

Homelessness in Ireland

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Alcohol and cannabis use among school-aged children in Ireland

Dr James Reilly TD, Minister for Health, launched the report of the Health Behaviour in School-aged Children (HBSC) survey 2010¹ on 16 April 2012. Researchers at the National University of Ireland, Galway, did the survey. Previous surveys were conducted in 2006, 2002 and 1998 (www.nuigalway.ie/hbhc).

Overall, 46% of children (aged 10–17) reported that they had consumed an alcoholic drink at some point in their life, a fall of seven percentage points on the 2006 figure of 53%. Girls (43%) were less likely than boys (48%) to report drinking alcohol, and as children grew older they were more likely to report drinking alcohol.

The proportion of children (aged 10–17) who had consumed alcohol in the 30 days prior to the survey was 21%, a fall of five percentage points on the 2006 figure of 26%. Boys (22%) were more likely than girls (19%) to have had alcohol in the last 30 days.

Twenty-eight per cent of children reported having been 'really drunk' at some point in their life, a fall of four percentage points on the 2006 figure of 32%. More boys (29%) than girls (26%) reported this, and the proportion reporting drunkenness increased with age: 4% of 10–11-year-olds, 16% of 12–14-year-olds and 52% of 15–17-year-olds. Children from lower social class groups were more likely to report having been 'really drunk' than those from middle and higher social class groups. The proportion who reported having been 'really drunk' in the 30 days prior to the survey was 18% in 2010 and 20% in 2006, a marginal decrease which may be explained by sampling variation or the sample representation by socio-economic group.



Eleven per cent of 15-year-old girls and 15% of 15-year-old boys had their first episode of drunkenness at the age of 13 years or under.

Eight per cent of children (aged 10–17) reported having used cannabis in the 12 months prior to the survey, a halving of the 2006 figure of 16%. More boys (10%) than girls (6%) reported such use. The proportions increased with age: for example, 1% of 10–11-year-olds compared to 17% of 15–17-year-olds reported such use.

Five per cent of children reported having used cannabis in the 30 days prior to the survey, a fall of two percentage points on the 2006 figure of 7% which may be explained by sampling variation. More boys (7%) than girls (3%) had used cannabis in the month prior to the survey.

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Alcohol and cannabis use among school-aged children (continued)

The HBSC survey is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe (www.hbsc.org). The survey runs on an academic four-year cycle, and in 2010 there were 43 participating countries and regions. HBSC collects information on the key indicators of health and health-related attitudes and behaviours (including alcohol and cannabis use) among young people aged 11, 13 and 15 years. In Ireland, the HBSC 2010 survey collected data from children aged 9 to 18 years, and the data analysed on alcohol and cannabis is for children aged 10 to 17 years.

A nationally representative sample of primary and post-primary schools in Ireland was randomly selected and subsequently, within schools, classes were randomly selected. The HBSC questionnaire was developed by the international research network and is administered by teachers and completed by the selected students. Younger children receive a shorter questionnaire. Just over two-thirds (67%) of invited schools and 85% of students participated in the survey. Compared to the 2006 survey, the 2010 survey had higher representation from social classes 1 and 2 and lower representation from social classes 3, 4, 5 and 6.

Overall, there was a decrease in self-reported alcohol and cannabis use among school children in Ireland in 2010 when compared to 2006. This may represent a true decrease, possibly owing to children having less pocket money in recent years, or it may be the result of sampling variation, or a combination of both factors. These decreases are welcome, but we must note that at least one in ten 15-year-olds has been drunk by the age of 13, and that more than half our 15–17-year-olds have been drunk at some point in their lives. It is illegal to sell alcohol to children in Ireland, and public health professionals recommend that children should not drink alcohol. This is because the relative immaturity of the adolescent brain compared to that of an adult renders excessive drinking especially hazardous for young people. The American Medical Association reported that an adolescent need drink only half as much as an adult to experience the same negative effects and that even occasional binge drinking can

damage the young brain.² Adolescent drinkers are more likely to perform poorly in school, and to experience social problems.³ In addition, people who begin drinking before the age of 15 are four times more likely to develop alcohol dependence at some time in their lives than those who have their first drink at age 20 or over.⁴

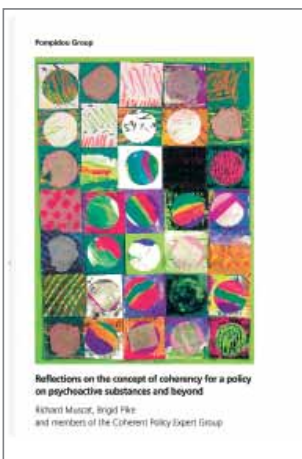
(Jean Long)

1. Kelly C, Gavin A, Molcho M and Nic Gabhainn S (2012) *The Irish Health Behaviour in School-aged Children study 2010*. Dublin and Galway: Department of Health and National University of Ireland. www.drugsandalcohol.ie/17360
2. American Medical Association (2002) *Harmful consequences of alcohol use on the brains of children, adolescents and college students*. Summary report. Retrieved 14/5/2012 from www.ama-assn.org/resources/doc/alcohol/harmful_consequences.pdf
3. US Department of Health and Human Services (2007) *The Surgeon General’s call to action to prevent and reduce underage drinking*. Rockville MD: US Department of Health and Human Services, Office of the Surgeon General. www.ncbi.nlm.nih.gov/books/NBK44360
4. Grant BF and Dawson DA (1997) Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse*, 9: 103–110.

Combining drug and alcohol policies – ‘a big challenge’

It is still too easy to compartmentalise the elements for which organisations are responsible, but when it comes to an issue such as drug or alcohol use, it crosses all those boundaries. ... We know from our prevention work that what are needed are not only programmes but also systems that can work together, ... That is where we need to go, but it is a big challenge. I do not think anyone has cracked that yet.

Mary Ellen McCann, Vice-Chair of the NACD, speaking to the Joint Committee on Health and Children, 22 September 2011



In April 2012 the Council of Europe published the third in a series of reports intended to help ‘crack the big challenge’, exploring what structures and systems might support integrated policies on psychotropic substances (including illicit drugs, alcohol and tobacco).¹ The three reports are the result of the ongoing deliberations of an ‘expert group’ set up under the auspices of the Pompidou Group.²

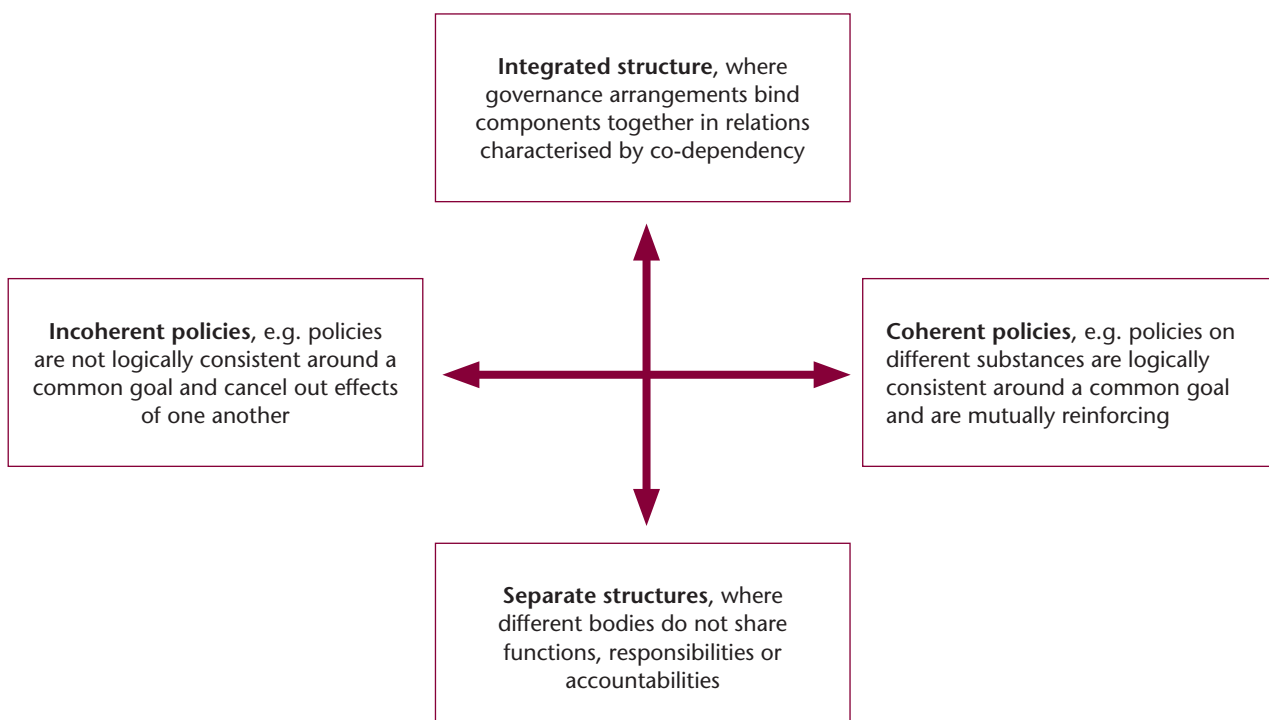
The first two publications from the expert group focused on the ‘context’

within which the combining of policies on illicit drugs, alcohol and tobacco may be considered,³ and the ‘systems’ that could support the integration of policies in these three areas.⁴ This third report focuses on ‘measurement’.

Measuring substance misuse policies

In order to measure the extent to which different policies are combined, the expert group has agreed that all policies need to be goal-directed, to lead to a valid outcome as a result of their implementation. It identifies two ‘formidable’ goals for policies relating to illicit drugs, alcohol and tobacco – (1) the ‘well-being’ of the targeted population and (2) prevention of the harm/s caused by substance use.

The expert group goes on to explore the relationship between integration and coherence as a way of measuring the achievement of the policy outcomes. **Integration** is about combining parts into a single, unified whole, while **coherence** is about sticking a number of different parts together in a logically consistent manner. The former is like a chemical process, irreversible, with the whole being greater than the parts, while the latter is more like a physical process, reversible, in which the elements can be separated out again. The expert group suggests that ‘integration’ may be used to assess policy-making structures while ‘coherence’ may be used to assess policies, and the extent to which they align with each other around common goals and are mutually supportive while retaining their individual and separate characters – see diagram below.



Combining drug and alcohol policies (*continued*)

The group suggests that gauging the extent of integration is useful for getting a broad-brush understanding of a particular set of policy and structural arrangements, their character. Gauging the degree of coherence around a common goal yields a more detailed, more fine-grained picture, which may increase the capacity of policy makers to respond flexibly as a policy domain changes over time, i.e. the framework may be a tool for policy makers to both understand the overall nature of their policy approach and also to manage their policies in a timely and responsive manner.

Coherency of Irish policies on tobacco, illicit drugs and alcohol

The report proposes a formal definition of ‘policy coherence’ and identifies six ‘indicators’ that may be used to gauge the degree of coherency between policies on different substances. It also explores the validity, feasibility and practicality of using this concept in the psychotropic substances policy domain. Proceeding from this basis, each member of the expert group has written a chapter, reflecting on the coherency of drug, alcohol and tobacco policies in their own countries, including Austria, Belgium, Ireland, Israel, Netherland, Norway, Portugal and Switzerland.

In the case of Ireland, a preliminary assessment against the six proposed indicators or, more accurately perhaps, ‘markers’, of coherency suggests that tobacco is the policy area most consistently aligned with a population-based approach to health. Defining tobacco use as a public health problem, and one causing a substantial number of deaths, Ireland’s tobacco policy focuses on prevention, of both individual use and environmental exposure to tobacco smoke. Research and monitoring are also designed and undertaken to support effective prevention efforts. A population-based health approach has also been used when planning responses to problematic illicit drug use. However, on account of the criminal activities and public disorder, anti-social behaviour and violence that may be associated

with illicit drugs, criminal justice responses have also been adopted. While these responses may achieve the desired criminal justice outcomes, such as a lower incidence of violent crime or safer communities, they may also serve to undermine the population health ethos by criminalising and/or stigmatising problem drug users. With regard to alcohol policy, considerable ambivalence was found. With no overall strategy in place (at the time the report went to press) to guide decisions, responses have included self-regulation, licensing and criminal justice measures. Moreover, implementation has been inconsistent.

While the assessment methodology may not lead to a precise measure of policy coherency, it does facilitate identification of options for strengthening the impact of different policies relating to the misuse of psychoactive substances.

(Brigid Pike)

1. Muscat R, Pike B and members of the Coherent Policy Expert Group (2012) *Some reflections on the concept of coherency in relation to a policy on psychoactive substances and beyond*. Strasbourg: Council of Europe Publishing.
2. The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group) was an inter-governmental body formed in 1971 at the initiative of the late French President Georges Pompidou. In 1980 the Group was incorporated into the institutional framework of the Council of Europe and at present it comprises 35 member states. Its core mission is to contribute to the development of multidisciplinary, innovative, effective and evidence-based drug policies in its member states.
3. See Pike B (2008) Illicit drugs, alcohol and tobacco – understanding the policy issues. *Drugnet Ireland*, (29): 3–4.
4. See Pike B (2011) Merging policies on psychoactive substances. *Drugnet Ireland*, (39): 8–9.

UN affirms 100 years of international drug control

On 23 January 1912 the world’s first multi-lateral legal instrument to control drugs, the International Opium Convention, came into force. Holding its 55th annual session in Vienna in March 2012, the Commission on Narcotic Drugs (CND), the policy-setting body of the United Nations on drug control matters, passed a resolution reaffirming the three UN drug conventions, and the CND’s ‘unwavering commitment to ensure all aspects of demand reduction, supply reduction and international co-operation are addressed in full conformity with the purposes and principles of the Charter of the United Nations, international law and the Universal Declaration of Human Rights’.¹

Seven of the other 11 resolutions adopted by the CND are also directly relevant to Ireland’s national drug policy.²

New psychoactive substances

Member states are encouraged to monitor the situation in their own countries; share information (including patterns of use, risks to public health, forensic data and regulation of new psychoactive substances) with other member states and with the United Nations Office on Drugs and Crime

(UNODC); adopt measures to reduce supply and demand in accordance with national legislation; and improve research, analysis and forensic and toxicological capability. They are also encouraged to consider a wide variety of responses, such as temporary and emergency drug control measures in response to an imminent threat to public health, the use of consumer protection, medicines legislation and hazardous substances legislation, and, where appropriate, criminal justice measures aimed at preventing the illicit manufacture of and trafficking in new psychoactive substances, and are urged to co-operate, in accordance with national law, in judicial and law enforcement activities to tackle the trade in and distribution and manufacture of those new psychoactive substances that have already been identified as posing risks to public health and that are subject to control within certain member states.

Drug-dependent persons released from prison

Member states are invited to consider developing or strengthening regulatory frameworks for the implementation of measures facilitating the continued treatment, care,

International drug control (*continued*)

rehabilitation, social reintegration and related support services for drug-dependent persons being released from prison settings. They are also called on to consider developing and implementing pre-release and post-release programmes aimed at preventing relapse and reoffending, and to provide service providers with the training necessary to work with drug-dependent persons in pre-release and post-release programmes. In addition, member states are encouraged to integrate these measures in their national strategies on drug demand reduction.

Strategies and measures specifically for women

This resolution is discussed in a separate article on International Women's Day elsewhere in this issue of *Drugnet Ireland*.

Electronic drug import and export authorisation system

Member states are encouraged to provide the fullest possible financial and political support for developing, maintaining and administering an electronic import and export authorisation system in accordance with the requirements of the international drug control conventions.

Drug overdose prevention

Member states are encouraged to include effective elements for the prevention and treatment of drug overdose, in particular opioid overdose, in national drug policies, where appropriate, and to share best practices and information on the prevention and treatment of drug overdose, in particular opioid overdose, including the use of opioid receptor antagonists such as naloxone. They are also encouraged to strive to ensure that all efforts are made to implement comprehensive supply and demand programmes that promote the health and well-being of their citizens.

Evidence-based drug prevention

Member states are urged/encouraged to:

- develop, promote and implement cost-effective policies and interventions to prevent the use of illicit drugs, with special emphasis on children, youth and populations at risk, using current academic, scientific and practitioner-based studies;
- continue to raise the awareness of policymakers of the risks and the threats posed to society by abuse of drugs and of the individual and social conditions that make people vulnerable to abusing drugs;
- target their prevention programmes towards domains where individuals, in particular children and youth, are most likely to encounter illicit drugs;
- develop and implement specific policies and interventions aimed at the healthy and safe development of children and youth that are particularly vulnerable to individual or environmental risks;
- take into account gender-specific services in their drug prevention systems;
- promote public health and healthy lifestyles, such as physical activities, sport and recreation programmes, in order to facilitate drug prevention;

- engage in close co-ordination with all stakeholders in their societies to target prevention with a cross-cutting and multidisciplinary approach;
- co-operate, on both the bilateral and regional levels, to strengthen national capacities with respect to prevention policies and their implementation;
- exchange experiences and best practices on the prevention of the use of illicit drugs in families, schools, universities, workplaces, communities and other domains.

Alternatives to imprisonment

Member states are encouraged/invited to:

- consider allowing the full implementation of drug dependence treatment and care options for offenders, as an alternative to incarceration, in order to help strengthen drug demand reduction policies while promoting both public health and public safety;
- share their experiences and good practices, based on successful implementation of evidence-based alternative approaches to the prosecution and imprisonment of drug-using offenders, including examples of legislation, and to provide technical assistance to interested states, upon request;
- promote co-ordination and co-operation between competent authorities, such as health, public security and justice authorities, as well as service providers;
- consider including in their national anti-drug strategies alternative approaches to prosecution and imprisonment for drug-using offenders that could act as a valuable link between demand reduction programmes, particularly those relating to treatment, and the areas of law enforcement and justice.

(Brigid Pike)

1. United Nations (2012) *Commission on Narcotic Drugs Report of the fifty-fifth session (13 December 2011 and 12–16 March 2012)*. Unedited advance version. Economic and Social Council, E/2012/28, E/CN.7/2012/18.
2. See the session report for the background to each resolution and full list of actions. The four resolutions not described here relate to alternative development and issues to be addressed in Africa and Afghanistan.

International Women's Day and the drugs issue



In 1975, International Women's Year, the United Nations nominated 8 March as International Women's Day. It is seen as an annual opportunity to celebrate women's economic, political and social achievements and to renew calls for gender equality and women's empowerment. International drug-related organisations use the day to draw attention to the gender-specific problems that women experience in regard to illicit drugs.

UN Office for Drugs and Crime (www.unodc.org)

The theme of International Women's Day 2012 was 'Empower rural women – end hunger and poverty'. In line with this theme, the UNODC is working with rural women in parts of Asia and Latin America to equip them with knowledge relating to sources of livelihood that are alternatives to the cultivation of illicit crops used in the manufacture of illegal drugs, such as heroin and opium, to address drug abuse and HIV and to protect the environment.

EMCDDA (www.emcdda.org)

The European Monitoring Centre for Drugs and Drug Addiction marked International Women's Day 2012 by listing on its home page all its publications that have reported on drug-related gender issues since 1995.

In Europe, up to a quarter of people who have developed serious problems related to the use of illegal drug use are women. Approximately one in four drug users entering drug treatment are female and one in five deaths directly related to drug use are among women.

EMCDDA

- *Women's voices (Thematic paper, EMCDDA, 2009)* – quotations gleaned from interviews with women in eight countries. Through these testimonies, the report illustrates how qualitative research can provide glimpses into the experiences and perceptions of women facing drug issues that statistics alone cannot provide.

- *Sexual assaults facilitated by drugs or alcohol (Technical datasheet, EMCDDA, 2008)* – population surveys carried out in six EU countries suggest that up to 20% of women experience some form of sexual assault in their adult lifetime. A lack of appropriate monitoring systems means that the full scale of drug-facilitated sexual assault (DFSA) remains unknown.
- *A gender perspective on drug use and responding to drug problems (Selected issue, EMCDDA, 2006)* – based on a scientific analysis of the available data, this selected issue concludes that policymakers, professionals and scientists must always take gender into consideration in the planning of research, analysis, interventions and policy in the drugs field.
- *Differences in patterns of drug use between women and men (Technical datasheet, EMCDDA, 2005)* – men in the EU are more likely than women to use illicit drugs, but the study indicated possible signs of a 'narrowing of the gap' between male and female drug use, and greater similarities in lifetime drug-taking experience, particularly among school students.
- *Problems facing women drug users and their children (Selected issue, EMCDDA, 2000)* – the issues examined include drug use among women; infectious diseases; pregnancy and women with children; drug treatment; and women-specific drug prevention.

Every year the EMCDDA publishes a **Statistical Bulletin** containing the most recent statistical data relating to the drugs situation in Europe. The bulletin includes gender-specific data on treatment demand, drug-related deaths, and drug use among youth and the schools population.

Commission on Narcotic Drugs (CND)

(www.unodc.org/unodc/en/commissions/CND/index.html)

Shortly after International Women's Day, at its 55th session, between 12 and 16 March, the CND, the policy-setting body of the UN in relation to illicit drugs, adopted a resolution 'promoting strategies and measures addressing specific needs of women in the context of comprehensive and integrated drug demand reduction programmes and strategies'.

The resolution urges/encourages member states to:

- incorporate female-oriented programmes and integrate essential female-specific services in their drug policies and strategies;
- accommodate the specific needs of drug-dependent parents, including childcare and parental education;
- take into account the needs of women who have experienced sexual and other violent trauma related to drug abuse when designing, implementing and evaluating integrated drug prevention and treatment and HIV prevention programmes;
- take into account the specific needs of women in the prevention, early detection and intervention, treatment

International Women's Day (continued)

and care of drug dependence and drug-related diseases, including infectious diseases and psychiatric disorders, as well as related support services, including for rehabilitation, reintegration and recovery, and to consider designing those services using a multi-agency approach so as to include specific female-oriented measures, promoting effective modalities such as special group offerings for women in inpatient and outpatient settings, family-based treatment and extra occupational training for women as part of recovery activities;

- implement female-oriented guidelines and quality standards in their drug policies;
- identify and firmly counter discrimination against, as well as degrading and undignified treatment of, drug-dependent women and women who abuse drugs, while simultaneously offering such women timely access to counselling, including voluntary HIV counselling and testing, and treatment and support services for rehabilitation and social integration that take into account the specific needs of women, including parental responsibilities and recovery from trauma related to drug abuse suffered as a result of sexual or other forms of violence; and
- provide a wide range measures that match the specific needs of women affected by drug abuse, including pregnant women and women who are parents or guardians with children.

Harm Reduction International (www.ihra.net)

On the opening day of the 55th session of the CND, Harm Reduction International (formerly the International Harm Reduction Association) launched *Cause for alarm: The incarceration of women for drug offences in Europe and Central Asia, and the need for legislative and sentencing reform*.

Eka Iakobishvili, human rights analyst at Harm Reduction International, and author of the report, collected data from 51 European and Central Asian countries on the number of women in prison for drug offences between August 2011 and February 2012. Data were obtained through government agencies, including national prison services, ministries of justice and drug agencies, as well as academic researchers and civil society organisations. Drug offences include possession, preparation, production, purchase and sale of illicit substances.

'Women are disproportionately facing prison for non-violent drug offences, often as a result of poverty and social marginalisation', said Iakobishvili. 'Many of these women have problems, including with drug and alcohol dependency and who are in need of support, not punishment. This research points to an over-reliance on criminal laws to address social and economic problems in many countries.'

The table below summarises the data on the female population in prison in the EU for drug offences.

(Brigid Pike)

Country	Number of women in prison	Number of women in prison for drug offences	% of female prisoners serving sentences for drugs	Female population in the country
Austria	165	18	11.0	4,285,367
Belgium	471	142	30.1	5,432,623
Bulgaria	300	40	14.0	3,896,823
Cyprus	45	4	8.8	446,895
Czech Republic	1,493	168	13.4	5,280,608
Denmark	136	18	14.0	2,758,756
Estonia	136	62	46.0	722,266
Finland	216	35	17.0	2,715,370
France	2,200	308	14.0	32,030,798
Germany	3,318	511	16.0	41,880,940
Greece	526	230	43.7	5,628,221
Hungary	1,253	62	4.9	5,249,210
Ireland	138	32	23.1	2,254,301
Italy	2,913	1,252	42.9	30,744,127
Latvia	278	191	68.7	1,212,656
Lithuania	421	88	20.9	1,748,624
Luxembourg	39	8	20.5	245,017
Malta	39	–	–	205,154
Netherlands	627	197	31.4	8,368,118
Poland	2,604	82	3.1	19,709,069
Portugal	682	325	47.6	5,522,407
România	1,370	177	12.9	10,932,250
Slovakia	477	131	27.4	2,783,408
Slovenia	68	16	23.5	1,033,426
Spain	6,461	2,935	45.4	22,763,627
Sweden	289	119	41.0	4,659,255
United Kingdom	4,668	759	16.0–18.0	31,363,239
TOTAL	31,333	7,910	25.2	253,872,555

Drugnet digest

This section contains short summaries of recent reports and other developments of interest.

Dublin Lord Mayor's Commission on anti-social behaviour

As part of the Lord Mayor of Dublin's commission on anti-social behaviour, a conference entitled 'Preventing and responding to anti-social behaviour' was held in the Croke Park conference centre in February. A number of presentations were made. Dr Graham Connon, senior clinical psychologist with the Health Service Executive spoke on the topic 'Anti-social behaviour in young people – Prevention and early intervention'. Eburn Akpoveta, training and employment officer with EPIC (Employment for people from immigrant communities), spoke on the topic 'Intersection between discrimination, prejudice and anti-social behaviour'. Mark Finnis, from the Hull Centre for Restorative Practice in the United Kingdom spoke on the topic 'Towards a restorative city – Preventing and responding to anti-social behaviour'. The final presentation was by Mary Keane, national co-ordinator with the National Behaviour Support Services and Dr Ailish Rogers, chartered educational and child psychologist. The title of their paper was 'Promoting positive behaviour and mental health in secondary schools'. PowerPoint presentations of all papers can be viewed on the Lord Mayor's website at www.lordmayorofdublin.ie

INCB annual report 2011

The International Narcotics Control Board (INCB) is responsible for overseeing the operation of the international drug treaties, management of markets in medicines controlled by the treaties, and ensuring the supply of opioids for pain and other medical uses.¹ The Board, which comprises 13 experts elected by the United Nations Economic and Social Council, deems itself the guardian of the treaties and is often critical of countries it judges as having violated their provisions. In its annual report for 2011,² the state of Bolivia comes in for severe condemnation for denouncing aspects of the treaty provisions and defending traditional uses of the coca leaf in the Andean region. In his foreword to the report, Hamid Ghodse, President of the INCB, expressed the Board's regret at the step taken by Bolivia, and said: 'If the international community were to adopt an approach whereby States parties would use the mechanism of denunciation and reaccession with reservations, the integrity of the international drug control system would be undermined and the achievements of the past 100 years in drug control would be compromised.' Ireland comes in for milder criticism. As one of the 'major manufacturers and exporters of psychotropic substances', Ireland is cited for not having submitted the required annual statistical report on psychotropic substances by the appropriate deadline (p.19).

Addendum to best practice guidelines on treatment for opiate users

The Irish College of General Practitioners (ICGP) has issued an addendum³ to *Working with opiate users in community based primary care*,⁴ the best practice guidelines published in 2008. The addendum clarifies four items in the guidelines, as follows:

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To the sentence 'Increments should be no greater than 10mg at a time' is added '**total dose increases should not exceed 20-30mg in one week**'.

The sentence 'Patients usually stabilise on doses between 60mg to 80mg' is changed to '**Patients usually stabilise on doses between 60mg to 120mg**'. The ICGP states that this change is in line with international best practice, but they recommend that 'this statement is read in the context of the complete section on commencing doses'.

The sentence starting 'Higher doses of methadone (>80mg) may be required...' is changed to '**Higher doses of methadone may be required...**'. The ICGP states: 'It is not intended to suggest that >80mg would be interpreted as a high dose.'

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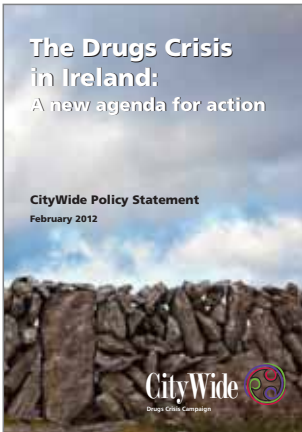
A similar rationale relating to dosage applies to the sentence starting 'If a patient requires a dose >80mg and you have limited experience ...', which is now changed to '**If a patient requires a higher dose and you have limited experience ...**'.

These changes will be made to the on-line version of the guideline document only, as new national guidelines on opiate treatment are currently being developed by a group comprising representatives of the HSE, the ICGP, the Irish College of Psychiatrists and the Pharmaceutical Society of Ireland.

(Contributors Johnny Connolly and Suzi Lyons)

1. For a recent article on the international drug conventions, see Room R and Reuter P (2012) How well do international drug conventions protect public health? *The Lancet*, 379(9810): 84–91.
2. For a copy of the full report see www.incb.org
3. The text of the addendum, in the form of a letter to colleagues, dated December 2011, from Dr Ide Delargy, Director of the ICGP Substance Misuse Programme, is available at www.drugsandalcohol.ie/17079
4. Irish College of General Practitioners (2008) *Working with opiate users in community based primary care*. Dublin: ICGP. Available at www.drugsandalcohol.ie/17079

CityWide launches policy document and drug alliance initiative



CityWide Drugs Crisis Campaign, along with the Services, Industrial, Professional and Technical Trade Union (SITPU), voluntary organisations, community drug services, church organisations, members of the artistic community and others, launched a new broad-based drugs alliance in February to give a renewed impetus to the response to the drugs crisis in Ireland.¹ CityWide also launched a film documentary about the

social history of the organisation² and a policy statement for 2012.³

The policy statement is based on a broad consultation with people living and working in communities most affected by drug problems. It highlights a number of current drug-related issues and sets out an eight-point agenda to address them. According to the statement, 'Polydrug use has replaced heroin as the key concern of communities. Polydrug use involves the consumption of a number of substances at the same time, most commonly alcohol, cannabis and prescription drugs but also psychoactive substances, other tablets, cocaine, heroin and methadone', the availability of which is facilitated by 'their easier access, online, by mobile phones and, in the case of alcohol, over the counter at ever decreasing prices' (p.3).



Pictured at the launch: Ministers of State, Róisín Shortall TD and Joe Costello TD

Another key issue identified by CityWide is what it sees as a weakening by the current drugs strategy of the partnership between government and affected communities, an approach followed by successive Irish governments since the 1990s. Speaking in advance of the launch and in support of the new alliance, Fergus McCabe of CityWide said:

Citywide and the communities we represent have always tried to cooperate with Government in the promotion and implementation of the national drugs strategy. But over the past few years this has become more and more difficult. Government are moving away

from a partnership approach and this is undermining the delivery of the strategy. We are confident that our coming together as an alliance will help strengthen the voice of the NGO drug sector and will locate the drugs issue squarely back on the political agenda.⁴

This position was supported by Joe O'Flynn, general secretary of SIPTU, who said: 'We need to ensure that our national drugs strategy is being defended across all departments. The principles of partnership cannot be abandoned simply because of our economic problems. It's at times like these that we need effective partnership – not less partnership'.⁴

Another issue highlighted as a key current concern is on-street drug dealing and the impact of drug-related gang violence and intimidation in local communities. According to CityWide: 'Often related to drug debt, intimidation includes threatened and actual damage to property, physical assault and in some cases murder, against debtors and their families' (p.3). Fear of gang reprisals mean that many of these incidents go unreported and therefore unchallenged by the authorities. A related issue is the 'grooming [of] vulnerable children and young people to join gangs' (p.3).

The CityWide policy statement concludes with the following eight-point proposed agenda for action (pp.4–5):

- Make partnership work.
- Improve protection, reporting and prosecution of debt intimidation.
- Systematically tackle gang activity.
- Support families, children and young people most at risk.
- Build community resilience.
- Strengthen information and harm reduction messages.
- Direct 'profits' from problem drug use (i.e. funds seized by the Criminal Assets Bureau) and introduce a social responsibility levy (on drinks industry).
- Debate decriminalisation.

In calling for an 'open debate about decriminalisation in Ireland', CityWide states that 'much of the harm related to drug use and drug dealing occurs because of their illicit nature.... the global war on drugs has failed and it is time for us to challenge rather than reinforce common misconceptions about drug markets, drug use and drug dependence' (p.5).

(Johnny Connolly)

1. CityWide was established in 1995 as a community based advocacy network. See www.citywide.ie
2. The film can be viewed at www.citywide.ie
3. CityWide Drugs Crisis Campaign (2012) *The drugs crisis: a new agenda for action*. Dublin: CityWide.
4. CityWide Drugs Crisis Campaign (2012, 17 February) *Launch of new broad based drug alliance initiative*. Press release issued by CityWide on the launch of alliance initiative. www.citywide.ie

Findings from a study of homeless women in Ireland

A research paper by Mayock and Sheridan¹ presents findings from an in-depth qualitative investigation of homelessness among women in Dublin, Cork and Galway. Data were collected from 60 women aged 18–62, using life-history interviews and a questionnaire to record socio-demographic data. Data were also collected by observation at four homeless services in Dublin City, by involving a small number of the women in a photography project, and by focus groups with providers of services to homeless women. The 60 women who participated in the research were either homeless at the time of data collection or had experienced homelessness in the preceding six months. The paper focuses on the women's routes or 'journeys' into homelessness.

Findings

When interviewed, 40 of the women were living in either emergency or transitional homeless accommodation; of the remaining 20, four lived in domestic violence refuges, four in long-term supported accommodation, three with a family member or friend on a temporary basis, one in a dilapidated house, one was sleeping on the street, and seven had recently entered private rented accommodation following a period of homelessness.

Education, employment and income source

Twenty-one of the 43 women of Irish or UK origin had no formal educational qualifications; a further 13 had progressed to Junior Certificate level prior to leaving school early. The women reported strained relationships with teachers and difficult home situations which impacted adversely on their early schooling. In contrast, 16 of the 17 migrant women interviewed had completed the equivalent of leaving certificate level or higher, and nine had achieved a third-level qualification. All but one of the 60 women were financially dependent on welfare payments.

Relationship status and children

Twenty-seven women were married, but all were either separated or estranged when interviewed; 21 reported being in a current relationship and 13 of these partners were also homeless. Forty-one women were mothers, with a total of 105 children between them, and three were expecting their first child when interviewed. Of the 105 children born to the women, 77 were aged under 18 years and 49 were aged under 12 years.

First experience of homelessness

Eighteen women had experienced homelessness as children, i.e. before the age of 18, of whom four had become homeless directly after leaving a care setting. Fourteen women first experienced homelessness between the ages of 18 and 25; these women tended to report longer histories of homelessness and more complex needs than those who became homeless later in life, related, in many cases, to traumatic childhoods, drug and alcohol misuse and mental health issues.

Hidden homelessness and rough sleeping

A large number of the women had spent periods of time in 'hidden' homeless situations, staying with friends or a family member for short time periods. To paraphrase the authors, these living arrangements concealed these women from homeless services and statistical counts of homelessness, thereby rendering them the hidden homeless. Twenty-seven of the women had slept rough at some time, 16 for a period exceeding one month.

Poverty and deprivation during childhood

A majority of the women had grown up in low-income households in disadvantaged areas and a number had spent time as children in homeless hostels with a parent, usually their mother. These episodes of family homelessness were often related to parental drug and alcohol misuse and/or domestic violence.

Violence and abuse during childhood

Forty-three of the women reported having experienced some form of abuse or violence as children; 30 had experienced domestic violence, either as victims or witnesses, with the violence most often perpetrated by their fathers. A small number reported domestic violence by a mother or a brother. Parental alcohol and drug abuse was often a factor in the domestic violence experienced by these women. Twenty-eight of the women reported sexual abuse during their childhood.

Histories of state care

Twelve of the women had spent periods of their childhood in state care, and all of these reported housing instability in adulthood, an experience often related to difficulties adjusting to life outside the care system. Four women reported sexual abuse in a state care setting.

Substance use and misuse

Thirty-seven of the women reported a current (32) or past (5) substance abuse problem. Ten named alcohol as their current primary substance of misuse and a further two named alcohol combined with cocaine. The remaining 22 women used heroin, often combined with cocaine, crack cocaine and benzodiazepines. According to the authors,

Substance misuse posed significant challenges for a large number of the women and had negative consequences for their health and well-being. For the majority, drug and alcohol use preceded first homeless experiences and some women attributed the loss of housing to problems arising from alcohol or drug use. However, substance misuse was rarely the sole presenting issue or problem at the time women first entered homelessness. Furthermore, problems related to drug or alcohol consumption were invariably exacerbated by the homeless experience itself. (p.12)

Homeless women in Ireland (continued)

Factors influencing a return to homelessness

An important feature of this research is the focus on both entry to and exit from homelessness. Half of the women interviewed reported multiple episodes of homelessness. The authors identify some of the 'triggers' that led to some women returning to homelessness; these included the transition from institutional settings such as places of detention, psychiatric hospitals or state care facilities. For example, some were unable to secure housing following time in prison and often returned to emergency accommodation where they became further entrenched in drug use and repeat offending. Other women reported problems in sustaining their housing tenancies because of disputes with landlords, domestic violence, drug and alcohol use and a general inability to cope with the financial and emotional demands of independent living. Eighteen women were using medication for depression and a further 20 had been prescribed such medication in the past; 15 had spent time in a psychiatric hospital.

Conclusion

This report is a welcome contribution to the knowledge base on the nature of homelessness among disadvantaged people in Ireland. The experiences of homeless women is a field of

inquiry that has often been overlooked in the past. The experiences documented in this report paint a vivid picture of the role of childhood poverty and deprivation, childhood trauma and abuse and family breakdown and addiction in the lives of these women. Contained in the narratives is evidence of the lasting influence that these experiences had on their subsequent entry into homelessness and on their many unsuccessful attempts to exit homelessness. The legacy of these fractured childhoods is inextricably linked in adulthood with their alcohol and drug misuse and mental health issues. Finally, it is hoped that the gender perspective conveyed in this research can, in the words of the authors, '...critically inform and influence policy and help to ensure that services work appropriately and effectively to meet the needs of homeless women' (p.16).

(Martin Keane)

1. Mayock P and Sheridan S (2012) *Women's 'journeys' to homelessness: key findings from a biographical study of homeless women in Ireland*. Women and Homelessness in Ireland, Research Paper 1. Dublin: School of Social Work and Social Policy and Children's Research Centre, Trinity College, Dublin. www.drugsandalcohol.ie/17047

Women's health and homelessness in Cork: a snapshot study

The Good Shepherd Services and Cork Simon Community, two voluntary agencies working with disadvantaged people in Cork, undertook a snapshot study of service users between 4 and 11 July 2011 in an attempt to document the health and related needs of people using their services.¹ This article is based on data collected from 115 women who used the services during that week and were homeless or at risk of becoming homeless.

Accommodation type and income status

Twenty seven per cent (31) of the women were living in emergency accommodation, 11 of them for six months or longer. Seventy-three per cent (84) were supported in different housing tenures, including high-support (9), low to medium support (11), local authority (20), private rental (31) and other (13). Eighty-seven per cent (100) reported having a medical card, indicating low income levels in this group.

Parental status

There were eight children living with their mothers (4) in emergency accommodation, ranging in age from eight months to 12 years; children belonging to the seven other women in emergency accommodation were living elsewhere.

Physical health

Fifty-seven per cent (66) self-reported a diagnosed physical health condition, the most common conditions being asthma, anaemia and high blood pressure. Twenty-eight per cent (32) reported two or more conditions, and 16% (18) reported three or more conditions; women reporting multiple conditions tended to live in emergency accommodation and high-support housing.

Mental health

Fifty-two per cent (46) self-reported a diagnosed mental health condition, the most common conditions being depression, bipolar disorder and anxiety. Fifteen per cent (17) reported a diagnosed intellectual disability; these women tended to live in emergency accommodation and high-support housing. Thirty-six per cent (41) reported a combination of physical and mental health conditions; women in emergency accommodation and high-support housing tended to report combined diagnoses.

Alcohol and drug use

Forty per cent (46) self-reported alcohol use, with 24% (27) indicating possible problem use. Women in emergency accommodation and high-support housing tended to report problems with alcohol use, including falling down/head injuries, memory loss and gastric problems. Twenty per cent (23) reported using drugs. Drug use was higher among women in emergency accommodation and high-support housing than among women in local authority and private rented housing; no use of drugs was reported by women in low-medium support housing. Heroin, cannabis, head shop substances and unprescribed benzodiazepines were the most common drugs used; 10 women reported injecting heroin. All 11 of the women living in emergency accommodation for six months or longer reported the use of drugs.

Self-harm, suicidal ideation and attempted suicide

Seventeen per cent (20) self-reported incidents of self-harm, 16% (19) reported experiencing suicidal ideation and 5% (6) reported a suicide attempt in the previous six months. Women with diagnosed mental health conditions, problem alcohol or drug use and living in emergency accommodation were more likely to have self-harmed, had suicidal thoughts and report a suicide attempt.

Women's health and homelessness in Cork (*continued*)

Health referrals

Twenty-eight per cent (29) self-reported an admission to Accident and Emergency (A&E), accounting for 38 admissions in the previous month, and 23% (26) had used hospital out-patient services, accounting for forty-one attendances in the previous month. The women reporting use of A&E and out-patient services tended to live in emergency accommodation and high-support housing, use drugs intravenously, have diagnosed mental health conditions and report problem alcohol use.

Barriers to healthcare

Seventeen per cent (20) reported barriers to healthcare; these women tended to use drugs intravenously, have problems with alcohol use and have diagnosed mental health conditions. Self-reported barriers included not having a medical card, 'other things being more important' and previous negative experience.

Triggers for homelessness

Family conflict, domestic violence, relationship breakdown and personal alcohol and drug use were among the most common factors contributing to the women's first experiencing homelessness.

Conclusion

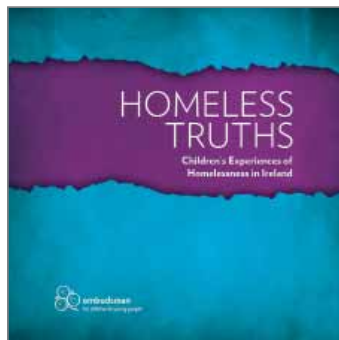
This snapshot study provides a useful insight into the health and related needs of women in Cork who were either homeless or at risk of homelessness. These women do not

form a homogenous grouping and at least 40 of the 115 who participated in the study appeared to be experiencing poorer health and related outcomes than the others. According to the authors: 'The health and related issues appear to be starker for women in emergency accommodation, with much higher rates of drug use, intravenous drug use, problem alcohol use, self-harming, suicide ideation and attempted suicide. They appear to be starker again for women who are long-term homeless, with higher rates of heroin use and intravenous drug use' (p. 23). In addition, women who self-reported diagnosed physical and mental health conditions tended to be living in emergency accommodation and high-support housing. These women also reported having used A&E and hospital out-patient services more frequently in the previous month. These findings suggest that poorer health and social outcomes are associated with living in emergency accommodation; a move towards more sustainable accommodation with appropriate supports might provide an opportunity for improved outcomes in the lives of the women affected in this study.

(*Martin Keane*)

1. Good Shepherd Services and Cork Simon Community (2011) *Women's health and homelessness in Cork: a joint snapshot study of the health and related needs of women who are homeless in Cork 04 – 10 July 2011*. Cork: Cork Simon Community. www.drugsandalcohol.ie/16071

Understanding youth homelessness



The Ombudsman for Children's Office (OCO) recently published a report detailing the experiences of homeless children in Ireland.¹ The report is based on face-to-face interviews with 15 young people aged 16–19 who were currently using, or had recent past experience of using emergency hostel accommodation services in Dublin and Cork.

Accessing emergency accommodation services

Homeless children needing access to emergency accommodation in the Dublin area are required to present at a Garda station and request the services of the out-of-hours social worker. Children then have to wait in the Garda station until the social worker arrives to link them in with available accommodation. Children who were interviewed by staff from the OCO were critical of this practice. They recalled feeling embarrassed, ashamed and anxious while waiting in the Garda station for the social worker to arrive and many questioned the appropriateness of this route to emergency accommodation. The OCO concurred with these concerns raised by children and report that 'children should not be expected to wait for hours in a Garda station for social work services to link with them' (p.38).

Some alternatives preferred by the children and suggested by the OCO include:

- access emergency accommodation during the daytime instead of having to wait until after 8 o'clock in the evening;
- present at a less intimidating setting than the Garda station;
- contact social work services directly through a Freephone number;
- present directly to emergency accommodation and contact social work services from there;
- present at a Garda station only when necessary, but wait in an alternative setting that is more appropriate and less intimidating.

Time spent and placements in emergency accommodation

Of the 15 children interviewed, five had spent between one and three months using emergency accommodation and seven had used the service for more than six months. Six children had been in one placement and six had been in up to three placements. Children who had moved between multiple placements criticised this practice and the instability it caused to their already fragmented lives, while some of the children who were able to reside in one stable placement over several months actually noted some benefits from their experience. The experience of multiple placements is often exacerbated by the requirement to present to the emergency services as homeless on a daily basis, a practice criticised by the OCO '...the practice of requiring children to present on a day-to-day basis should cease' (p. 39).

Understanding youth homelessness (continued)

The report suggests that care planning for homeless children should minimise the length of time spent in emergency accommodation and the number of placement changes and such plans should seek to integrate the views and preferences of homeless children into decisions taken about their care. While being critical of some of the practices around emergency care, children praised the staff who worked in the emergency accommodation units for providing both practical help and emotional support on an ongoing basis.

Time spent by children during the day

Eight of the 15 children interviewed were in full-time post-primary education when they first used emergency care services and only three continued in education without interruption while using the emergency services. Some of the children praised the support they received from staff in Youthreach, which encouraged them to return to education and training. However, most of the children voiced their concern at the considerable amount of time, that they and other homeless children spent hanging around the streets during the day. They reported using alcohol and drugs and engaging in petty criminal acts while hanging out with 'acquaintances'; they also talked about the intimidation, exploitation and violence that they were regularly exposed to as part of their immersion in street culture.

Similar experiences were reported by Mayock and Vekic,² who interviewed 40 young homeless people in the Dublin metropolitan area as part of a longitudinal cohort study of youth homelessness. The vast majority had used or were using the out-of-hours service (OHS) in the city centre and were moving between city-centre hostels where they were exposed to alcohol and drug use, criminal activity, intimidation and bullying. When this exposure lasted over an extended period, young people became heavily involved in using drugs; half of the cohort reported having used heroin, with almost all reporting their heroin use as problematic to the point of dependency. The majority of those who used heroin had first experimented with it *after* they became homeless. According to the authors, this long-term exposure to the street scene led to a process of 'acculturation' where they young people 'learned the street competencies they needed to survive by becoming embedded in social networks of homeless youths' (p. 23).

To counter the risk of vulnerable children becoming immersed in the damaging environment of street culture, the OCO report recommends a number of measures:

- additional and varied daytime educational and training activities, and accommodation units that offer

opportunities for homeless children to be active during the day;

- a mentoring network of young adults who have experienced similar circumstances, who can provide support to homeless children;
- professional counselling and psychological services for homeless children when they first access emergency services;
- further investment in drug prevention and recovery initiatives for homeless children.

The model and location of emergency accommodation

The OCO is highly critical of the model and location of emergency accommodation services for homeless children. The report states:

Short-term, hostel-style accommodation is not a suitable model for children under eighteen and should never be used to accommodate children under sixteen or children who are particularly vulnerable. The practice of accommodating children in Dublin city centre should cease because it exposes children to unacceptable risks and increases the likelihood of their involvement in harmful and criminal behaviours. ... Ideally, emergency care accommodation should be located in or close to children's local communities. (p.39)

Similar points were made in a report published six years ago. One of the first detailed strategies to prevent homelessness recommended that supported measures needed to be put in place at local level, particularly in the Dublin suburbs, to prevent young homeless people congregating in the city centre and becoming involved in drug use and criminal behaviours.³ The advantages of a decentralised approach to homelessness in Dublin are that these young people are accommodated closer to their homes, can continue contact with their families, and can remain in school.

(Martin Keane)

1. Ombudsman for Children's Office (2012) *Homeless truths: children's experiences of homelessness in Ireland*. Dublin: Ombudsman for Children's Office. www.oco.ie/issues/current-issues/homeless-children.html
2. Mayock P and Vekic K (2006) *Understanding youth homelessness in Dublin city: key findings from the first phase of a longitudinal cohort study*. Dublin: Stationery Office. www.drugsandalcohol.ie/6200
3. Pillinger J (2006) *Preventing homelessness: a comprehensive preventative strategy to prevent homelessness in Dublin, 2005–2010*. Dublin: Homeless Agency.

RADE group performs special song cycle

RADE (recovery through arts, drama and education) aims to engage drug users with the arts and therapeutic supports and provide a platform for their artistic expression. During May, musician Sean Millar and RADE participants performed 'The last ten years' song cycle in the Liberty Hall Theatre and in two shows in St Patrick's Cathedral. The production combines choral music and ritual performance exploring attitudes to legal and illegal drug use. Minister of State Róisín Shortall TD was guest speaker at the event.

RADE participants are looking forward to repeating their performance in St Patrick's Cathedral at this year's Dublin Fringe Festival on 19–22 September.



Reducing alcohol-related harm: evaluation of a SHAHRP intervention

The intervention

McKay *et al.*¹ recently published their findings from an evaluation of an alcohol-related harm reduction intervention targeting post-primary students aged 13–16 in the greater Belfast area. The School Health and Alcohol Harm Reduction Project (SHAHRP) aims to reduce the harms associated with teenage alcohol consumption and combines education and skills training to encourage positive behavioural change. The intervention is delivered using interactive and group-based activities, with an emphasis on discussing how alcohol-related harms might arise in specific settings, e.g. a night out, and a focus on establishing pre-planned strategies to reduce such harms.

A slightly modified version of SHAHRP, using approximately 75% of the original materials, was piloted in nine post-primary schools in the greater Belfast area. Feedback from the pilot suggested that both teachers and students found the materials helpful and easy to follow and the activities and discussion to be relevant. Based on these reports, a controlled non-randomised trial was developed to assess the effectiveness of the intervention.

The evaluation

Twenty-nine post-primary schools in the greater Belfast area took part in the study. Eight schools received SHAHRP delivered by teachers, twelve schools received SHAHRP delivered by external alcohol and drug education workers and nine schools, the control arm of the trial, received the standard curriculum on alcohol education. Both teachers and external facilitators were trained in the theory and practice of SHAHRP. In phase 1, six sessions combining 16 activities were delivered to students aged 13–14 (year 10) and in phase 2, four sessions combining 10 activities were delivered to students aged 14–15.

Data collection

Baseline data were collected in September 2005, with follow-up data collected in September 2006 after phase 1 implementation and in September 2007 after the implementation of phase 2. The final set of data was collected in March 2008, by which time no student had received any intervention for at least 11 months. Data were collected using a number of standardised instruments and all questionnaires were administered verbally. The baseline number of students (2,349) represented 34.3% of the total number of year-10 students in schools within the greater Belfast area. A total of 2,048 students remained in the cohort at the final data collection point in March 2008; this represented a 12.8% attrition rate over the 32-month period of the trial. Males made up 39.7% of the cohort at baseline and 40.2% at final follow-up.

Results

Participants receiving the SHAHRP intervention were significantly more likely to report increased levels of knowledge about alcohol and its effects, safer alcohol-related attitudes, fewer alcohol-related harms (both personal and

from others) and less alcohol consumption, in contrast to participants in the control group. These effects were maintained over the 11-month period in which none of the students had received any intervention. Students receiving SHAHRP from external alcohol and drug workers reported better outcomes on improving alcohol-related knowledge and attitudes, fewer personal alcohol-related harms and less alcohol consumption, in contrast to students receiving SHAHRP from teachers.

The authors caution against interpreting the finding on alcohol-related harm to read that no student receiving the SHAHRP intervention reported an increase in harm; the correct interpretation is that the majority of students receiving this intervention did not report an increase in harm. Alcohol-related harms included consuming more alcohol than planned, being sick after consuming alcohol, experiencing hangover symptoms, inability to recall events while under the influence of alcohol, being verbally and/or physically abusive and getting into trouble with parents and/or the police.

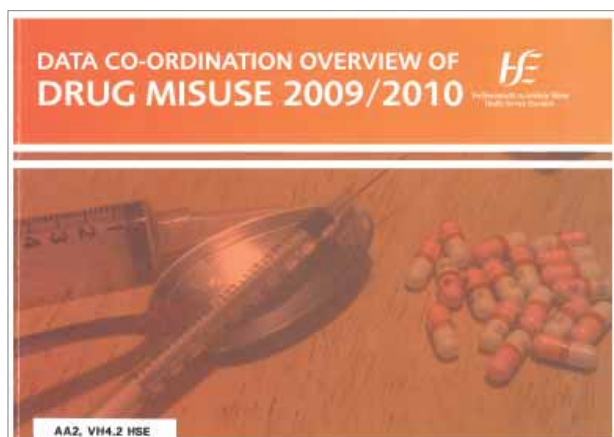
Conclusion

The authors conclude that ‘the adapted SHAHRP intervention [trialled in Belfast] is a promising means to address one of the major health and social challenges facing young people [alcohol consumption]’ (p.118). They also acknowledge that harm reduction interventions targeting young people can be controversial; however, as in the case of students receiving SHAHRP in Belfast, such interventions do not necessarily promote or produce alcohol-friendly attitudes and/or behaviours among target groups. The students in Belfast who received the SHAHRP intervention included abstainers, novice drinkers and more experienced consumers of alcohol, yet these groups were receptive to the themes of the intervention material and activities. Such themes include staying close to trusted friends when consuming alcohol, knowing basic first-aid, organising group transport home, having mobile phones available, not making decisions while drunk, being able to identify when friends are getting drunk, being on the alert for drink spiking and mixing alcohol with other drugs and avoiding arguments and aggressive behaviour by self and others. Finally, the authors concur with similar reporting from Australia that ‘young people are capable of processing harm reduction messages which are developed and presented within the reality of their drinking experiences’ (p.118).

(Martin Keane)

1. McKay M, McBride N, Sumnall H and Cole J (2012) Reducing the harm from adolescent alcohol consumption: results from an adapted version of SHAHRP in Northern Ireland. *Journal of Substance Use*, 17(2): 98–121.

Drug misuse in the south eastern counties of HSE South



The Health Service Executive (HSE) South published the report *Data co-ordination overview of drug misuse 2009/2010* in October 2011.¹ The report covers the south eastern counties of HSE South (Carlow, Kilkenny, Tipperary South, Waterford and Wexford), and comprises sections relating to treatment services, substance-related offences and cases dealt with by the Probation Service in the area.

Table 1 Characteristics of individuals treated in the south eastern counties of HSE South, 2009 and 2010

	2009	2010
Total number treated	2918	3157
	%	%
Gender		
Male	67	64
Female	33	36
Age group		
<15	2	1
15–19	15	14
20–34	41	43
35–49	26	27
>50	14	15
Unknown	0.4	0.4
Main problem		
Alcohol only	44	40
Polydrug use	40	37
Illicit drugs only	9	13
Other issues only	6	8
Licit drugs only	1	2

The section on treatment services analyses data collected from statutory and voluntary drug and alcohol treatment agencies, acute general hospitals and psychiatric hospitals in the south east. Data from the drug and alcohol treatment services are returned to the National Drug Treatment Reporting System in the Health Research Board.

The total number of individuals seeking treatment in 2009 was 3,339, increasing to 3,518 in 2010. The number of individuals who proceed to treatment increased from 2,918 in 2009 to 3,157 in 2010. Table 1 outlines the main characteristics of those treated in the region. The number of women attending services in the region increased from 969 in 2009 to 1,124 in 2010. In both years the majority of clients were in the 20–34-year age group, and alcohol was the most common main problem drug for which treatment was sought.

While alcohol was the main problem drug reported by treated clients in both years, in 2009 cannabis (15%) was the second most common main problem substance, followed by heroin (14%). In 2010, this trend was reversed and heroin (19%) was the second most common substance followed by cannabis (16%). In 2010, 1.5% of those treated for problem substance use were treated for headshop drugs, compared to only 0.07% in 2009. Of those treated for non-substance addictions in 2009 and 2010, most were treated for gambling. The outcomes for both years were similar, with similar proportions of clients completing treatment (Table 2).

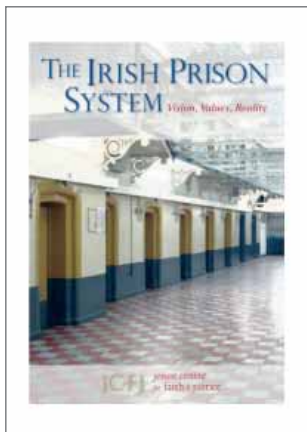
(Suzi Lyons)

1. Kidd M (2011) *Data co-ordination overview of drug misuse 2009/2010*. Waterford: HSE South. www.drugsandalcohol.ie/17057

Table 2 Treatment outcomes in the south eastern counties of HSE South, 2009 and 2010

	2009	2010
Total exiting in year	2434	2448
	%	%
Treatment completed	48	50
Refused further sessions or did not return	38	38
Transferred	9	6
Premature exit for non-compliance	3	3
Died	0.3	0.6
Other	2	2

Jesuit group calls for prison reform



The Jesuit Centre for Faith and Justice (JCFJ)¹ has called on the government to radically reform its approach to imprisonment and bring an end to what it describes as ‘the bankrupt policy of recent decades’.² Speaking at the launch of the centre’s report, *The Irish prison system: vision, values, reality*,³ Fr Peter McVerry SJ, a member of the JCFJ, said:

Penal policy over the past twenty years has passively accepted a continual rise in the prison population. More and more prison places have been provided – at huge cost. But the result has been a bit like running up a down escalator: the improvements in basic conditions that could have been expected to occur as a result of new prison building have been largely wiped out by increasing levels of overcrowding.

Fr McVerry called for a reduction of the number in prison to a limit of ‘around 2,700.’

The report provides a detailed analysis of existing research on a range of topics, including the links between imprisonment and socio-economic deprivation, which include poor education, unemployment, homelessness, and the incidence of mental illness and substance misuse among prisoners.

Citing an earlier study,⁴ the report states that ‘51% of male prisoners and 69% of female prisoners reported that they had been under the influence of drugs when they committed the offence for which they had been imprisoned’ (p.22). The report also highlights tensions and the potential for ‘extreme violence’ within prisons as a consequence of drug debts and ‘territorial disputes within and between groups involved in the sale and distribution of drugs’ (p.22).

Launching the report, John Lonergan, who was governor of Mountjoy Prison for 22 years, said that the issue of drugs in prison represented a huge policy failure: ‘Drugs have an enormously damaging impact on life within prisons and can undermine even the most positive programmes and enlightened regimes.’ Acknowledging that prison authorities had a duty to try and keep drugs out of prison, he said ‘the reality that the costly and intrusive measures needed to control the entry of drugs will be ultimately of very limited effect if the demand for drugs persists’.² He added that it was essential that there be an equal emphasis on providing drug treatment and that such treatment ‘needs to be accompanied by the opportunities for meaningful activity – education, training and work – and decent physical conditions, otherwise it is extremely difficult for prisoners to remain drug free’.

The report argues that, with more than a doubling of the prison population over the past decade, overcrowding is now one of the most serious issues in the Irish prison system, that it leads to a ‘pressure cooker’ atmosphere within prisons, and ‘impacts profoundly on the whole experience of imprisonment’, leading as it does to the enforced sharing of cells by ‘drug-user and non-drug-user, smoker and non-smoker, young prisoners and those convicted of sexual crimes against the young’ (pp.26–27).

The JCFJ calls for a closing of the gap between what it sees as the reality of Irish prisons and the espoused principles of Irish prison policy, as implied in the ratification of international human rights conventions and as expressed in official policy statements. The JCFJ argues that future prison policy must reflect five essential principles:

- It is the deprivation of liberty which constitutes the punishment of imprisonment: people are sent to prison *as* punishment, not *for* punishment;
- People in prison must be treated with humanity and respect for their inherent dignity;
- The prison system must seek to promote the rehabilitation and social reintegration of those imprisoned;
- Given that it is the loss of freedom which constitutes the punishment, and given the goal of rehabilitation, life inside prison should be as normal as possible, with security no greater than is required for safe custody;
- The use of imprisonment should be kept to a minimum, with non-custodial sanctions used as an alternative, wherever possible. (p.3)

Citing international prison conventions and research evidence in support, the final chapter of the report (at pp.115–121) makes a number of recommendations, including the following:

- Minimum use of custody: reduce, and set a limit to, the numbers in prison.
- Minimum use of security: have one third prisoners in open prisons and have a gradient security system in all other prisons.
- Make smaller prisons the norm.
- Ensure that no child is detained in a prison; and make specific provision for young men under twenty-one.
- Ensure that comprehensive drug and alcohol detoxification and treatment services are available promptly.
- Develop an independent prison authority, with a genuine care/custody agenda.
- Develop a more positive role for prison officers, to reflect a genuine care/custody balance.

The report also calls on the government to abandon current plans to build two further large prisons at Thornton Hall in Dublin and Kilworth in Co Cork as these institutions, it concludes, will be likely to continue the ‘detrimental conditions in Irish prisons’ outlined in this report (p.121).

(Johnny Connolly)

1. For further information about the work of the Jesuit Centre for Faith and Justice see <http://www.jcfj.ie>
2. Jesuit Centre for Faith and Justice (2012, 14 March) *Time to end bankrupt prison policy*. Press release issued by the JCFJ on publication of the centre’s report on the Irish prison system.
3. Jesuit Centre for Faith and Justice (2012) *The Irish prison system: vision, values, reality*. Dublin: Jesuit Centre for Faith and Justice.
4. Hannon F, Kelleher C and Friel S (2000) *General healthcare study of the Irish prison population*. Dublin: Stationery office.

Arriving at a definition of 'drug mules'



The use of human drug couriers, commonly referred to as 'drug mules', is a favoured method of trafficking drugs into Europe, with the drugs secreted either in the courier's body or in their belongings.¹ A thematic paper by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)² reports on efforts to determine if it is possible to identify a common European definition of the term 'drug mule', with a view to

assessing 'the implications of this for data gathering and future research'. The EMCDDA project involved a review of existing law enforcement data and academic literature about drug markets and a survey of academics and practitioners working in the field.

The report highlights the dearth of information and research in the area:

... vast amounts of resources are spent on securing external and internal borders against illegal drugs and punishing those who break drug laws; however... Very little is known about the operation of drug markets or about state and non-state responses to drug markets and the effects of these. There remains a disconnect between theoretical models and regular data gathering that empirical research has so far been unable to bridge' (p.4).

The report considers the utility of existing law enforcement data sources in drug market research and identifies two primary limitations that apply. First, data such as those on drug offences and seizures are often used by countries as a means of monitoring supply reduction activities and as indirect indicators of drug availability.³ However, the link between supply reduction activities and drug availability is difficult, if not impossible, to assess due to the hidden nature of the market. Rather, such data should be seen primarily as indicators of law enforcement activity, affected in turn by law enforcement resources and priorities. The second limitation relates to data reliability and comparability. The EMCDDA gathers data from '30 different legal systems, each with its own legislation, norms and practices' (p.7). Different cultures of 'information gathering, reporting and dissemination' (p.6) mean that there are significant gaps in data and, in some cases, estimated figures, which limit the comparability of data between countries.

Drawing upon the annual reports of the United Nations Office on Drugs and Crime, the EMCDDA and Europol, the report then describes what is known about the international market for the four main drug types in order of European consumption estimates (cannabis, amphetamine-type stimulants including ecstasy, cocaine and heroin). 'These agencies have shown consistently, over a number of years, that markets for [these drugs] may follow basic commercial and logistic patterns: production, transit and arrival in primary markets' (p.8).

The report then describes the methods, or 'technologies' used by drug traffickers and the targeted intelligence-led responses used by law enforcement agencies to counter these activities. One problem highlighted by the report, from the perspective of trying to shed further light on the roles involved in drug importation, is that law enforcement

interventions are usually deemed internal operational matters and are therefore not subject to public or academic analysis and appraisal.

The report then considers various academic contributions to the study of illicit drug markets. Academic research is concerned, according to the report, with complementing official data sources such as those described above 'with "bottom up" or "street-level" data, that is from interviews or observations of offenders involved in the drug markets' (p.11). A limitation identified with research of this nature is that 'access to the actors working in the drugs trade is severely limited because of the illicit nature of the activity and the danger to the researcher, and data from criminals are rarely verifiable'. Furthermore, data obtained from typical approaches such as interviews with incarcerated offenders 'reflect successful law enforcement operations and/or unsuccessful trafficking operations' and it is unclear how representative they may be of the market as a whole (p.11).

Nevertheless, following a review of the literature, the authors arrive at a proposed typology of drug importers: 'the organiser/manager type, who is responsible for the organisation of the drug importation; the importation auxiliary, who assists in importations in the origin or destination country or both; and the courier' (p.18). The courier type is defined as the importer who is in physical possession of the drugs while crossing an international border. The courier type is then further sub-divided into the 'self-employed' courier and the 'mule'. The former is someone who derives their benefit from the sale (or use) of the drugs upon arrival, while the latter is 'paid a fee, wage or salary (including the reduction of debts) to transport the drugs' (p.20).

The final part of the EMCDDA project involved testing the proposed conceptual framework of 'drug mules' by means of a survey of academics and practitioners throughout Europe and beyond. The following definition was proposed: *A drug courier who is paid, coerced or tricked into transporting drugs across an international border but who has no further commercial interest in the drugs.*

The survey revealed that there was a general understanding of the roles that exist within the drug courier market, including that of 'drug mule'. However, this was not clearly reflected in policy or legislation. The final stage of the research led to two conclusions relevant for future research and practice. First, improved understanding of the international drug market 'rests not solely on a reliance on hard data sets or in-depth studies but rather using these together to create tools which allow for reliable international comparison'. Second, with regard to drug importation, 'the role of the drug mule is one that features in many, if not most, markets. Drug mules are reported to be transporting all the major illicit drug types and making full use of all European transport routes' (p.30).

(Johnny Connolly)

1. United Nations Office on Drugs and Crime (2008) *Drug trafficking as a security threat in West Africa*. Vienna: UNODC. www.unodc.org
2. European Monitoring Centre for Drugs and Drug Addiction (2012) *A definition of 'drug mules' for use in a European context*. Lisbon: EMCDDA. www.emcdda.europa.eu/publications
3. The first comprehensive study of illicit drug markets in Ireland is due to be published later this year by the National Advisory Committee on Drugs and the Health Research Board.

In brief

In 2011 **YODA (Youth Organisations for Drug Action)** was set up in Europe. Its 'activities' include promoting the collaboration and unity of young people across Europe in the pursuit of evidence-based drug policies which respect their human rights, providing representation for young people's interests in drug policy in an international arena, and building the leadership skills of young people through promoting civic participation and providing advocacy training. www.euro-yoda.org

In April 2012 **UNODC youth initiative: discussion guide** was released. It provides materials to support the facilitation of discussions with young people on the following themes:

Perceptions about drug use

1. What is vulnerability?
2. The direct effects of using drugs
3. Abuse of prescription drugs
4. Consequences and risks associated with drug use
5. Prevention of drug use
6. Treatment of drug dependence
7. The role of youth in the global effort to prevent drug use

www.unodc.org/unodc/en/prevention/youth-initiative.html

On 12 January 2012 the **Organization for Security and Co-operation in Europe (OSCE)** heard Ireland's Tánaiste and Minister for Foreign Affairs, Eamon Gilmore TD, give his inaugural speech as Chairperson-in-Office, which position Ireland will hold for the whole of 2012. With 56 member countries, the OSCE offers a forum for political negotiations and decision-making in the fields of early warning, conflict prevention, crisis management and post-conflict rehabilitation. Minister Gilmore stated that under the Politico-Military Dimension of the OSCE's work, 'Ireland will seek to continue work on tackling transnational threats such as organised crime, cyber threats including cyber-crime, drugs, terrorism and trafficking.' www.osce.org

On 23 January 2012 the **Children's Rights Alliance Report card 2012** was published. The section on 'alcohol and drugs' gets a 'D' grade, an improvement on last year's 'F' in alcohol, but, according to the authors, 'still a dangerously low grade reflecting the failure to publish the National Addiction Strategy and the lack of budgetary measures to curb access to cheap alcohol'. www.childrensrights.ie

On 24 January 2012 the **Vienna declaration on drug policy** was the subject of a response by Minister for Justice and Equality, Alan Shatter TD, to a Parliamentary Question: 'In 2010 the International AIDS Society convened the XVIII International Aids Conference in Vienna. As stated in the official declaration of the Conference (also known as the 'Vienna Declaration') the aim of the declaration is to seek to improve community health and safety by calling for the incorporation of scientific evidence into illicit drug policies. The declaration calls on governments and international organisations to undertake a number of measures including a transparent review of the effectiveness of current drug policies, the implementation of a science-based public health approach to address individual and community harms stemming from illicit drug use, decriminalisation of drug users and the meaningful involvement of members of affected communities in developing services and policies etc.' Minister Shatter stated that the Government's approach to tackling the problem of drug misuse is set out in the National Drugs Strategy (2009–2016), which was drawn up on foot of an extensive public consultation process. <http://debates.oireachtas.ie/dail/2012/01/24/00311.asp>

In March 2012 **Towards revision of the UN drug control conventions: the logic and dilemmas of like-minded groups**, written by Dave Bewley-Taylor, was published. He makes the following key points:

- Despite interpretative tensions around some policy approaches, inherent flexibility within the UN drug control conventions allows members of the drug control regime some policy space at the national level.
- Should they wish to do so, however, states already pushing at the limits of the regime would only be able to expand further national policy space via an alteration in their relationship to the UN drug control conventions and the prohibitive norm at the regime's core.
- Mindful of the political and procedural dynamics of the regime, the formation and operation of a group, or groups, of like-minded nations appears to be the most logical and promising approach for some form of treaty revision.
- The varied nature of dissatisfaction with the prohibitive ethos of the regime combines with the character of drug policy to generate dilemmas for the like-minded group approach.
- Within the current environment it is plausible to suggest groupings around traditional and religious uses, cannabis regulation, technical issues and system-wide coherence.
- The centenary of the regime is an opportune moment to consider some form of treaty revision and the formation of like-minded groups to that end.

<http://idpc.net/> or www.tni.org

In March 2012 the **Programme for Government: annual report 2012** was released. Reporting on the coalition government's first year in office, in relation to illicit drugs it reported three achievements: (1) The National Substance Misuse Strategy Steering Group launched its report on 7 February 2012. An Action Plan to implement the recommendations in the report is being drawn up and is expected to be completed by summer 2012. (2) Attention is being focused on increasing the availability of methadone treatment services outside Dublin; an increased number of detox facilities have come on stream in various locations; and needle exchange services are being provided in over 60 community pharmacies at various locations outside Dublin. (3) The catchment area of the Drug Treatment Court was extended significantly with effect from July 2011. A review of the court commenced in early 2012 with a view to completion by Q3, 2012. www.taoiseach.gov.ie

On 17 April 2012 the **US National Drug Control Strategy 2012** was released. The new Strategy is guided by three facts: addiction is a disease of the brain, which can be treated, rather than a behavioural problem; people with substance use disorders can recover; and innovative new criminal justice reforms can stop the revolving door of drug use, crime, incarceration, and re-arrest. The Strategy outlines programs that work to significantly reform the criminal justice system by diverting non-violent drug offenders into treatment instead of incarceration, addressing substance use disorders through the healthcare system and youth outreach, targeting violent transnational criminal organizations, and strengthening international partnerships. www.WhiteHouse.gov/ONDPCP

(Compiled by Brigid Pike)

Recent publications

On our shelves

Books recently acquired by the National Documentation Centre on Drug Use



Fixing drugs: the politics of drug prohibition
by Sue Pryce
Palgrave Macmillan (2012)
ISBN: 978-0-230-35971-0

Journal articles

The following abstracts are cited from recently published articles relating to the drugs and alcohol situation in Ireland.

Crack-ing the case: a patient with persistent delirium due to body packing with cocaine

Ní Chróinín D and Gaine S

Irish Medical Journal, 2012, 105(4)

www.drugsandalcohol.ie/17444

A 36-year-old male presented acutely with encephalopathy, following his return to Ireland from a visit to West Africa. Clinical findings included confusion, agitation and tonic-clonic seizures. Difficulties in weaning sedation prompted repeat urine toxicology screening at day 8, which was positive for cocaine. Work-up for a source of continued cocaine exposure led to the discovery of cocaine-containing packages in the gastrointestinal tract. An index of suspicion should be maintained in patients presenting with drug toxicity following cross-border travel.

Maternal smoking and alcohol consumption during pregnancy as risk factors for sudden infant death

McDonnell Naughton M, McGarvey C, O'Regan M and Matthews TG

Irish Medical Journal, 2012, 105(4)

www.drugsandalcohol.ie/17443

A population based case control study was conducted to examine alcohol consumption and maternal smoking during pregnancy and the risk of SIDS in an Irish population. Each SIDS case (n=287) was compared with control infants (n=832) matched for date and place of birth for infants born from 1994 to 2001. Conditional logistic regression was used to investigate differences between Cases and Controls establishing Odds Ratio's (OR) and 95% Confidence Intervals (CI). Mothers who smoked were 3 times more likely to have a SIDS Case, and a dose response effect was apparent, with mothers smoking 1-10 cigarettes/day OR 2.93 (CI 1.50-5.71), and those smoking >10 cigarettes/day OR 4.36 (CI 2.50-7.61). More Case mothers consumed alcohol during pregnancy than Control mothers and, within drinkers, the amount of alcohol consumed was also greater (p<0.05). A dose response with frequency of drinking was apparent. The adjusted odds ratio for those consuming alcohol in all three trimesters was 3.59 (CI:1.40-9.20). Both of these risk factors are modifiable and need to be incorporated into antenatal education from a SIDS point of view.

Service user involvement in drug treatment programmes: barriers to implementation and potential benefits for client recovery

Van Hout MC and McElrath K

Drugs: education, prevention and policy, 2012, 10 April; Early online
www.drugsandalcohol.ie/17331

Service user forums have the potential to improve awareness of services, empower service users and strengthen community partnerships within an inclusive treatment and rehabilitation framework. The research aimed to investigate perspectives about service user involvement in order to inform the development of effective service user forum(s) in the west of Ireland.

A total of 30 interviews with key service providers and 12 interviews with service users were conducted, with interview questions focusing on: (1) awareness of the Service User Support Team and (2) barriers to service user involvement and the development of service user forums in the region. An integrated data collection and thematic analysis was undertaken. Current levels of service user involvement were low, restricted by one-way communication and appeared grounded in user-provider power differentials and stigma relating to drug dependency. Service providers queried the actual terms of reference, capacity and training that would be needed for service user forums to advocate and lobby for service users. The use of existing support groups, creation of internet user forums and rotation of rural meetings were recommended to promote engagement among service users. The research underscores the need for transparency, resources and a framework for good practice that reflects a participatory approach.

The incidence and repetition of hospital-treated deliberate self harm: findings from the world's first national registry

Perry IJ, Corcoran P, Fitzgerald AP, Keeley HS, Reulbach U and Arensman E

PLoS ONE, 2012, 7(2)

www.drugsandalcohol.ie/17030

Suicide is a significant public health issue, with almost one million people dying by suicide each year worldwide. Deliberate self-harm (DSH) is the single most important risk factor for suicide, yet few countries have reliable data on DSH. We developed a national DSH registry in Ireland to establish the incidence of hospital-treated DSH at national level and the spectrum and pattern of presentations with DSH and repetition.

Between 2003 and 2009, the Irish National Registry of Deliberate Self Harm collected data on DSH presentations to all 40 hospital emergency departments in the country. Data were collected by trained data registration officers using standard methods of case ascertainment and definition. The Registry recorded 75,119 DSH presentations involving 48,206 individuals. The total incidence rate per 100,000 fell from 209 in 2003 to 184 in 2006 and increased again to 209 in 2009. The most notable annual changes were successive 10% increases in the male rate in 2008 and 2009. There was significant variation by age, with peak rates in women in the 15-19-year age group (620 per 100,000), and in men in the 20-24-year age group (427 per 100,000). Repetition rates varied significantly by age, method of self-harm and number of previous episodes.

Population-based data on hospital-treated DSH represent an important index of the burden of mental illness and suicide risk in the community. The increased DSH rate in Irish men in 2008 and 2009 coincided with the advent of the economic recession in Ireland. The findings underline the need to develop effective interventions to reduce DSH repetition rates as a key priority for health systems.

The untold truth about 'bath salt' highs: a case series demonstrating local tissue injury

Dorairaj JJ, Healy CM, McMenamin M and Eadie PA

Journal of Plastic, Reconstructive and Aesthetic Surgery, 2012, 65(2): e37-e41

www.drugsandalcohol.ie/16978

The epidemic of injecting cathinone derivatives, marketed as 'bath salts', by intravenous drug users among inner city Dubliners led to an associated rise in soft tissue complications. The spectrum of the cases, ranging from self-limiting cellulitis to extensive abscess formation, encountered at a single institution is described.

Opioid maintenance in European prisons: is the treatment gap closing?

Hedrich D and Farrell M

Addiction, 2012, 107(3): 461-463

www.drugsandalcohol.ie/16949

Opioid maintenance treatment (OMT) is effective in prison, as it is in the community. Of 30 European countries, 24 sanction prison OMT, but only eight provide coverage that matches average EU community levels. It is important to challenge negative perceptions of prison OMT and promote equivalence of care and continuity of treatment. This systematic review concludes that OMT is an effective treatment option for opioid-dependent prisoners that offers benefits similar to those reported in community settings.

Upcoming events

(Compiled by Joan Moore – jmoore@hrb.ie)

June

23 June 2012

Introducing drugs and alcohol interventions

Venue: All Hallows College, Drumcondra, Dublin 9

Organised by / Contact: Community Awareness of Drugs

Email: info@cadaboutdrugs.ie

Web: www.cadaboutdrugs.ie

Information: One day training for those wishing to make effective drugs and alcohol interventions in a variety of settings. Programme will include the following presentations:

- *Drugs and their effects* – Dr Des Corrigan, chair of the National Advisory Committee on Drugs
- *Introducing Motivational Interviewing* – Mr Brian Foley, addiction counsellor, Ballymun Youth Action Project
- *Shared personal experiences* – Coolmine Therapeutic Community and Family Support Network

28 June 2012

Employee health and well-being – Developing a strategic approach

Venue: The Large Room, Waterford City Hall

Organised by / Contact: EAP Institute

Email: anita@eapinstitute.com

Tel: 051 855733

Web: www.eapinstitute.com

Information: *The Workplace health and wellbeing strategy* published by the Irish Health and Safety Authority (HSA) proposes a 'Model for Action' built on the principles of prevention, health promotion and rehabilitation in the workplace. This one-day learning seminar will address the issues outlined in the strategy. The seminar will be opened by Tom Murran, Waterford Chamber of Commerce, and speakers will include Maurice Quinlan, director of the EAP Institute, Kathleen Treanor, risk management consultant, Dr Robert Kerr, Managing Well-Being, and University of Ulster. The afternoon session will be chaired by Ann Murran, psychotherapist in private practice.

October

5–6 October 2012

ACCESS Conference; Drug users in custody: Learning the lessons

Venue: ASAG, Università Cattolica, Milan, Italy
Organised by / Contact: COMPASS, UK, and ACCESS partner organisations

Email: cinziabrentari@hotmail.com

Web: www.accessproject.eu/conference

Information: The ACCESS project is a European initiative to bring together organisations from EU member states to contribute to the knowledge base and practice of harm reduction services, with the aim of improving access to treatment for drug users within the criminal justice system in European countries. The event will expose participants to EU and international policy development, research and examples of service establishment and delivery at local, national and international level on harm reduction and treatment in prison and in the criminal justice system.

The conference is directly relevant to professionals and service users from health, drugs and social organisations, as well as law enforcement and judiciary bodies, funders, academics, NGO representatives, politicians and policy makers at local, European and international level. The official languages of the conference will be English and Italian.

10 October 2012

Drugs and Alcohol at Work – Risks, Controls, Resources 30th Annual EAP Conference and Learning Institute

Venue: The Convention Centre IFSC, Dublin

Organised by / Contact: The EAP Institute

Email: anita@eapinstitute.com

Web: www.eapinstitute.com

Information: Speakers and session chairs will include:

- Maurice Quinlan, Conference Chair, Director, EAP Institute;
- Frank Cunneen, Session Chair, Chairman, Workplace Safety Initiative, IBEC;
- Michelle Peate-Morgan, Session Chair, Head of Environmental Health & Safety, Acuman;
- Níav O'Higgins, Solicitor, Head of Construction and Engineering Group, Arthur Cox;
- Paul Hoover, EAP & Behavioural Health Consultant, Texas, US;
- Esther Lynch, Head of Legal Affairs, ICTU;
- Helen Vangikar, Toxicology Consultant, President of the European Workplace Drug Testing Society (EWDTTS);
- Dr Mark Piper, Toxicology Manager, Randox Laboratories.

November

26–27 November 2012

Plotting a new course: 2nd annual conference on drugs, alcohol and tobacco

Venue: Friends House, 173–177 Euston Road, London NW1 2BJ

Organised by / Contact: Esprit de Bois, Knowledge-Action-Change, and H2 Events

Web: www.plotnewcourse.org.uk/conference

Information: Plotting a New Course is the leading forum for the critical analysis of responses to drugs, alcohol and tobacco. Two days of high level presentations, debate and discussion. The programme will explore new ways of working on, thinking about and tackling difficult or controversial issues and will provide a platform for honest and transparent debate.

- Critical examination of key policy, treatment and public health issues
- Cross-cutting themes linking alcohol, drugs and tobacco
- Four main plenary sessions each day
- Moderated debates and panels
- Major opportunities for audience participation
- Social networking opportunities

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