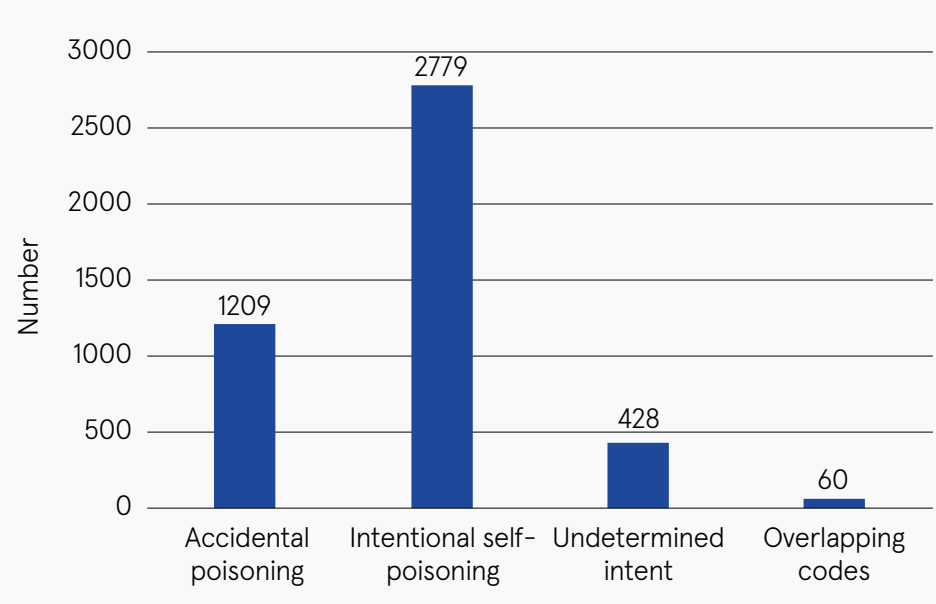


Source: HIPE, Healthcare Pricing Office, 2024

Figure 4: Narcotics and hallucinogens involved in non-fatal overdose cases admitted to Irish hospitals, 2023

Overdoses classified by intent

For 62.1% (n=2779) of cases in 2023, the overdose was classified as intentional (see Figure 5). For 9.6% (n=428) of cases, classification of intent was not clear.



Source: HIPE, Healthcare Pricing Office, 2024

Figure 5: Non-fatal overdose cases admitted to Irish hospitals, classified by intent, 2023

Non-fatal drug-related hospital admissions

continued

Table 2 presents the positive findings per category of drugs and other substances involved in cases of intentional self-poisoning in 2023 (n=2779).

In 2023, non-opioid analgesics were involved in 1,297 of cases, benzodiazepines in 531, and psychotropic agents in 838 of cases.

Table 2: Categories of drugs involved in intentional self-poisoning cases admitted to Irish hospitals, 2023

Drug category	2023
Non-opioid analgesics	1297
Benzodiazepines	531
Psychotropic agents	838
Antiepilepic/sedative/antiparkinson agents	1375
Narcotics and hallucinogens	479
Alcohol*	207
Systemic and haematological agents	128
Cardiovascular agents	127
Autonomic nervous system	97
Anaesthetics	17
Hormones	89
Systemic antibiotics	40
Gastrointestinal agents	80
Other chemicals and noxious substances	116
Diuretics	24
Muscle and respiratory agents	15
Topical agents	19
Anti-infectives/antiparasitics	21
Other gases and vapours	6
Other and unspecified drugs	562

Source: HIPE, Healthcare Pricing Office, 2024

Note: As some discharges may be included in more than one drug category, the total count in this table exceeds the total number of discharges.

* Alcohol was only included for cases where any code from any of the other drug categories in this table was also reported.

Seán Millar

1 For further information on HIPE data, visit the Healthcare Pricing Office website: http://www.hpo.ie/

Emergence of synthetic opioids on the Irish heroin market

On 9 November 2023, Ireland's Health Service Executive (HSE) was made aware of an overdose cluster in Dublin, with 24 cases notified throughout the day and another 10 cases the following morning. This triggered an urgent review across a number of information sources to identify possible signals of change on the Dublin drug market.[1] Data were monitored by the HSE on 9–12 November, and a total of 57 non-fatal overdoses were recorded during this period. Analysis by Forensic Science Ireland of a sample obtained by An Garda Síochána on the evening of 10 November confirmed the emergence of nitazenes in a light brown/sandy-coloured powder on the Dublin heroin market, which resulted in the HSE issuing a Red Alert for the city. The nitazene was later confirmed as *N*-pyrrolidino protonitazene (protonitazepyne), which was a first identification for Ireland and a substance under intensive monitoring by the European Union Drugs Agency (EUDA). Samples were also found to contain caffeine, paracetamol, benzoic acid, and mannitol.[2]

Nitazenes are strong synthetic opioids developed in the 1950s as opioid analgesics, but due to their high potential for overdose were never approved to market. Nitazenes have been connected to a number of overdose deaths worldwide and have also been found in tablets (fake oxycodone), heroin, ketamine, and synthetic cannabinoids.[3]

In addition to the initial Dublin outbreak, nitazenes have since been detected on the Cork market following a steady increase of overdoses in the city; on 12 December 2023, there were 13 non-fatal overdoses reported to the HSE over a 6-day period. This outbreak was attributed to the same nitazene identified in Dublin. On 15 March 2024, the HSE extended a Red Alert to Irish prison settings following a number of overdoses (<5).

On Thursday, 18 July 2024, the Irish Prison Service issued an urgent drug alert to all prisons following analyses conducted by the HSE which confirmed the presence of a nitazene-type substance associated with a number of overdoses in Irish prisons, one of which was fatal. The HSE has convened a National Red Alert Group consisting of key stakeholders to monitor and respond to synthetic opioids. Frontline services nationally have been advised to convene and begin developing strategies for managing outbreaks. This includes establishing coordination groups and formal reporting of drug market changes or overdose clusters to the HSE.

In a letter to the editor of the journal *Addiction*,[4] Killeen *et al.* note that the Irish nitazene outbreaks are examples of how substances can emerge without warning and sporadically on the illicit drug market. Outbreaks require urgent responses and, in the Irish case, current structures were adapted without unwieldy policy amendments. They suggest that this approach will not be sustainable on a long-term basis and that increased budget allocation should be provided to improve early warning mechanisms, to expand harm reduction and treatment responses, and to enhance drug checking through a dedicated drug-monitoring laboratory in Ireland.

Seán Millar

1 Drugs.ie (2023) *Synthetic opioid preparation: HSE update on the emergence of synthetic opioids on the Irish market.* Available from: https://www.drugs.ie/synthetic_opioid_preparation/

2 Killoran S, McNamara S, Kavanagh P, O'Brien J and Lakes R (2024) Identification of N-pyrrolidino protonitazene in powders sold as heroin and associated with overdose clusters in Dublin and Cork, Ireland. *Drug Test Anal.* Early online. Available from: https://www.drugsandalcohol.ie/41058/

Emergence of synthetic opioids on the Irish heroin market

continued

3 Pergolizzi J, Raffa R, LeQuang JAK, Breve F and Varrassi G (2023) Old drugs and new challenges: a narrative review of nitazenes. *Cureus*, 15(6): e40736.

4 Killeen N, Lakes R, Webster M, Killoran S, McNamara S, Kavanagh P, *et al.* (2024) The emergence of nitazenes on the Irish heroin market and national preparation for possible future outbreaks. *Addiction*, 119(9): 1657–1658. Available from: https://www.drugsandalcohol.ie/40996/

Review of Pharmacy Needle Exchange Programme in Ireland

Pharmacy needle exchange in Republic of Ireland

The current national drugs strategy (2017–2025) aims to reduce harms arising from substance misuse and to reduce the prevalence of blood-borne viruses among people who inject drugs (PWID) through the expansion of needle exchange provision to include community pharmacy-based programmes. In October 2011, the HSE rolled out the national Pharmacy Needle Exchange Programme, which is a partnership initiative between the Elton John AIDS Foundation, the Irish Pharmacy Union, and the HSE. Once pharmacies have signed a service level agreement with the HSE, their contact details are passed on to the relevant HSE services so they can promote access to sterile injecting equipment at the participating pharmacies and accept referrals for investigation and treatment. There are pharmacies providing needle exchange in each Regional Drugs and Alcohol Task Force (RDATF) area, apart from those covering Counties Dublin, Kildare, and Wicklow, which are served by a mix of static and outreach needle exchange programmes.

As no published review of the programme has occurred since 2015, a 2024 report aimed to provide an overview of the performance of the HSE Pharmacy Needle Exchange Programme.[1]

Specifically, the objectives of the study were to show patterns in terms of the following:

- The number of pharmacies enrolled and retained to provide a pharmacy needle exchange programme
- The number of people attending the programme
- The number of pharmacy needle exchange packs (containing needles, syringes, swabs, vials, citric acid packs, and water)
- The number of sterile needles provided each month and the average number of needles per person returned.

This article presents the main findings from this study.

Main findings

Number of participating pharmacies and number of attendees

The number of pharmacies providing the programme has declined since 2015 (see Table 1). The report noted that if this pattern continues, it is forecast that by 2027 the number of pharmacies will decline by a further 25% (n=68, CI: 59.78–76.13). In 2022, some 1,612 unique individuals per month used the programme.

Review of Pharmacy Needle Exchange Programme in Ireland

continued

The number of people using the programme increased by 15% from 2015 to 2019, followed by a decline of 19% from 2019 to 2022.

Table 1: Number of pharmacies providing needle exchange in Ireland, by RDATF area, 2013–2023

RDATF area	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Midland: Longford, Laois, Offaly, Westmeath	15	16	17	18	18	17	17	17	17	17	17
North Eastern: Meath, Louth, Cavan, Monaghan	16	21	22	21	21	16	16	15	17	12	17
Northwest: Sligo, Leitrim, West Cavan, Donegal	7	6	6	6	6	5	5	5	4	7	4
Southern: Cork, Kerry	16	21	19	21	21	17	16	17	16	16	19
South-East: Carlow, Kilkenny, Waterford, Wexford, South Tipperary	22	24	17	17	16	14	14	14	13	14	15
Western: Galway, Mayo, Roscommon	10	13	11	12	13	10	10	12	12	10	11
Mid-West: Clare, Limerick, North Tipperary	13	14	15	16	16	19	19	12	12	12	15
Total	**99**	**115**	**107**	**111**	**111**	**98**	**97**	**92**	**91**	**88**	**98**

Source: Unpublished data from the HSE (2023)

Number of pharmacy needle exchange packs and number of sterile needles provided

In 2022, some 3,775 packs were provided per month, which represents an overall decline of 19% compared with 2015. There has also been a decline in the number of packs returned; the overall proportion of packs returned has declined from 23% in 2015 to 16% in 2022. This represents a 28% decline in the proportion of packs returned. There were 21,296 needles provided each month by the programme in 2022, with each person receiving 9.8 needles on average each month. There has been a 4.2% reduction in the average number of needles per individual since 2017.

Recommendations

The report authors suggest that further investigation into the reasons why the programme has declined in terms of the number of pharmacies participating and the level of usage is warranted, and that a survey of those pharmacies that have withdrawn from the programme may provide useful insights in this regard. Anecdotal evidence for Ireland suggests that negative experiences of providing sterile needles to people who use 'crack' cocaine may have contributed to the withdrawal of some pharmacies from the programme in 2019.

Prevalence studies in the 2020s have highlighted the increase in cocaine use in Ireland and identified the emergence of crack cocaine use among a marginalised population that may previously have used heroin.[2]

Review of Pharmacy Needle Exchange Programme in Ireland

continued

The provision of additional training for pharmacies may also encourage ongoing participation in the programme, particularly in terms of emerging trends such as the use of crack cocaine by people who inject drugs, as the needs of people who inject crack may present additional challenges.

Seán Millar

1 Evans D and Keenan E (2024) *Pharmacy Needle Exchange Programme: review of performance indicators*. Dublin: Health Service Executive. Available from: https://www.drugsandalcohol.ie/40586/

2 HRB National Drugs Library (2024) *Factsheet: Cocaine – the Irish situation*. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/17308/

'K culture' – the emergence of ketamine on the Irish drug scene

In January 2024, addiction services warned of a concerning increase in the use of ketamine in Ireland. In 2023, Revenue seized 41.2 kg of ketamine, valued at €2.47m. The drug, known for its use as a horse tranquiliser, has become popular among revellers at festivals and parties. In 2022, Revenue seized 7.86 kg of ketamine, while in 2021 officers seized 25.19 kg of the drug.[1] A letter to the editor of the *Irish Journal of Medical Science (IJMS)* by the HSE National Social Inclusion Office noted that ketamine has become a prominent feature of recreational drug repertories in Ireland, often used in combination with other 'club drugs' for stimulant and euphoric effects when socialising.[2]

A 2019 review of festival drug use found that 63% of respondents to a web survey (n=1093) had used ketamine at an event in Ireland within the last year.[3] Ketamine use was also confirmed as a common trend among third-level students in the Drug Use in Higher Education in Ireland (DUHEI) Survey 2021.

Of the 11,592 respondents, ketamine was the fourth most commonly used drug, with 16% of students reporting that they had have ever used ketamine in their lifetime, and 46.7% of those considered 'current substance users' reporting ketamine use.[4] Recent use was further identified in Irish results from the European Web Survey on Drugs 2021 (n=5796), where 23% of respondents reported ketamine use, which positioned it as the fourth highest drug used among participants following cannabis, cocaine, and ecstasy.[5]

Findings from HSE Safer Nightlife Programme harm reduction outreach and 'back of house' drug checking in 2022–2023 found that across four festival events, among 266 substances surrendered to the HSE, 117 were ecstasy, 40 were ketamine, and 34 were cocaine.[6]

In their letter to the IJMS,[2] Killeen *et al.* noted that results for ketamine use in Ireland from the European Web Survey on Drugs 2021 were considerably higher than the overall proportion of ketamine use reported from the other 30 participating countries.[5] They suggest that the upward trajectory in the use of ketamine and the evolution of ketamine products may lead to increased risks for people who use drugs and new issues for healthcare providers.

The emergence of ketamine on the Irish drug scene

continued

They recommend the inclusion of ketamine in national drug surveys in Ireland to capture the prevalence of use among the general population over time and suggest that physicians should be aware of the signs and symptoms of long-term ketamine use and consider this within their healthcare screening, particularly in presentations relating to cognitive or bladder problems among young people.

Seán Millar

1 Loughlin E and Murphy A (2024) Warning of increase in ketamine use as seizures of drug spike. *Irish Examiner*, 21 January 2024. Available from: https://www.irishexaminer.com/news/arid-41313883.html

2 Killeen N, McNamara S and Keenan E (2024) 'K culture', ketamine's prominent yet overlooked role on the Irish drug scene and implications for health [Letter to the editor]. *Ir J Med Sci*, 193: 1557–1559. Available from: https://www.drugsandalcohol.ie/40174/

3 Ivers JH, Killeen N and Keenan E (2022) Drug use, harm-reduction practices and attitudes toward the utilisation of drug safety testing services in an Irish cohort of festival-goers. *Ir J Med Sci*, 191(4): 1701–1710. Available from: https://www.drugsandalcohol.ie/34860/

4 Byrne M, Dick S, Ryan L *et al.* (2022) *The Drug Use in Higher Education in Ireland (DUHEI) Survey 2021: main findings*. Cork: University College Cork. Available from: https://www.drugsandalcohol.ie/35515/

5 Mongan D, Killeen N, Evans D, Millar SR, Keenan E and Galvin B (2022) *European Web Survey on Drugs 2021: Irish results*. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/36571/

6 Killeen N, Corrigan N and Keenan E (2023) *The HSE 'Safer Nightlife' Programme 2022: volunteer feedback on the provision of harm reduction outreach in Irish festival settings*. Dublin: Health Service Executive. Available from: https://www.drugsandalcohol.ie/39205/

Injecting trends in Dublin and Midlands regions: results from Syringe Analysis Programme, 2021–2022

Background

In 2022, the HSE, in partnership with Merchants Quay Ireland, collected 165 used syringes from the Dublin and Midlands regions during September and October. Residual drugs were extracted from these syringes and the data obtained were used to compare drug trends from the two regions.

The Syringe Analysis Programme is the first of its kind in Ireland and enables the HSE to identify temporal and geographical trends annually as part of its emerging drug trend monitoring. Analysis of 235 drugs and metabolites was performed using liquid chromatography–mass spectrometry.

Injecting trends in Dublin and the Midlands

continued

These analyses spanned a wide range of substances, such as opiates (including new synthetic opioids), benzodiazepines, amphetamines, cocaine, new psychoactive substances (NPS), Z-drugs, gabapentinoids, ketamine, and various cutting agents. In 2023, the HSE published a report[1] detailing the findings from the 2022 analysis programme; it also compared 2022 programme results to findings from a syringe analysis programme conducted in 2021. The main findings are discussed below.

Results

As expected, heroin was the most common drug identified over the two-year period (see Tables 1 and 2). Cocaine was the second most common drug detected in syringes (71.0% Dublin and 50.8% Midlands); however, there was a reduction in the presence of cocaine in Dublin and Midlands syringes when compared with 2021 findings (86.5% Dublin and 89.1% Midlands). Overall, there were reductions observed in a number of drugs; notably, there were significant reductions in the presence of cathinones (11.3% to 1% in Dublin and 23.6% to 0% in Midlands); methamphetamine (32.6% to 0% in Dublin and 18.2% to 0% in Midlands); and pregabalin (24.7% to 3% in Dublin and 34.5% to 15.4% in Midlands).

The only documented increases since the 2021 study were the presence of ecstasy and the injecting of flurazepam both in the Dublin and Midlands regions.

There was also less variety in the types of drugs identified in the 2022 study compared with 2021. This could be due to shifts in injecting practices or that the samples obtained did not capture a diverse enough user population.

Table 1: Dublin region syringe analysis comparison, 2021–2022

Drug	2021	2022
Cathinones		
3-MMC	11.3%	1.0%
Amphetamines		
Methamphetamine	32.6%	0.0%
Amphetamine	9.0%	2.0%
Ecstasy	1.1%	7.0%
Benzodiazepines		
Flurazepam	0.0%	2.2%
Diazepam	2.2%	1.0%
Alprazolam	1.1%	1.0%
Cocaine		
Cocaine	86.5%	71.0%
Opioids		
Heroin	93.3%	90.0%
Oxycodone	7.8%	0.0%
Methadone		
Methadone	61.8%	33.0%
Other medicines		
Zopiclone	4.5%	0.0%
Dextromethorphan	0.0%	0.0%
Pregabalin	24.7%	3.0%
Piperidines and pyrrolidines		
Methylphenidate	1.1%	0.0%
Ketamine		
Ketamine	7.0%	3.0%

Source: McNamara *et al.* (2023)[1]

Injecting trends in Dublin and the Midlands

continued

Table 2: Midlands region syringe analysis comparison, 2021–2022

Drug	2021	2022
Cathinones		
3-MMC	23.6%	0.0%
Amphetamines		
Methamphetamine	18.2%	0.0%
Amphetamine	1.8%	1.5%
Ecstasy	0.0%	3.1%
Benzodiazepines		
Flurazepam	12.7%	20.0%
Diazepam	3.6%	0.0%
Alprazolam	0.0%	0.0%
Cocaine		
Cocaine	89.1%	50.8%
Opioids		
Heroin	98.2%	78.5%
Methadone		
Methadone	50.9%	50.9%
Other medicines		
Zopiclone	9.0%	7.7%
Dextromethorphan	3.6%	0.0%
Pregabalin	34.5%	15.4%

Source: McNamara *et al.* (2023)[1]

Comparison of results

The report authors noted that while applying the same methodology with the same services in the Dublin and Midlands regions for both years, there was difficulty in obtaining diverse and representative syringe samples for the 2022 programme. This was due to new deposit points in hostel accommodation where people discard syringes and also as a result of drug market shifts, with increases in crack cocaine smoking among service users. Based on these changes, there are some early indications of a reduction in injecting practices by some individuals. As a result, the 2022 results are based on fewer numbers of people who inject drugs and may not accurately reflect the drug trends among the wider community. The project was set to be expanded in 2023 to help gain greater market insights, with the HSE partnering with a number of services in Tallaght and Clondalkin to capture trends within Dublin but which are outside the city centre.

Seán Millar

1 McNamara S, Killeen N, Eagleton M and Keenan E (2023) *HSE emerging drug trend monitoring: year 2 results from the Syringe Analysis Programme 2022. The identification of injecting trends in the Dublin and Midland Region through the application of syringe analysis methodology.* Dublin: Health Service Executive. Available from: https://www.drugsandalcohol.ie/40165/

Responses

Launch of study on human rights and equality issues in drug treatment services in Dublin's North-East Inner City

Background

Serious human rights and equality concerns emerged regarding the lived experience of service users in Dublin's North-East Inner City. In 2009, drug service users, their representatives, and community activists formed a coalition after concerns were raised about the practice of and over-reliance on urine testing and the lack of information and choice on pathways to health for each service user. A study was conducted[1] to identify issues experienced by service users of drug treatment projects and to review the key monitoring points and changes arising from the Health Service Executive (HSE) Action Plan. A great emphasis of this study was on peer-led processes, as the voice of the service user is rarely heard.

Methods

In October 2022, an advisory group consisting of Inner City Organisations Network (ICON), Service Users Rights in Action (SURIA), and Community Action Network (CAN) was established. This group reviewed previous peer research before developing and piloting a questionnaire, which included questions on demographics, treatment plans, supervision of urine sampling, engagement, and complaints mechanisms. The survey was implemented in early 2023 and the results analysed and reported on later that year.

Results

The survey consisted of 138 interviews, with 36% of respondents living in Dublin 1, while another 36% were homeless.

Entering and remaining in recovery is more difficult in homeless hostels and on the streets. More than three in four (77%) of all those who responded were between 36 and 55 years of age. More males than females (58% vs 41%) participated, as women tend to experience additional barriers when accessing treatment. For example, mothers are expected to make huge leaps in recovery, further fuelling the assumption that because they are on an opioid treatment programme they are incapable of looking after their children.

The survey interviewees came from disadvantaged and marginalised communities, which are disproportionately impacted by the negative effects of drug use activities. The overall statistics mask true deprivation and the average figures tell nothing of the real experiences of the most disadvantaged. People in deprived communities are twice as likely to experience drug-related intimidation than others. More than one-third of respondents reported a considerable problem with people using or dealing drugs in their local area.

Many service users felt that there was no end in sight for their treatment journey: 87% had never been offered an alternative to methadone treatment. Furthermore, 57% of service users did not know how to make a complaint, while one-half did not know what a care plan entailed (49%). Many participants were told they were not ready to move on from methadone, even when requesting a change. Service users felt stigmatised because they had an addiction or because they were in treatment.

Human rights and equality issues in drug treatment services in Dublin's North-East Inner City

continued

They felt watched in shops and in the community, even when they were clean, often excluded by family, and experienced discrimination from healthcare services. Many reported that people's attitudes changed once they learned that the person they were dealing with was on methadone: the respondents felt that their opinions ceased to matter and they were treated as second-class citizens.

The service users also reported poor quality of life as a result of addiction and prolonged treatment: more than one-half (56%) had been in treatment for more than 16 years. More than one-third (35%) said that methadone had not improved their quality of life. Service users voiced a huge issue with lack of control regarding their own treatment, with many expressing that they felt chained to the clinics they had been assigned to by 'liquid handcuffs'. Looking for employment, going on a holiday or moving house were not options for many, as frequent visits to the clinic determined their movements and controlled their daily lives. When asked, respondents expressed that they had many goals in life, though the majority of them felt they had not reached them.

Most goals related to entering into new treatment and becoming drug-free and generally improving their quality of life. However, many respondents were told that they had to stay on methadone as they were not ready to detox. For those who did ask for an alternative to methadone, they felt their requests were not being listened to and their voice in their treatment choice was not being heard.

Conclusion

The study recommendations include the cessation of the use of urine sampling by all drug treatment service providers and other agencies; meaningful engagement and participation for service users (including that the HSE engage with service users to review the treatment choice); and for the HSE to engage with service users to develop and implement a positive action plan to ensure that information on a complaints system is available in an accessible manner.

Tiina Lynch

1 Inner City Organisations Network (ICON), Service Users Rights in Action (SURIA) and Community Action Network (CAN) (2024) *Trapped in treatment: applying a public sector equality and human rights duty approach to the human rights and equality issues identified by service users of drug treatment services in the North-East Inner City (NEIC).* Dublin: ICON/SURIA/CAN. Available from: https://www.drugsandalcohol.ie/40596/

HSE Integrated Alcohol Service: A coordinated approach to alcohol treatment

Background

The Health Service Executive (HSE) Integrated Alcohol Service (IAS) began operating on North Great Clarence Street, Dublin 1 in 2022, following the growing recognition of and concern regarding widespread problem alcohol use in the area, particularly during the COVID-19 pandemic. The IAS is based on the recommendations outlined in the *National Drugs Rehabilitation Framework Document*, and provides a coordinated response to address both prevention and the provision of services and support to those who require it.[1]

IAS for Dublin's North City and County

The acknowledged necessity and value of the IAS has meant that the number of locations around Ireland has increased. A visit to the service on North Great Clarence Street to meet the IAS team demonstrated the range of supports and services that the IAS provides for those with alcohol-related issues and their families.

The HSE team includes a nurse, a general practitioner (GP), case workers, counsellors, administrative staff, and the Service Coordinator. This service has established a strong partnership approach with six funded community and voluntary organisations. Between them, these organisations provide holistic and comprehensive care to individuals through the provision of multiple interventions and supports. This integrated approach addresses the physical, psychological, and social aspects of problem alcohol use and delivers personalised, effective, and coordinated care in order to help those who seek advice and support to reduce their alcohol use and improve their overall well-being.

Families and others affected by drug and/or alcohol use can avail of family support, which seeks to enhance family well-being and strengthen coping abilities by reducing stresses and strains for family members or others affected by drug and/or alcohol use. Family members are considered service users in their own right.

Referral process

Where an individual is recognised as potentially requiring support for their alcohol use and is willing and has consented to engage, the referral process begins. A major advantage of the IAS is the streamlined referral pathway, meaning that referrals can be made from acute services, primary care, and community organisations, in addition to self-referrals. A centralised referral system ensures that a standardised and integrated care pathway is quickly and easily identified with links to relevant services for both alcohol-related and other issues.

Guided by the principles of the *National Protocols & Common Assessment Guidelines to Accompany the National Drugs Rehabilitation Framework*, early engagement is fundamental to the IAS.[2] Upon referral, an initial assessment is conducted in order to gauge the seriousness and urgency of the alcohol problem. At this point, there may be an immediate onward referral, or the most suitable care plan is discussed and prepared by the team. This is a shared care model and is completed together with the service user and their family or carer, where appropriate, who actively participate in, and lead the development of, the care plan. This systematic approach to identifying and addressing the needs of the service user ensures that they receive the most appropriate service to meet their needs.

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Interventions provided by the IAS

For some, a brief intervention approach may be the extent of their interaction with the service, while others will require more intensive interventions and active engagement with the IAS. The on-site GP, Dr Hugh Gallagher, discussed the medications that can be prescribed for some service users trying to cut down their alcohol use as well as those who have gone through detoxification and are trying to stay sober. One such medication is disulfiram, also known by the brand name Antabuse, which is commonly used in the treatment of alcohol use disorders; another is naltrexone.[3] Dr Gallagher often applies the Sinclair Method to service users who are prescribed naltrexone. This method can be effective for those who may not want or are not ready to entirely cut out alcohol, but do want to drink less, and it works on the reward pathways in the brain to reduce the good feeling the individual gets from consuming alcohol and thus help the individual drink less.[4]

An additional medication, acamprosate, can help reduce the urge to drink so that people in recovery can focus on maintaining sobriety. Most effective if used along with counselling and social support, it helps those who have stopped drinking heavily to avoid drinking alcohol again by changing the way the brain works.[5]

As well as medical support, the IAS is currently part of a national pilot programme for the SAOR (Support, Ask and Assess, Offer Assistance, Refer) Extended Brief Intervention (EBI) in primary care centres. The SAOR EBI allows a service user to avail of up to six sessions in their primary care centre, with onward referral pathways to specialist services where required.

Other interventions include case management to link individuals with appropriate services in order to address their specific needs and achieve their stated goals; community detox programmes; referrals to residential beds; education; supports for those with a dual diagnosis of alcohol use disorder and a mental health disorder; and telehealth/eHealth. Support groups are also soon going to be added to the list of interventions provided by the service, where individuals can encourage and aid each other in their recovery journey.

The IAS also assists in a programme called Sobriety Sampling, whereby an individual undertakes a period of abstinence.[6] During this time, they can consider what works best for them as well as what does not, and this experimentation with abstinence can initiate permanent change. Abstinence becomes a personal journey that the individual can control, making it less daunting than traditional methods, and by setting their own goals, the individual is more likely to progress in a positive direction.

Supporting and empowering the community: A collaborative engagement

The streamlined referral process and the growing suite of services provided by the IAS has already seen numerous people access the service and receive the support they need. Service Coordinator Paul Duff explains that relapses have to be expected and are often part of the recovery journey, but the door to treatment is always open.

Anne Doyle

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Updates

Recent publications

Prevalence and current situation

An exploration of organizational climate in community-based opiate prescribing services; a mixed methods study.

Kelly P, Searby A and Goodwin J (2024) *Journal of Substance Use and Addiction Treatment*, 162, 209362.
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Dempsey S and O'Grady MJ (2024) *Archives of disease in childhood. Fetal and neonatal edition*, 109, (3), pp. 261-264.
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A spatial examination of alcohol availability and the level of disadvantage of schools in Ireland.

Doyle A, Foley R and Houghton F (2024) *BMC Public Health*, 24, (795).
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Male patient attendances at Sexual Assault Treatment Units in Ireland: an analysis of 381 cases and a comparison with female patients.

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Sexual, domestic, and gender-based abuse. A collection of experience and opinion.

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Millar S, Harrington JM, Perry IJ and Phillips C (2024) *Brain, Behavior, and Immunity*, 37, 100759.
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Postoperative opioid prescribing patterns in Ireland: a retrospective multicentre analysis.

Nolan, R Angelov S, Geoghegan L *et al.* (2024) *British Journal of Anaesthesia*, Early online.
https://www.drugsandalcohol.ie/40791/

Recent publications

continued

Responses

Advancing early detection of suicide? A national study examining socio-demographic factors, antecedent stressors and long-term history of self-harm.

McMahon EM, Cully G, Corcoran F, Arensman E and Griffin E (2024) *Journal of Affective Disorders*, 350, pp. 372-378.
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Examining the relationship between adversity and suicidality and self-harm in Irish adolescents from 2020 to 2022.

Silke C, Heary C, Bunting B *et al.* (2024) *Journal of Affective Disorders*, 349, pp. 234-243.
https://www.drugsandalcohol.ie/40281/

A comparison of rate and methods of probable suicide for 2 years pre and post the onset of the COVID-19 pandemic.

Mannix D, and Holleran L, Cevikel P *et al.* (2024) *Irish Journal of Psychological Medicine*, Early online.
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Community pharmacy needle exchange programme: what can analysis of the data tell us about the changing drug market in Ireland?

Evans DS, Harnedy N and Keenan E (2024) *International Journal of Environmental Research and Public Health*, 21, (3), p. 289.
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Big alcohol: universities and schools urged to throw out industry-funded public health advice.

Davies, M and Boytchev H (2024) *BMJ*, 385, q851.
https://www.drugsandalcohol.ie/40918/

National Drugs Forum 2024

Emerging drug trends: monitoring, communicating and responding

DrugsForum@hrb.ie

Croke Park, Dublin
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