

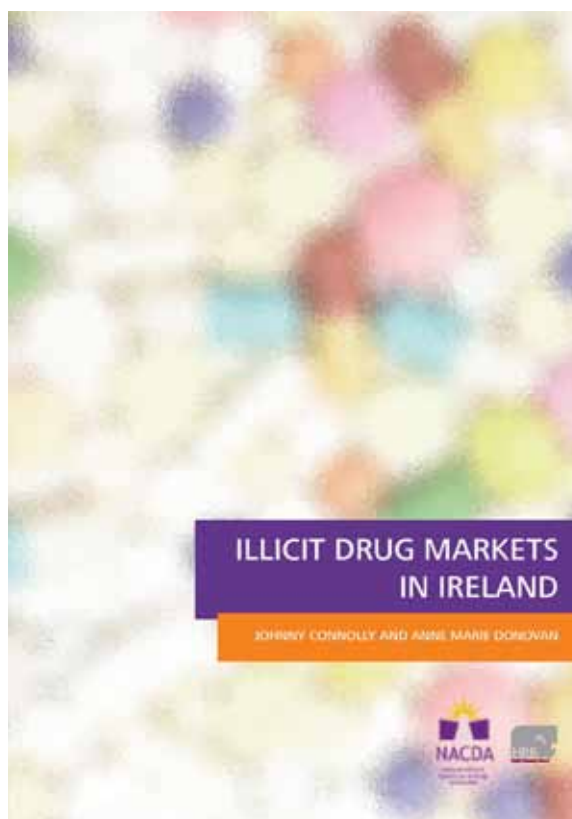
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Illicit drug markets in Ireland



The first national study on illicit drug markets in Ireland, conducted by the Health Research Board, was recently published by the National Advisory Committee on Drugs and Alcohol (NACDA).¹ The study provides in-depth research and analysis on the various factors that influence the development of local drugs markets; the nature, structure and organisation of the Irish drugs market; the impact of drug-dealing on local communities; and an evaluation of current interventions in response to illicit drug dealing. This article provides a summary of the key findings of the study.

This exploratory study was conducted over a 36-month period (from 2008 to 2010) and included a cross-section of four local drug markets: two urban, one suburban and one rural drug market (anonymised as A–D). The study adopted a mixed methodological or triangulation approach to the investigation. This included the following:

- face-to-face in-depth interviews with both former and active drug users and street sellers and with individuals serving prison sentences of more than seven years for drugs supply;
- 24 interviews with experienced members of dedicated garda drug units in the four study sites and with senior members of the Garda National Drugs Unit;
- Interviews with drug treatment workers, public health specialists and a family support group;
- a street survey of 816 local residents and business people (approximately 200 respondents in each location);
- analysis of 1,200 drug offences and seizures on the Garda PULSE IT system throughout the four study sites and nationwide seizures made by Customs Drug Law Enforcement (CDLE) from 18 stations; and
- analysis of cocaine and heroin purities and adulterants in all study sites by the Forensic Science Laboratory.

Illicit drug markets *(continued)*

Evolution and organisation of illicit drug markets

When asked what they thought were the main reasons for local drug use, most survey respondents highlighted social issues, with drug use seen as a symptom of deeper underlying factors. These included the absence of facilities for young people, high unemployment, boredom, poor parental supervision and drug availability. A number of explanations were also advanced during interviews as to how illegal drugs entered the areas. Factors mentioned included the relocation of people from deprived urban centres to suburban and rural areas, the influence of prison where people had developed addictions and/or met people who would subsequently introduce them to drug-dealing, and the arrival in an area of people, both national and non-national, with heroin habits.

Despite popular portrayals of illicit drug markets as hierarchical entities controlled by organised crime groups, recent international research has emphasised a more complex, decentralised and fluid phenomenon involving numerous participants, most of them strangers to each other.² The findings of this research correspond with this more nuanced perspective. There were a number of key

differences in how drug markets were organised across the four sites surveyed, from more loosely structured to more co-ordinated arrangements. Site D, for example, was highly structured in terms of distributing heroin, cocaine and cannabis, with several high-level suppliers involved in drug importation and distribution over this very wide area. The middle market in this location was reportedly heavily populated with individuals and groups or 'gangs' supplying kilograms or more. Although crack cocaine had originated with West Africans in site D, it now involved more Irish sellers. In site C, the distribution of drugs such as cannabis and cocaine was concentrated among a small number of established families. Heroin distributors were described as non-local, both Irish and non-Irish, who had arrived in the area with an addiction. The heroin market was also described as less structured and easier to penetrate from a law-enforcement perspective. In site B, the heroin supply was regarded as having originated within specific families but more recently it involved a looser network of individuals. Heroin was not imported directly but sourced from the major cities of Dublin and Limerick. Cocaine distribution in site B was more structured and lucrative and dominated by a particular group of individuals who used legitimate

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Illicit drug markets (continued)



Dr Johnny Connolly, HRB, lead author of Illicit drug markets in Ireland which was published in November

businesses as a means of transporting drugs throughout the region. Across all sites, it was found that a large number of individuals performed roles on behalf of higher-level suppliers. Another common factor we found across all sites was that higher-level suppliers usually avoided any contact with drugs once they had been imported.

In site A, a large number of individuals performed roles on behalf of higher-level suppliers, including diluting or preparing drugs. Those involved in the storage and transport of drugs were generally relatively minor participants, either earning drugs for their own use or trying to pay off a drug debt. The involvement of young people in the drugs trade was also a factor. In site A, young people played a substantial role in drug distribution at street level. Storing or running drugs was a financially lucrative option for teenagers. Over a six-month period, PULSE data revealed that one-fifth of suspected supply offenders were aged 18 or younger. (PULSE [Police Using Leading Systems Effectively] is the computer system that the Gardaí use in their work.) Not all these runners used drugs themselves and some were doing it as a way of earning money. The profile of runners was different in site B. They were often older heroin addicts running drugs in return for a personal supply. Non-drug-using young people (aged under 18) were not reported as playing a significant role in drug distribution. Similarly, in site C, although runners did exist, there was little evidence to suggest the involvement of very young people (aged 16 and under). It was reported that this would not have been tolerated by local residents. By contrast, in site D, young people were reported to be heavily involved in running drugs.

The main drug sold across all four sites surveyed was cannabis. Heroin, crack cocaine and prescription drugs could be purchased at different levels in all areas. All the main drugs were available in all four study locations, although heroin was a relatively recent phenomenon in site C. The research indicated that some dealers sold multiple substances. PULSE data also suggested a degree of overlap between drug types, with multiple substances often being seized from the same individual in supply type offences. However, there were also many sellers who concentrated on only one substance, such as cannabis.

Where drugs are sold was shown to vary across sites – not all drugs were sold on the open market. No drugs were reported to be sold openly in sites B and C, yet sites A and D had several highly visible open street-level markets, often located in the midst of legitimate commercial businesses. In

site A, dealers took turns to sell drugs to buyers who came from outside the area. Across all sites, it was reported that closed markets were to be found in pubs and flat complexes. There were thriving open markets for crack cocaine in sites A and D, while site B, which was a rural town, had an emerging crack problem. Drug sellers in all sites reported the increased use of mobile phones to assist in the carrying-out of drug transactions.

Impact of illicit drug markets

When asked if they avoided areas in their neighbourhood (and why), many respondents noted that this was mainly because of people hanging around in groups taking drugs. This figure varied across the sites, however – from almost three-quarters of respondents in site A to under half of respondents in site D (40%). Most respondents considered illegal drugs to be a big problem in their area (ranging from 67% of respondents in site C to 90% in site A). However, we found that residents' direct exposure to drug problems, whether through witnessing drug-using behaviour or seeing discarded syringes in their neighbourhoods, varied.

All four sites reported an increase in violence associated with the drug trade – violence that was increasingly visible in public in the form of fights or damage to property. Violence in all four markets was largely related to unpaid debts, although territorial disputes did occasionally emerge in less ordered drug markets. Drug debts were acquired through people consuming their own supply or as a result of Garda seizures. Where gardaí seized drugs, debts remained outstanding and still had to be paid. This may be described as an unintended or adverse consequence of drug law enforcement, whereby effective supply reduction activities can indirectly contribute to greater levels of drug-related violence. In site A, drugs were provided on credit at all levels of distribution and most of the violence related to money owed.

Drug market disputes over debt or territory could also 'spill over' into public displays of violence, or innocent third parties could become embroiled in such conflicts. In site A, in a busy open street market for crack cocaine, dealers took turns in selling to new buyers. If one dealer began to dominate, however, this could contribute to conflict, which could lead to public fights. However, not all drug markets studied here can be described as equally violent. In site C, where the drug market was described as competitive but relatively ordered, with everyone 'knowing their place', violence was almost always related to drug debts.

Our research found that one of the major consequences of drug-related violence and intimidation is that it can act as a major disincentive to residents or local business people taking action and/or engaging with state agencies in responding to such problems. Explaining their refusal to report local drug-related problems, the majority of residents in all locations stated their fear of reprisal from those involved in the drug trade.

It must also be acknowledged that drug markets can have an ambiguous relationship with their 'host' communities: although there may be opposition to them – particularly in terms of the stigma they can bring to the local area – they can also provide a source of cheap goods in deprived communities. Residents in all four study sites reported being offered stolen goods by people they suspected of being drug users. Interviews with drug users and sellers revealed that stolen property was an important currency in everyday drug transactions, so there was clearly a local market for

Illicit drug markets *(continued)*

the proceeds of drug-related crime. Stolen goods, such as jewellery, mobile phones, satellite navigation devices and computer games were regularly exchanged for drugs. Stolen goods were either retained by the dealer for their personal use or they were sold in the local community.

Law enforcement responses

With regards to drug seizures, the air mail unit (Dublin), the Athlone mail centre and Dublin airport passenger terminal accounted for most of the seizures made by Customs Drug Law Enforcement (CDLE) during the research period. The drugs seized were generally en route from source/transit locations such as Amsterdam, South Africa or South America. Mail stations such as Portlaoise reported a high rate of low-volume seizures of substances such as cannabis, and licit but prescribed medication such as benzodiazepines.

Of the 1,378 CDLE seizures of illegal or controlled drugs between January and June 2009, 90% were of cannabis herb or resin. The vast majority (90%) of these seizures weighed less than 28g and were most likely for personal use. CDLE made 52 seizures of illegal substances that weighed 1kg or more (4% of total seizures). Cocaine and cannabis herb accounted for 89% of these seizures. It is not possible to determine accurately the proportion of these drugs that were destined for the Irish market or whether these seizures had any significant impact on drug availability in Ireland.

Garda Síochána drug unit strategy focused on middle-market suppliers, primarily using intelligence from informants. Such intelligence was acquired through developing relationships with offenders working in the lower levels of distribution. It was shown across all four sites that supply offences accounted for between 17% and 33% of all drug offences, and that the largest proportions of supply offences were in sites A and D. On the one hand, this reflects the intelligence-led and focused nature of activity by individual Garda drug units. On the other, it reflects the greater availability of drugs in these areas. While some drug sellers acknowledged the importance of being wary of Garda activity, our research showed no evidence that drug availability was affected for any significant period because of successful law enforcement. In all four sites, most prosecutions were for simple possession of cannabis: most of these related to stop and search activity by Garda members and the amounts seized were valued at between €10 and €20. Local tolerance of cannabis use was highlighted by Garda members and by treatment workers in a number of sites.

Assessing impact of drug-related law enforcement

Drug availability

The report highlights the challenges that arise in any attempt to assess the effectiveness of responses to illicit drug markets. Such problems are related to the obvious difficulties in trying to account for largely hidden activities, but they are due also to the limitations of criminal justice data. Moreover, the absence of reliable evidence of a straightforward link between supply-reduction initiatives and sustained reductions in drug availability has been highlighted in the international literature.² The public demand for illegal drugs and the profits which can be earned from drug-dealing ensure that Irish drug markets, like those elsewhere, remain resilient and adaptable to law-enforcement interventions.

For instance, a convicted drug courier claimed that he had smuggled cannabis across Europe into Ireland for many years without detection. For this individual, the transporting of drugs was a lucrative business and one in which he participated for monetary gain. Also, a number of imprisoned non-national female drug couriers interviewed for the study, who had been apprehended in airport passenger terminals, generally reported being in desperate financial circumstances, and had agreed to courier kilograms of illegal drugs, sometimes for as little as €500. The incarceration of such individuals, while it removes some drugs from circulation, is unlikely to have any real impact on those individuals higher up the supply chain, and thus its effect on drug availability will be limited in the longer term.

Market disruption

In sites A and D, despite several targeted operations, gardaí acknowledged that they were unable to disrupt market activity for any length of time, nor had they been able to displace activity to another location. The limitations of such Garda crackdowns in busy hotspots were also highlighted by local drug sellers, who would disperse quickly when gardaí approached and resume when they left the area. Drug sellers adapted to drug law enforcement by managing risk exposure. For instance, many interviewees did not keep drugs on their person: they would divide up consignments and leave them at different locations, for buyers to collect. Higher-level sellers often used others to transport drugs for them. Drug sellers also reported using people as decoys, where they would give them a small amount of drugs and then inform the gardaí so as to distract the latter from a larger drug-deal happening simultaneously elsewhere.

Engaging and reassuring communities

Another way of determining the impact of law-enforcement approaches is whether they reassure the public. Residents' perceptions of Garda anti-drug activity were investigated in the street survey. In site A, only one-third of survey respondents believed the gardaí to be effective or very effective in dealing with crime. In sites B and C, approximately half of respondents believed gardaí to be effective or very effective in dealing with crime in their area. In site B, more than half of them knew a Garda by name, while in site C more than a third knew a Garda member by name. In site D, just under half of respondents believed gardaí to be effective or very effective in dealing with crime, while 36% of residents said they were not very effective. Just one quarter of respondents knew a Garda member by name and/or had spoken to a Garda about the area. These findings suggest that there may be a link between perceptions of Garda effectiveness and familiarity with Garda members working in the community; they support the findings of other research which suggest that police visibility can increase residents' confidence in the ability of the authorities to address public nuisance.

Illicit drug markets (continued)

Partnership responses

Evidence is growing, both internationally and in Ireland, that partnership approaches involving drug law enforcement, local communities and other stakeholders offer the most sustainable method of responding to many drug problems, including illicit drug markets.³ Drug unit members' contact with treatment providers varied across sites. In three sites (A, B and C), Garda members had little contact with local drug-treatment agencies and factors such as confidentiality issues were cited as possibly preventing closer links. However, in site C, it was felt that better working relationships with social welfare services and housing authorities could produce beneficial outputs for all agencies involved. There was also doubt expressed about the suitability or effectiveness of Garda members taking a bigger role in diverting offenders to treatment.

In site D, inter-agency partnership was developing and proving beneficial. The relationship with local municipal housing authorities was described as positive, and local housing authorities assisted efficiently in the eviction of drug-dealers. Recent improvements in relationships with drug-treatment services had also produced positive results such as the identification of persistent drug sellers stationed outside drug-treatment clinics. However, gardaí had no official relationships or structures to help guide problematic users and sellers to treatment.

Research implications

The study raises a number of general implications for future responses to illicit drug markets. First, the complete removal of illicit drug markets through drug law enforcement is not an achievable goal in the foreseeable future. The aim must be to consider how future drug law enforcement might evolve to address the complexities and particular harms associated with Irish drug markets. It is suggested that such an approach does not necessarily require a change in the legal control framework but rather a more pragmatic use and co-ordination of existing resources and the targeting of those resources at the most harmful aspects of drug markets.

Second, not all drug markets are equally harmful. For example, some are more violent than others and open markets cause more disruption to communities than closed ones. Third, law-enforcement interventions that focus on the particular harms associated with a specific market have the potential to have an impact on those harms and they may also lead to a more effective and economically viable use of public resources.

Finally, approaches that seek to divert problematic drug users into treatment and that prioritise local community perspectives, and those that occur in collaboration with other relevant agencies, are more likely to be sustainable over time and to win public support.

The study concludes with a discussion about how to address four key challenges which, it is suggested, need to be overcome if such an approach is to be successful:

- how to deliver change through inclusive community-based, inter-agency partnerships,
- how to engage with communities in light of the widespread localised fears that drug markets and those involved in them can create,
- how to prioritise harms and use resources to their maximum effect, and
- how to profile drug markets and monitor responses to them.

Conceptualising drug markets

The illicit drug market can be understood as loosely incorporating three inter-related levels or dimensions. First, the global or 'international market' incorporates drug production and international trafficking; second, the 'middle market' involves the importation and wholesale distribution of drugs at a national level with research seeking to describe how drugs are moved from importation to street level and by whom; and third, the 'local market' involves distribution at a retail level.

May and Hough⁴ provide a classification of retail markets distinguishing between open markets, semi-open markets such as pubs and clubs, closed markets and crack or dealing houses. Some of their main features are described as follows:

- Open Markets – open to any buyer with no requirement for prior introduction to the seller and few barriers to access.
- Semi-open markets – pub and club-based markets, mostly for ecstasy and other drugs used by clubbers. Sellers will generally do business in the absence of any prior introduction, 'provided the buyer looks the part'.
- Closed markets – sellers and buyers must know and trust each other, or be introduced by a mutual third party.
- Crack/Dealing House Markets – Have evolved since early 1990s in UK. 'Crack houses' sell a wide range of illicit drugs and so are more accurately referred to as 'dealing house markets'. Can be in residential, uninhabited or semi-derelict properties and often for a short period until enforcement closes them down. Can attract large numbers of buyers, often calling at day and night and are often associated with anti-social behaviour in the building or in the surrounding area.

(Johnny Connolly)

1. Connolly J and Donovan A (2014) *Illicit drug markets in Ireland*. National Advisory Committee on Drugs and Alcohol and Health Research Board. Dublin: Government Publications <http://www.drugsandalcohol.ie/22837/>
2. Babor T *et al* (2010) *Drug policy and the public good*. Oxford: Oxford University Press
3. Connolly J (2006) *Responding to open drug scenes, drug-related crime and public nuisance – towards a partnership approach*. Strasbourg: Council of Europe Pompidou Group; Jacobs K *et al.* (2007) *Making sense of partnerships: a study of police and housing department collaborations for tackling drug and related problems on public housing estates*. Project Report. Tasmania: National Drug Law Enforcement Research Fund
4. May T and Hough M (2004) Drug markets and distribution systems *Addiction Research & Theory* 12(6): 549–63.

Local residents' views on illicit drug markets

As part of the illicit drug markets study described in the previous article, a street survey of approximately 800 local residents and business people was carried out to gather information about the local community in relation to illicit drug use. The survey incorporated almost 60 questions related to local drug markets. Below we look at just three of the key responses – reasons for drug use, future responses needed and fear of drug dealers.

Perceived reasons for drug use

Residents were surveyed on the perceived reasons for drug use in the area. Of those who responded to the question, one quarter highlighted issues impacting on young people: unemployment, boredom, the absence of facilities and poor parenting. Seventeen per cent highlighted the availability of drugs.

Table 1: Perceived reasons for drug use (n=494)

	n	%*
High unemployment	117	23.6
Boredom	110	22.2
No facilities for young people	99	20
Poor parental supervision	96	19.4
Availability of drugs	86	17.4
Poor education	55	11.1
Poverty	43	8.7
It's just the way society is	41	8.2
Other	34	6.8

*Percentages exceed 100% as multiple answers permitted; 'don't knows' excluded.

Future responses needed

With regards to the measures needed to reduce drugs and crime, almost 50% highlighted the need for improved amenities for young people along with education and awareness programmes targeted at young people. However, a clear majority across all four study locations called for an increase in the number of gardaí visible on the streets, patrolling. Despite other findings of the study to the effect that the gardaí could only have limited sustained impact on local drug markets, clearly the importance of a police presence is regarded as crucial. On the one hand this reflects the reassurance that a police presence can bring to local residents; on the other hand it reflects the idea that such a continuous presence can help ensure open drug markets do not become entrenched in an area. Police patrolling can ensure that drug markets are continuously disrupted.

Table 2: Measures needed to reduce drugs and crime, site A (n=560)

	n	%*
More gardaí on the streets/ patrolling	276	49.2
Improved amenities for young people	167	29.8
Education and awareness programmes targeting young people	102	18.2
Other	76	13.5
Harsher sentencing for dealers	74	13.2
More drug-treatment facilities	37	6.6
Regeneration of housing estates and flat complexes	37	6.6
Increase in family support services	19	3.3
Increased social services in the area	12	2.1

*Percentages exceed 100% as multiple answers permitted; 'don't knows' excluded.

Fear of drug dealers

The need for a local police presence is also highlighted in Table 3 below. The research found that one of the major consequences of drug-related violence and intimidation is that it can act as a major disincentive to taking action and/or engaging with state agencies in responding to such problems. When asked whether they would report drug-related information to the gardaí and, if not, why not, most respondents (41.4%) highlighted their fear of reprisal from those involved in the drug trade. In National Crime Victimization Surveys, such as those conducted by the Central Statistics Office, fear of reprisal is never reported as a significant reason for people not reporting crimes to the Garda Síochána.¹ Twenty-three per cent believed that the gardaí would not act or stated that they did not wish to involve gardaí; a further 23% responded that it was not their business; and almost 10% stated that they did not want to be seen as a 'grass', or informer.

Table 3: Reasons for reluctance to report drug-related information to gardaí (n=251)

Reason	n	%*
Fear of reprisal	104	41.4
Not my business	59	23.5
Gardaí would not act	33	13.1
Don't want to be a grass	25	9.9
Would not wish to involve gardaí	25	9.9
Social reasons	22	8.7
Other	13	5.1

*Percentages exceed 100% as multiple answers permitted

Local residents' views (continued)

The fear and intimidation that can be generated locally as a consequence of illicit drug dealing reveal the insidious and disproportionate impact that crime can have on specific locations where drug markets develop. It also represents a significant policy obstacle in terms of obtaining community consent or participation in community-based and partnership responses to crime. A number of interview respondents commented on this very real issue. The following imprisoned drug dealer felt that, although violence has always been associated with the illicit trade in drugs, the debt-related intimidation of family members of those who owed money to drug-dealers was relatively recent.

Violence, it was, it was always in it. It was part and parcel of like you get stigmatised, you know, drugs – with drugs comes violence and it is true. With drugs comes violence but I was never violent. I was always sympathetic to those who

went off them, always. I would never go around as they do now fucking like tapping on doors, looking for the aul' fella, looking for the fathers or mothers to pay but I was never like that. I would write it off – more times out of 10 like if I got out of pocket from doing it, but I would never use violence.

Prison Interview

(Johny Connolly)

1. Central Statistics Office (2009) *Quarterly National Household Survey: Unemployment*. Available at: www.cso.ie See also Connolly J (2003) *Drugs, crime and community in Dublin: monitoring quality of life in the north inner city*. Dublin: North Inner City Drugs Task Force

Ireland's drug policy – progress in 2013

Since 2001 Irish governments have endorsed the national drugs strategy (there have been two) as Ireland's national drug policy. Each year the Department of Health publishes a progress report on implementing the actions contained in the strategy.

In recent years Ireland's newly-elected coalition governments have also published a 'programme for government', outlining the government's priorities and objectives across all policy domains. In the current programme for government, national policy on illicit drugs, alcohol and tobacco is discussed in the chapter entitled 'Fairness', along with government policies on health, education, criminal justice and a range of other social issues. Each year the government publishes a report on progress in implementing this programme for government.

Some of the highlights, as reported in the 2013 progress reports on the implementation of the programme for government and the national drugs strategy, are listed below.¹

Following the government's self-report, an assessment by a civil society organisation (CSO) of the government's performance in relation to alcohol and drug policy in 2013 is outlined.² Focusing on areas where there has been little progress, this assessment is notably more critical. However, it also suggests how progress in developing and implementing policy could be made. The implications of the difference of perspective between government and non-government sources are considered in a separate article – 'Who should decide national drug policy?'

Tobacco-free Ireland

As part of *Healthy Ireland*, a new government framework for action to improve the health and wellbeing of Irish people, *Tobacco Free Ireland* was published – a strategy for making Ireland tobacco free by 2025.

National substance misuse strategy

The government approved a package of measures to deal with alcohol misuse, to be incorporated in a Public Health (Alcohol) Bill. It will cover minimum unit pricing, regulation of marketing and advertising, structural separation of alcohol from other products in mixed trading outlets, enforcement

powers to be given to Environmental Health Officers, and health labelling to include warnings and advice. The regulation of sports sponsorship was given back to a working group for further examination.

Supply reduction

Drug seizures for the first three quarters of 2013 were estimated to have a provisional value of €67 million and An Garda Síochána's Operation Nitrogen continued to be very successful in identifying and dismantling cannabis cultivation sites across the country. Revenue drug-smuggling detection seized €20.8 million in drugs and €20.7 million in illegal tobacco and cigarettes. The Criminal Assets Bureau returned approximately €6 million to the Exchequer in 2013, the majority of which resulted from drug trafficking but also some from tobacco smuggling.

Drug-related policing

The Department of Health progress report for 2013 records that (1) guidelines for the operation of local policing fora (LPF) in LDTF areas and other areas experiencing serious and concentrated drug misuse problems were circulated to the relevant bodies for implementation; (2) a drug-related intimidation programme was established jointly by An Garda Síochána, the Family Support Network and the HSE's Social Inclusion Unit to respond to the needs of drug users and their families and friends who may be experiencing intimidation to pay drug debts; and (3) a framework was developed to support the nomination of an Inspector in every Garda division to target adults involved in the drugs trade who use children to engage in illegal activities associated with the drugs trade.

Drugs in prisons

A full range of security initiatives continued to be implemented to eliminate the supply of drugs into prisons, and drug-free units continued to be rolled out in all closed prisons. These units accommodate and cater for the needs of both drug-free prisoners and those prisoners stable on methadone. There were 522 places filled in drug-free units operating across nine closed prisons, with 35 places due to become operational shortly in Portlaoise Prison.

Ireland's drug policy 2013 (continued)

Prevention

The HSE established a National Hidden Harm Project Management Group to ingrain awareness of hidden harm into the overarching substance misuse and childcare policy frameworks, in order to bridge the gulf between the two systems and ultimately to improve outcomes for children. A key performance indicator (KPI) in the national drugs strategy, to reduce early-school leaving from 11.5% in 2007 to 10% by 2012, had been exceeded: the figure for 2012 was 9.7%, below the EU average of 12.8%.

Drug treatment and rehabilitation services

In 2013, €91.5 million (not including funding of community and voluntary and prison-based services) was allocated for the HSE's Addiction Services. Over 12,500 people received drug treatment for all types of drug use, including over 9,600 people in opioid substitution treatment. At the end of 2013 almost 100% of people over the age of 18 could access treatment within one month of assessment, and almost 100% of children could access treatment within one week of assessment.

The HSE's National Addiction Training Programme (NATP) provided an introduction to dual diagnosis (DD) as an awareness-raising exercise. Following an initial presentation to staff of addiction and allied health and social care services in Bridge House in Cherry Orchard Hospital, conferences were held for wider audiences.

The HSE National Hepatitis C Strategy Implementation Committee was established and set up three sub-groups to progress the recommendations in the hepatitis C strategy – Treatment; Surveillance and Screening; and Education, Prevention and Communication.

A National Rehabilitation Framework to improve the quality and quantity of interagency referrals between drugs services was implemented on a phased basis at ten pilot sites across the country. A process evaluation was completed during 2013, and an implementation plan for national rollout of the framework is being developed in 2014.

Drug-specific Community Employment (CE) schemes

With a budget of almost €15 million in 2013, drug-specific CE schemes facilitated stabilisation and recovery from problem drug use by providing individual care plans and tailored supports for clients. At the end of 2013 there

were 790 participants on drug-specific CE schemes and 161 support workers. The proportion progressing onto employment or further education/training as at December 2013 was 28.3%.

The view from civil society

In February 2014 the Children's Rights Alliance (CRA) issued its annual report card evaluating the government's progress during 2013 in meeting its commitments to children, as set out in the Programme for Government.² Alcohol, illicit drug and tobacco policies are assessed in Chapter 3, 'Right to Health'; five pages are devoted to reviewing the evidence and discussing the policy options.

CRA concludes that progress in 2013 was 'very slow': apart from the Tobacco Free Ireland Report published in October 2013, the promised national addiction strategy had not been published, there was no government policy on tackling alcohol misuse, and no government decision on recommendations of the steering group on the alcohol section of the national substance misuse strategy. The government is given a 'D+' grade for its alcohol and drug policies, a slight improvement on 2013 ('D-'), reflecting the 'initial steps taken towards creating a Tobacco Free Ireland and some positive movement in relation to alcohol'. But concrete actions are called for.

(Brigid Pike)

1. Department of Health (2014) *National Drugs Strategy 2009–2016: progress report to end 2013*. Dublin: Department of Health <http://www.drugsandalcohol.ie/21621/> and Government for National Recovery (2014) *Programme for Government: annual report 2014* http://www.taoiseach.gov.ie/eng/Work_Of_The_Department/Programme_for_Government/Programme_for_Government_Annual_Report_20141.pdf
2. Children's Rights Alliance (2014) Report card 2014: *is government keeping its promises to children?* Dublin: Children's Rights Alliance. The Children's Rights Alliance is a coalition of over 100 civil society organisations, including the Ana Liffey Drug Project, which works to secure the rights of children in Ireland, by campaigning for the full implementation of the UN Convention on the Rights of the Child. It aims to improve the lives of all children under 18 years, through securing the necessary changes in Ireland's laws, policies and services. <http://www.childrensrightrights.ie/>

Who should decide national drug policy?

The previous article 'Ireland's drug policy – progress in 2013' pointed to a difference of perspective between government and non-government sources in how progress was assessed. This contrast highlights the issue, who should be responsible and accountable for drug policy? How might different, even conflicting, views and approaches be reconciled or a balance struck? These types of question are the theme of a recent special edition of the *International Journal of Drug Policy* – 'Towards good governance in drug policy'.¹

Understanding governance

The editors of the special edition note a consensus in the burgeoning literature on the importance of governance: given the increasing complexity of societies, intensifying globalisation and accelerating technological change, new processes of governing drug policy are essential. Drawing on a range of authors, the editors characterise governance as follows: the interest in governance comes from a desire to understand how societies or organisations 'steer' themselves, are 'directed, controlled and held to account'; governance encompasses a complex mesh of interacting events and actors, 'multiple agencies and sites, with action on many levels, from global to local'; and the way to approach the

Who should decide drug policy? (continued)

study of governance is to look at the structures, processes and mechanisms through which policy is 'informed, made, implemented and assessed'.

The editors acknowledge the work of three policy research groups in the study of governance in illicit drugs policy – the Australian-based Drug Policy Modelling Program; the UK Drug Policy Commission, which wound up in 2012, after five years; and ALICE RAP (Addictions and Lifestyles in Contemporary Europe – Reframing Addictions Project) funded by the European Commission's 7th Framework Programme. Many of the authors of the empirical accounts and critical analyses (15 in total) included in the special edition are or have been associated with one of these entities.²

Reflecting on the assembled articles, the editors observe that the policy decision process in relation to illicit drugs needs to be 'flexible', adapting to different substances and contexts, and 'appropriate' to different local and national needs and cultures. Although transparency is a desirable feature of any policy process, the editors note how some of the most effective (i.e. realistic, cooperative and science-based) drug policy has emerged behind closed doors, away from the media and the general public. They conclude:

But decisions taken by experts and insiders are not what representative democracy is supposed to be about. The challenge for proponents of good governance is to show how to marry the goals of transparency and democratic accountability with respect for logic and evidence.

What constitutes 'good governance'?

One of the editors of the special edition is also co-author of an article that identifies the key requirements for good governance: goals; leadership and coordination; use of evidence; feedback and learning; stakeholder engagement; accountability; and a 'safe space in which debate can take place'.³ However, the editors point out that many of the case studies problematise this ideal: government agendas, public concerns and expert opinion are often at odds, and including all relevant stakeholders in the policy process and seeking to incorporate all their views may well result in 'a compromise (mish-mash or fudge) of contradictory and opposing views with no settled resolution'. Lancaster and Ritter conclude that effective collaboration might be possible through building shared values and interests and developing mutual trust through greater use of mechanisms such as committees and networks.⁴

What counts as 'evidence'?

Not an easy question to answer. Monaghan highlights the need for a clear definition of what counts as evidence, including specific criteria for inclusion/exclusion, and determining how to accommodate competing expert, ideological and political perspectives on what constitutes evidence.⁵ Using a social constructionist approach, Lancaster questions whether researchers can ever really be apolitical and independent producers of 'policy-relevant knowledge'. She suggests they answer questions posed by wider society and the resulting evidence is inevitably enmeshed in a particular policy context.⁶

Who are the 'stakeholders'?

The stakeholders are those who have an impact on policy, or are impacted on by policy. They include a wide range of different groups and actors. Stakeholders may come from various disciplines such as science, medicine or journalism, from different sectors such as public or private sector or civil society, and will reflect a wide variety of ideologies, values and belief systems. Two separate case studies, about the introduction of drug consumption rooms in Denmark, and the provision of opioid substitution treatment in England, demonstrate how the outcome of a policy process reflects, and is to some extent determined by, who has participated or been excluded from participation, and also by the relative power of different groups and individuals.⁷

(Brigid Pike)

1. MacGregor S, Singleton N and Trautmann F (2014, September) Towards good governance in drug policy: Evidence, stakeholders and politics. Editorial. *International Journal of Drug Policy* (25/5): 931–934.
2. For more information on these three entities, visit <https://dpmp.unsw.edu.au/> ; <http://www.ukdpc.org.uk/> ; <http://www.alicerap.eu/>
3. Singleton N and Rubin J (2014) What is good governance in the context of drug policy? *International Journal of Drug Policy* (25/5): 935–941.
4. Lancaster K and Ritter A (2014) Making change happen: a case study of the successful establishment of a peer-administered naloxone program in one Australian jurisdiction. *International Journal of Drug Policy* (25/5):985–991.
5. Monaghan M (2014) Drug policy governance in the UK: lessons from changes to and debates concerning the classification of cannabis under the 1971 Misuse of Drugs Act. *International Journal of Drug Policy* (25/5):1025–1030.
6. Lancaster K (2014) Social construction and the evidence-based drug policy endeavour. *International Journal of Drug Policy* (25/5): 948–951.
7. Houborg E and Frank VA (2014) Drug consumption rooms and the role of politics and governance in policy processes. *International Journal of Drug Policy* (25/5): 972–977; Duke K and Thom B (2014) The role of evidence and the expert in contemporary processes of governance: the case of opioid substitution treatment policy in England. *International Journal of Drug Policy* (25/5):964–971.

Towards UNGASS 2016

Since Issue 48, Drugnet Ireland has carried 'Towards UNGASS 2016' as a regular column. It reports briefly on policy initiatives, research and debates launched by UN member states and civil society organisations in the lead-up to the UN General Assembly Special Session (UNGASS) on the world drug problem, due to be held in 2016 (A/RES/67/193).

Released in July 2014, *From drug war to culture war: Russia's growing role in the global drug debate* is the fifth policy brief published by the **Global Drug Policy Observatory (GDPO)** based in Swansea University. Prepared by Alexander Marshall, the policy brief outlines how, in the last decade, Russia's drug policy has shifted from a 'health and psychiatric-dominated discourse' towards a 'securitisation model' and a 'conservative cultural discourse'. Marshall describes how Russia has used this general drug war discourse to increase its levers of influence in the international arena: 'Russia in toto has implemented a relatively complex set of policies that appear set to present an explicit alternative agenda to proposals favouring greater harm reduction or decriminalisation at the next UNGASS summit in 2016.' <http://www.swansea.ac.uk/gdpo/>

In October 2014 **New Zealand's regulatory framework for new psychoactive substances (NPS)** was the subject of a 'critical first assessment' and discussion by a panel of international experts, published in the journal *Addiction* (109/10: pp.1580–94). Lead author Chris Wilkins describes the framework as 'the world's first pre-market approval regulatory regime for NPS': introduced in July 2013, the new regime provides that where clinical trial data show that an NPS product poses a 'low threat', it may be approved for manufacture and sale. While applauding the attempt at regulation, Wilkins and the expert panel raised some serious concerns.

- **Evaluation criteria:** Wilkins points out that standard medical clinical trials may not capture data relevant to recreational drugs, e.g. binge use, polydrug use, use by vulnerable groups and high-risk modes of administration. Lisia van Diemen points out that as a therapeutic effect is not the aim, the dosage of the product that is to be tested may be too low to detect any side-effects: the sample size of the product to be tested must be sufficient to detect side-effects.

For Alison Ritter, the key problem is that medical models of drug evaluation focus on therapeutic efficacy, e.g. alleviating symptoms, improving health and/or treating a disorder, and ignore the pleasure obtained from recreational drug use. She suggests it is possible to measure 'pleasure outcomes', and that users may be prepared to bear some degree of risk in exchange for the stated outcome.

- **Market dynamics:** Wilkins identifies possible distortions in the legal market for NPS. The overt advertising of approved NPS products may make it difficult to suppress the illegal market in unapproved NPS products as they may appear identical to the approved versions. Lisia van Diemen asks what incentives exist for NPS manufacturers to submit their drugs for approval: it is an expensive and time-consuming exercise and many existing manufacturers are already operating successfully in the illegal market. Anne Line Bretteville-Jensen adds that manufacturers in the prevailing illegal environment

have had little incentive to consider safety matters such as quality and consumer information, that maximising profits has been their main motivation, and why should they change now, particularly if, after the long evaluation process, their products are not approved, or are approved but do not succeed in the legal market place?

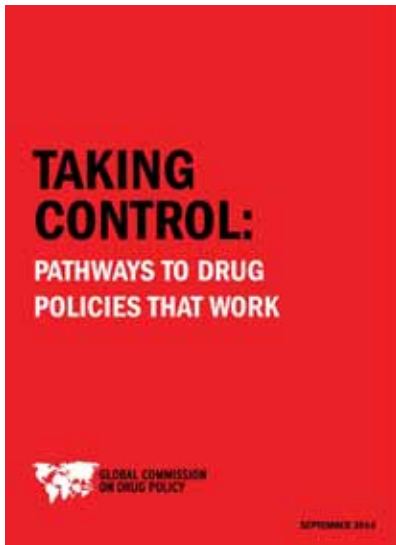
Brendan Hughes and Paul Griffiths of the EMCDDA compare the New Zealand regulatory framework with that adopted in the EU, where responsibility for and cost of assessment does not lie with the producer, and the EU does not take any action with regard to substances deemed 'low risk' but does prohibit a consumer market for 'moderate risk' substances and controls 'high risk' substances. They discuss three EU member states – Poland, Romania and Ireland – that have introduced legislation banning the supply of any unregulated NPS that do not meet certain criteria until specific permission is given. They note that Poland and Romania also have 'pre-market approval regimes'.

Van Diemen, as well as Hughes and Griffiths, question whether legalising an NPS with no therapeutic effect will either reduce the introduction of other unregulated NPS or reduce the illegal use of controlled drugs. They argue that, to date, there is no evidence to support these assumptions.

- **Attitudes to risk and prohibition:** Wilkins points out that what constitutes 'low risk' is not defined in the New Zealand legislation. Having discussed the need to consider the pleasure benefits derived from NPS use, Ritter concludes that unless the debate on drug regulation addresses the benefits as well as the risks of drug use, if it continues to focus on the risks alone, 'it is unlikely that regulatory schemes will be able to resolve the bias of decision-makers towards prohibition'.

Looking at the drugs, rather than the users, Stephen Rolles and Danny Kushlick of the Transform Drug Policy Foundation argue that it is prohibition that is driving the NPS phenomenon: as long as certain categories of psychoactive substances are prohibited, manufacturers will continue to try and replace prohibited substances with uncontrolled ones. They comment: 'It is reasonable to speculate that no substantial market for synthetic cannabinoids would have emerged had cannabis been available via a legally regulated market-place, not least because evidence suggests that users prefer cannabis, and synthetic cannabinoids products appear to be more risky in terms of more adverse health effects.'

Towards UNGASS 2016 (continued)



On 9 September 2014 the **Global Commission on Drug Policy** released *Taking control: pathways to drug policies that work*. Anticipating the debates at UNGASS 2016, the Commission proposes five pathways whereby governments may 'improve the global drug policy regime':

1. put people's health and safety at the centre of the picture,
2. ensure access to essential medicines and pain control,
3. end the criminalisation and incarceration of users,
4. provide targeted prevention, harm reduction and treatment strategies for dependent users, and
5. regulate drug markets and adapt enforcement strategies to target the most violent and disruptive criminal groups rather than low-level players.

The Global Commission calls on governments to 'rethink the problem, do what can and should be done immediately, and not to shy away from the transformative potential of regulation.' www.globaldrugcommission.org

(Compiled by Brigid Pike)

Urban and rural youth attending a treatment centre

Murphy and colleagues analysed data collected about a cohort of young people aged under 21 who presented for treatment for substance use to the Matt Talbot treatment service between 2001 and 2011.¹ The aim of the study was to investigate the differences in substance use between young people residing in urban and rural areas. The cohort consisted of 436 young people; just over half (51.3%) were rural attendees – 223 from Cork County and one from Kerry (rural attendees) and 212 from Cork City (urban attendees). Young males accounted for over 95% of both urban and rural attendees; overall, both groups had a similar mean age, urban attendees with a mean age of 16.7 years and rural attendees 16.8 years. Over 90% of both groups resided with their parents.

Employment and education status

The groups differed markedly in terms of current employment and education status. A third (33.3%) of urban attendees reported being unemployed compared to 22.2% of the rural group; 10.3% of rural attendees were in paid employment compared to 4% of urban attendees. A higher percentage of rural attendees (47.4%) reported to be a student compared to 37.4% of urban attendees; however, urban attendees made up a higher percentage of those attending an adult training course (22.2%) compared to 17% of rural attendees.

Problem substance use

Over half of both groups (59.6% rural attendees and 54% urban attendees) presented for treatment for cannabis use as their main problem substance. Marked differences were observed between both groups for problems with alcohol use and benzodiazepine use. A higher percentage of rural attendees (32.3%) presented for treatment for problem alcohol use, in contrast to 22.5% of urban attendees; conversely, 16% of urban attendees compared to 4% of rural

attendees reported presenting for treatment for problem benzodiazepine use. With regard to 'head shop' drugs, 4.2% of urban attendees presented for treatment for problem use of these substances, compared to 0.9% of rural attendees. Less than 2% of the overall cohort reported opioids as their main problem substance, while a slightly higher percentage of rural attendees (2.2%) reported problems with cocaine compared to 1.9% of urban attendees.

Poly-substance use

A higher percentage of urban attendees reported poly-substance use: 73.7% reported using at least three different substances during their lifetime compared to 52.2% of rural attendees; 49.3% of the urban group reported using three different substances in the last month compared to 31.3% of rural attendees; and daily use of at least two different substances was reported by 11.3% of urban attendees compared to 4.9% of rural attendees.

Initial use of substances

There were no marked differences in age of first use of any substance, with the mean age for urban attendees being 12.4 years and rural attendees 12.7 years. The vast majority of both urban (81.7%) and rural (80.9%) attendees reported cannabis as the first substance used. A higher percentage of urban attendees (4.1%) reported benzodiazepines as first substance used compared to 1.5% of rural attendees, and 6.1% of urban attendees reported inhalants as first substance used compared to 0.5% of rural attendees. On the other hand, 16% of rural attendees reported alcohol as first substance used compared to 7.6% of urban attendees.

Urban and rural youth (*continued*)

Referral to treatment

A higher percentage of rural attendees (44.3%) compared to urban attendees (37%) were referred for treatment by the Irish legal system; this finding suggests these attendees were likely to have experienced problems with crime and/or social misbehaviour.

Concluding remarks

The authors point out that this is the first Irish study comparing service users from urban and rural settings; on this basis alone the study is welcome as it helps to close a gap in the literature. The main aim of the study was to investigate differences in substance use between young people residing in urban and rural areas.

The main differences found were:

1. almost a third of the rural group presented for treatment for alcohol use as their problem drug, in contrast to 22.5% of the urban group,
2. 16% of the urban group presented with benzodiazepine as their main problem drug, in contrast to 4% of the rural group, and
3. a higher proportion of the urban group reported using a variety of substances during their lifetime, during the past month and during the past week.

(*Martin Keane*)

1. Murphy KD, Byrne S, Sahn LJ, Lambert S and McCarthy S (2014) Use of addiction treatment services by Irish youth: does place of residence matter? *Rural and Remote Health*, (14): 2735 <http://www.drugsandalcohol.ie/22461/>

Psychiatric and psycho-social characteristics of suicide completers

A recently published article examines the psychiatric and psycho-social characteristics of people dying by suicide in the West of Ireland.¹ As background, the authors note national statistics showing that between 2001 and 2013 there were approximately 500 deaths by suicide in Ireland, and that the incidence of suicide among Irish males was four times greater than among females. The authors also cite a WHO report showing that, while the rate of death by suicide in Ireland is the eighth lowest in Europe compared to 26 other countries, in the 15–24-year-old age group Ireland ranks fourth highest.

The authors list the large number of potential risk factors for death by suicide that have been recognised in the literature. Psychological autopsy studies have shown that 60% to 90% of individuals have suffered with a psychiatric illness before their death by suicide. Alcohol abuse and/or psycho-active substances as well as borderline personality disorder have been highlighted as risk factors. There is an increased risk if the person has experienced adverse childhood trauma such as a violent episode or sexual abuse, although confounding factors need to be considered. Previous contact with mental health services and prior suicide attempts have also been found to be significant risk factors: the first two weeks following discharge are the period when individuals are at most risk. Other epidemiological studies show that genetic factors, independent of mental illness, are another important risk factor to consider for suicide.

Previous episodes of deliberate self-harm are also a major risk factor for death by suicide: studies assessing self-harm have shown that 52% to 63% of individuals who have had one or more episodes of self-harm have later died by suicide. Death by hanging has been shown to be the most common method of suicide. Gender differences have also been found, with hanging and death by firearm more prevalent among men and self-poisoning more prevalent among women.

Aim and objectives

The aim of the study was to identify the demographic, psycho-social and clinical characteristics of individuals known to mental health services who died from probable suicide in the West of Ireland (HSE West region including West Galway, East Galway and Roscommon). The study examined each individual's method of death and toxicology findings at time of death. It also characterised previous deliberate self-harm and suicide attempts and mental health diagnoses.

Method

All post-mortems carried out in University College Hospital Galway (UCHG) between January 2006 and May 2012 (n=1,991) were reviewed. The post-mortem reports, which included detailed reports from the consultant pathologist, witness statements, garda summaries and toxicology reports, were assessed against the study inclusion criteria, and 181 individuals were determined to have died by probable suicide. Of these, 57 individuals were found to have been known to the mental health services and these individuals formed the cohort for the study.

Results

There were more males to females in the study cohort (ratio 4:1), the majority were unemployed (58%) and the mean age was 47 years. The highest proportion was aged between 34 and 55 years (Table 1).

Table 1: Age group of individuals who died probably by suicide in HSE West, January 2006–May 2012

Age	n	%
18–34	17	30
34–55	22	39
55+	18	32

Suicide completers (continued)

Many individuals had a history of identifiable risk factors:

- A recurrent depressive disorder or a major depressive episode was the most common psychiatric diagnosis (44%), followed by alcohol dependence syndrome (35%).
- Eight individuals with depression (32%) were alcohol dependent or made harmful use of alcohol.
- 23% suffered from chronic pain, with six of these individuals reporting a chronic medical illness.
- 44% had a history of adverse childhood experiences.
- Those with chronic pain (23%) had higher rates of childhood trauma compared to those without a history.

Attendance at mental health services was as follows:

- 33 individuals (58%) were still registered (actively attending) mental health services at the time of their death;
- 20 individuals (35%) had been in contact with the mental health service in the month before their death; and
- 40 individuals (70%) had been previously admitted to a psychiatric unit, of whom eight had been discharged within a month of their death.

Table 2 sets out the methods of death. It shows that hanging was the most commonly used method (58%), followed by drowning (23%).

Table 2: Methods of death

Method of death	n	%
Hanging	33	58.0
Drowning	13	22.8
Overdose	7	12.3
Other*	4	6.9

* Other methods included gunshot and road traffic accidents.

Suicide had been previously attempted by 37 individuals (65%), with 11 (19%) having made three or more attempts. All individuals who were reported to have had chronic pain (n=13) had had at least one previous suicide attempt. Table 3 shows that overdose was the most common previously attempted method of suicide, followed by attempted hanging. Fourteen individuals had previously attempted hanging, with 11 of these (79%) later dying by the same method.

Toxicology reports were available for 56 individuals (see Tables 4 and 5). Antidepressants and benzodiazepines were the most common medications identified. Of those individuals with a history of depression, only nine had antidepressants detectable in their toxicology. Only one of the five individuals who had been previously diagnosed with schizophrenia had antipsychotic agents in their toxicology. Thirty-four individuals had no alcohol in their blood at the time of death. Of those who did, 11% had levels above 200mg%.

Table 3: Previous suicide attempts

Method of death	Attempted hanging n (%)	Attempted drowning n (%)	Attempted overdose n (%)	Attempted cutting n (%)	Attempted poisoning n (%)	No previous suicide attempts n (%)
Hanging	11 (13.3)	3 (9.0)	14 (42.4)	3 (9.0)	5 (15.2)	10 (30.3)
Drowning	1 (7.7)	2 (15.3)	6 (46.2)	1 (7.7)	0 (0.0)	7 (53.8)
Overdose	1 (14.3)	1 (14.3)	5 (71.4)	1 (14.3)	1 (14.3)	1 (14.3)
Other*	1 (25.0)	1 (25.0)	1 (25.0)	0(0.0)	0(0.0)	2 (50.0)
Total	14	7	26	6	6	20

* Three individuals died by gunshot and one by crashing a vehicle at high speed.

Table 4: Toxicology data obtained from post-mortem reports

Toxicology (drugs)	n	%
No drugs detected	25	44.6
Antidepressants	19	33.9
Benzodiazepines	16	28.6
Analgesics	9	16.1
Antipsychotics	7	12.5
Opiates	4	7.1
Mood stabilisers	4	7.1
Hypnotics	4	7.1
Cocaine	2	3.6

Table 5: Alcohol level at post mortem (mMol/l)

Toxicology (alcohol level)	n	%
None detectable	34	60.7
1–79mg%	9	16.1
80–199mg%	7	12.5
>200mg%	6	10.7

Conclusions

The study found that a history of previous attempted hanging was an important predictor of 'completed suicide' by hanging. The authors concluded that local policy for admission should reflect this risk.

The study also confirmed that recent discharge from inpatient service is a time of increased risk of completing suicide. Toxicology results also showed that less than one third of the individuals were taking their prescribed medication. The authors deemed this a high rate of non-compliance with treatment, and an important risk factor to consider when working with this group of patients.

High rates of adverse childhood experience were reported in the case notes of individuals who died by probable suicide. The high levels of suicide attempts and/or deliberate self-harm show that a greater emphasis needs to be given to the national clinical programme for the management of self-harm.

While alcohol was not detected in 60% of individuals, it is still an indicator of increased risk.

(Linda O'Connor)

1. Kielty J, van Laar A, Davoren M, Conlon L, Hillick A, McDonald C and Hallahan B (2014) Psychiatric and psychosocial characteristics of suicide completers: a comprehensive evaluation of psychiatric case records and post-mortem findings. *Irish Journal of Psychological Medicine*, available at CJO2014. doi:10.1017/ipm.2014.47

HRB publishes drug and alcohol evidence reviews



In December 2014 the Health Research Board published the first two issues in its drug and alcohol evidence review series. The reviews are on the topics of prevention¹ and recovery capital.² The series is part of the process of knowledge transfer and exchange between the HRB and those engaged in developing and implementing responses to problem drug and alcohol use in Ireland. The reviews are intended to support drug and alcohol task forces, service providers and policy makers in using research-based knowledge in their decision-making, particularly in regard to assigned actions in the National Drugs Strategy.

Topics for review are selected following consultation with stakeholders to identify information gaps and to establish how the review will contribute to evidence-based selection and implementation of effective responses.

The authors of the first two reviews used a technique known as Rapid Evidence Assessment (REA) which is designed to get to grips with available research evidence on a policy or practice issue, as comprehensively as possible within a limited period. To determine if there was a solid evidence base in the two chosen areas, the researchers looked at (1) the quality of research studies that make up the body of evidence, identifying well designed and executed studies that used reliable measures to assess if something worked; (2) the quantity of studies, as the strength of the evidence depends on the number of studies that have tested a particular approach; (3) the consistency of the findings produced by those studies, to see how many report the same or similar findings; and (4) the social context in which the research was done.

Some of the findings from the two reviews are presented here.

Efficacy and effectiveness of drug and alcohol abuse prevention programmes delivered outside of school settings

The researchers focused on studies published since 2008. Following their initial search they filtered the literature by quality and relevance. The review is based on 33 articles, 12 of which are original research studies and 21 are reviews.

The research evidence suggests that while community-based approaches to preventing drug and alcohol abuse by young people are promising, the evidence is not strong enough to say with certainty which specific programmes work best. Some good-quality evaluation studies have measured the impact of community-based drug and alcohol prevention programmes but there are not yet enough studies looking at the same kind of services in a way that would tell us what works best. Several studies are good, using appropriate research designs and reporting their results properly, but many failed to implement the research methods effectively, or did not adequately report data from their outcome measures.

Despite this we can say that the literature does support community-based prevention interventions that address the range of social and personal issues typically faced by young people who experience difficulties arising from substance abuse. There is potential in multi-dimensional or multi-model approaches. There are many published evaluations of standardised prevention programmes supported by clear instructions and manuals, many of which involve working with the families of young people. They typically include work to address family functioning, parental support, monitoring children's behaviour and normative beliefs, social skills, and self-efficacy. Evidence for impact of family interventions such as Communities That Care (CTC), Strengthening Families Program (SFP) and Focus on Families (FOF) is promising.

Because they each look at different approaches to prevention, and tend to use different ways of measuring outcomes, it is impossible to pull results from good-quality studies together to get a clear picture of what works best. This inconsistency could be overcome if services would agree to use a common set of measures to assess impact. This would help to increase understanding of what works best and for which client groups, facilitate the sharing of good practice and, ultimately, build a solid body of evidence.

Developing shared outcome measurement would involve services working together to identify what is common in the reasoning behind choosing particular programmes and the similarities in their delivery. They could then also work to develop common data collection systems.

Role of social and human capital in recovery from drug and alcohol addiction

This review looked at recent evidence of how social capital can make a difference to people recovering from drug and alcohol addiction. The authors focused on studies published since 2008. Following their initial search they filtered the literature they found by quality and relevance. The review is based on 26 articles, 21 of which are original research studies, and 5 are reviews.

Research has consistently shown how important it is to understand the social lives of recovering addicts. A good social network seems to provide recovering addicts with a sense of their own self-worth, what psychologists call self-efficacy. The extent to which friends and families support abstinence, the ability to be financially independent, a

HRB evidence reviews (continued)

safe and secure place to live and activities that provide alternatives to substance abuse all contribute to what researchers call 'social capital' or 'recovery capital'. Having supportive friends or family helps to persuade recovering addicts that they can change their substance-abusing behaviour: friendships can provide a person in recovery with examples of success, knowledge that others care about what they are trying to achieve, and a sense that they are capable of planning their own lives. This kind of support is what may be provided through the social networking aspects of fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

One of the purposes of the research was to support task forces in identifying useful ways of measuring their work and the review found a number of examples of how the availability of social capital could be monitored. These include:

- The Perceived Sense of Community Scale (PSCS) looks at the extent to which recovering addicts feel a sense of belonging to social groups they consider to be part of their community;
- The Recovery Capital Scale (RCS) is a 35-item self-report questionnaire that can be administered as an interview;
- The Assessment of Recovery Capital (ARC) scale is a brief and easy-to-administer measurement of recovery capital, designed for use as an outcome measure for dependent individuals in and out of treatment; and
- Quality of Life (QoL) measures assess an individual's satisfaction with life in general and provide a useful means of measuring personalised support.

There is good evidence that social capital contributes to recovery. The reviewers identified a number of areas in which further work needs to be done so that this process can be understood better. We need to know more about how self-help groups provide a source of social capital; how the need for social support changes for people over the course of the recovery process; what types of social capital suit particular people and why needs in this area differ from person to person; and what are the financial costs and benefits of providing the kinds of support that will lead to recovery.



Dr Barry Cullen, HRB board member, who launched the first two reports in the HRB's Drug and Alcohol Evidence Review series, and John Bennet, Coordinator Finglas Cabra Drug and Alcohol Task Force.



Coordinators of local drug and alcohol task forces who attended the launch of the HRB's drug and alcohol reviews in the HRB on the 3rd of December.

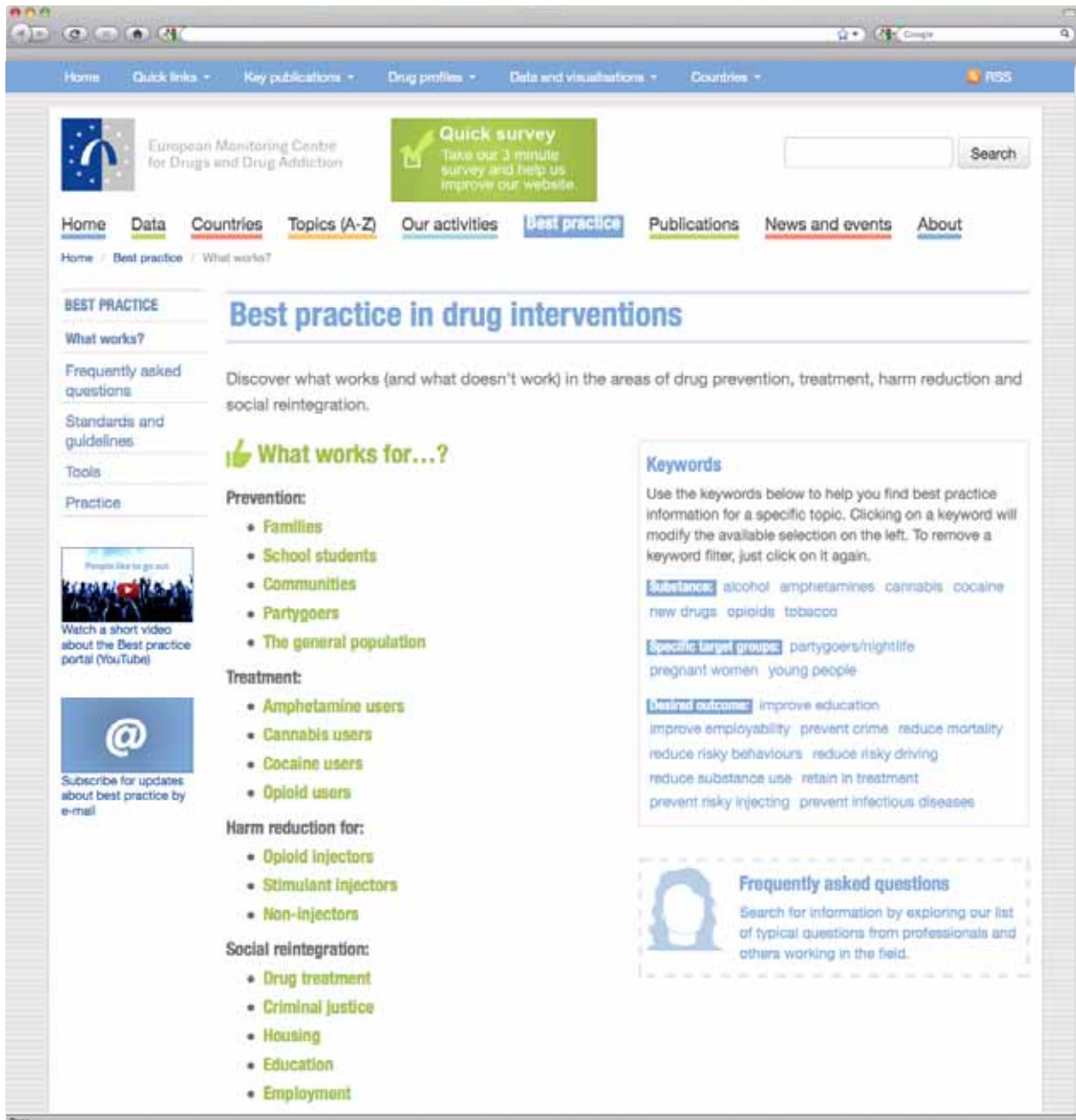
As in the prevention area, developing shared measurements for the impact services have on recovering drug users would both help to improve services and make achievements in this work more apparent. Service providers would need to identify shared ways of measuring social capital, consider how shared working with housing and other services could be improved and learn to collect information that will help contribute to cost-benefit analyses.

Hard-to-measure qualitative outcomes of community-based programmes, involving extensive collaboration between stakeholders, have been captured and these examples could be applied very usefully to evaluate programmes supporting recovery. It would be a significant achievement if different services were to use a common approach to measuring impact, as it would lead to better outcomes for the people using services and provide evidence that task forces play an integral and valuable part in responding to problem drug use in Ireland.

(Brian Galvin)

1. Munton AG, Wedlock E and Gomersall A (2014) *The role of social and human capital in recovery from drug and alcohol addiction*. HRB Drug and Alcohol Evidence Review 1. Dublin: Health Research Board <http://www.drugsandalcohol.ie/23078/>
2. Munton AG, Wedlock E and Gomersall A (2014) *The efficacy and effectiveness of drug and alcohol abuse prevention programmes delivered outside of school settings*. HRB Drug and Alcohol Evidence Review 2. Dublin: Health Research Board <http://www.drugsandalcohol.ie/23079/>

EMCDDA's new-look best-practice portal



The EU drugs agency (the European Monitoring Centre for Drugs and Drug Addiction) has a new-look best practice portal. Designed as a practical and reliable source of what works, and what doesn't, in drug-related prevention, treatment, harm reduction and social reintegration, the portal helps practitioners and professionals to:

- identify tried and tested interventions quickly,
- allocate resources to what's effective,
- evaluate and improve interventions applying practical tools, standards and guidelines, and
- take better decisions, gaining from experience and expertise across Europe.

Summarising the evidence in plain language, demystifying terminology and answering real questions from the field

(through a dynamic FAQ section), the re-designed portal provides an accessible tool to support the development of evidence-based interventions. Information is presented in top-level 'answer sheets', supplemented by underlying levels setting out the most recent evidence. Links to further information sources are available throughout the resource.

With the new portal, the EMCDDA aims to bridge the gap between scientific evidence and current practice in the drugs field. By enhancing the communication of evidence, it aims to promote the sharing of best practice between countries and better inform decision-making processes, both at national and European level. Intended as a 'living product', it will be regularly updated as new information and research on interventions emerge.

(Mary Dunne)

National Drugs Rehabilitation Framework pilot evaluated

Arising from the recommendations outlined in the report of the Working Group on Drugs Rehabilitation,¹ a National Drugs Rehabilitation Framework (NDRF) was developed.² Its purpose is to improve the provision of rehabilitation services to current and former drug users by creating integrated care pathways (ICPs) with the co-operation of different service providers. The NDRF was piloted in a number of locations and the evaluation of the pilot was recently published.³ Ten sites were selected for the pilot, but the evaluators report that only six implemented the framework.

As part of the evaluation, data were collected from 14 service users via a structured questionnaire and in-depth interviews. All 14 service users had completed an assessment as part of engaging with the NDRF, all had been allocated a key worker and two thirds had been allocated a case manager. When asked about their experience with their key workers and case managers, service users were generally very positive about the support they had received. They spoke about the benefits of connecting with services. For example, they highlighted care planning as a direct benefit; the majority had a clear idea of their goals and aspired to build on current successes. Overall, service users reported being satisfied with the service they had received through the NDRF.

Data were also collected from 48 key workers/case managers and 19 service managers. Three quarters of key workers/case managers reported always engaging in care planning, and the remainder reported engaging sometimes; similar levels of engagement in inter-agency meetings were reported. Service managers reported some difficulty in undertaking comprehensive assessments with clients. All but one service manager said care planning was being implemented but of these 18, all but three reported difficulties. Around three quarters of service managers reported some difficulty in implementing confidentiality protocols. Service managers also reported varying levels of access to support services such as addiction services, education and employment, housing, justice and law reform services. All service managers reported some engagement in inter-agency working but all reported some difficulty implementing service level agreements. Both service managers and key workers/case managers reported an improvement in communication, in sharing of information and in making referrals following implementation of the framework.

The authors point out that the evaluation was 'an examination of procedures and process rather than outcomes, with input from mostly service providers' (p. 80). This means that they do not know how the majority of service users were experiencing the work practices within the NDRF and do not know how effective these practices were in delivering identified outcomes. However, what they can say is that for a small number of service users engaging with the framework, their experience of care planning seems to have been beneficial. From the perspective of service providers, there were difficulties in implementing the NDRF; in particular, there was a need for better access to services for clients, including housing, education and employment. There was also an identified need for improved inter-agency working between services engaging with the framework.

In conclusion, the authors suggest, '...there is much goodwill towards the framework and a real desire for it to be implemented and supported in full...' (p. 97). They identify a number of overarching themes relevant to refining and implementing the framework in the future. A brief note on each theme is presented below.

Sustainability

Fears were expressed that the momentum, which was said to have carried through from the publication of the NDRF to the pilot phase of implementation, could be lost when the pilot evaluation concluded. Respondents wanted a re-emphasis of support for the principles of the NDRF from the relevant government departments.

New ways of working

In many locations the introduction of case management was reported to be problematic. Linked to this were problems with inter-agency working. Moving from the principle of inter-agency working to its implementation has to be actively worked on; these issues can be resolved through strong and consistent leadership.

Culture

New ways of working that are promoted in the NDRF, particularly inter-agency working, challenge existing cultures of working in the sector. Appropriate training to address these local cultural issues is required as part of implementation.

Non-implementation

It came as a surprise to the authors that some sites were not implementing the framework. It would help if the requirements around implementation were more direct and less open to misinterpretation.

Client-centredness

Most respondents agreed with the principle of putting the client at the centre of care planning and case management. However, respondents in statutory services had differing views from those in non-governmental organisations, with the former displaying a greater degree of scepticism.

Framework instruments and information technology

There is a tension between rigorous documentation and excessive paperwork. The majority of service provider respondents felt that the framework errs on the side of the latter: it is not possible to track service users' progress through the various steps in the framework, owing to the burden of paperwork and information technology requirements.

NDRF pilot evaluated (*continued*)

Structures

In the event of further of further evaluation, structures need to be strengthened in order to avoid a situation where pilot sites are unsure whether they are in or not, as happened with this evaluation.

Concluding remarks

This evaluation provides insights into how the NDRF is both perceived and used. Clearly there were differences in perceptions both within and across the sites that participated in the evaluation; on the one hand, there appears to be general support for the framework, while on the other hand, issues remain around some key components such as inter-agency working. In addition, some service providers clearly have difficulties in implementing elements of the framework, for example care planning.

(Martin Keane)

1. Working group on drugs rehabilitation (2007) *National Drugs Strategy 2001–2008: rehabilitation. Report of the working group on drugs rehabilitation*. Dublin: Department of Community, Rural and Gaeltacht Affairs. <http://www.drugsandalcohol.ie/6267/>
2. Doyle J and Ivanovic J (2010) *National Drugs Rehabilitation Framework document*. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/13502/>
3. Barry J and Ivers JH (2014) *Evaluation report of the National Drugs Rehabilitation Framework pilot*. Dublin: Health Service Executive. <http://www.drugsandalcohol.ie/21600/>

Quality Champions Training for addiction services

To help ensure drug treatment and rehabilitation outcomes are achieved and to maintain a high standard of client safety, Action 45 in the National Drugs Strategy 2009–2016 calls for the introduction of ‘a clinical and organisational governance framework for all treatment and rehabilitation services in Ireland’.

To implement Action 45, the Health Service Executive adopted the QuADS standards as the quality standards for drug and alcohol services in Ireland.¹ It has also engaged the Quality Standards Support Project (QSSP) to ‘contextualise’ the QuADS for Irish addiction services.²

Among the supports developed by the QSSP for projects implementing QuADS is the Quality Champions Training. It is designed to enable the learner to develop the skills they will need to champion quality improvement in their service and is delivered as a series of multimedia-based learning modules through Moodle on drugs.ie.

The modules are delivered in five sessions:

Session 1: Introduction to quality

Session 2: Organisation review and mapping

Session 3: Consultation

Session 4: Policy writing

Session 5: Implementation and policy review

Taking into account the limited resources available in community and voluntary sector services, the online learning platform on drugs.ie/quality was developed to enable learners to access training free of charge, at a time that suits them and in a location convenient to them. When asked to rate the effectiveness of online learning on a scale of 1 to 10 where 1 indicates *very poor* and 10 indicates *excellent*, participants so far have scored effectiveness at 8. Of the participants so far, 91% have self-reported an increase in their knowledge of quality standards after completing the training.

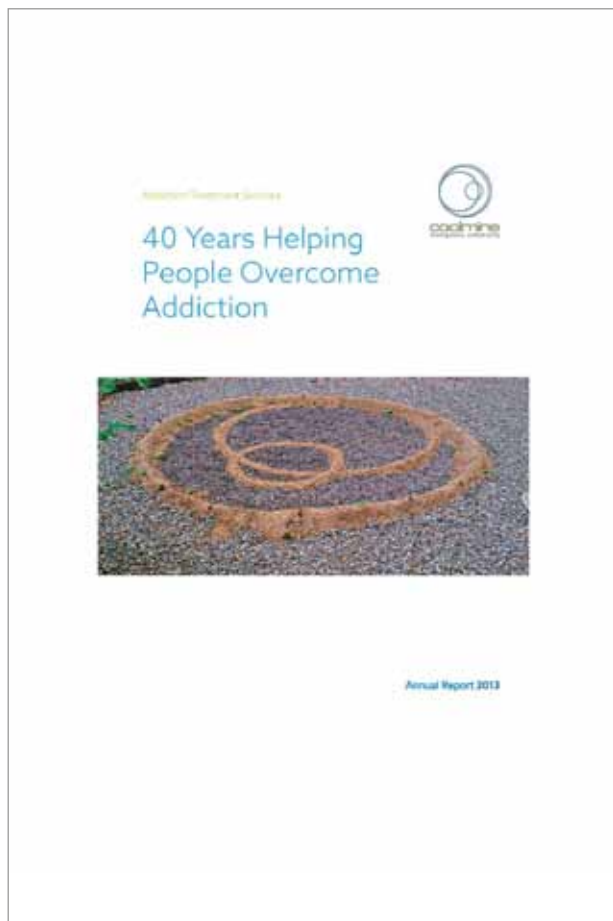
The training is accessed through a unique login, all learners need in order to participate in the course is access to a PC or laptop with internet access and basic computer skills. The learner can participate in the course at their own pace and complete it in under one day or over four weeks, and all for free.

Following a successful pilot roll-out of the course, Quality Champions Training is now open for registration. To find out more or to register for the course, contact Nicola Corrigan on nicola.corrigan@aldp.ie or quality@aldp.ie.

1. QuADS – Quality in Alcohol and Drug Services – is a quality standards framework developed in the UK by Alcohol Concern and SCODA in 1999. For more information on QuADS, see the *Report of the HSE Working Group examining Quality & Standards for Addiction Services*.
2. With the support of the HSE and Dublin’s North Inner-City Local Drugs and Alcohol Task Force, the QSSP works to support drug and alcohol services in Ireland. It supports projects to develop their services in line with good practice by providing a sustainable model to support the national development of good practice, providing learning supports, and facilitating the sharing of information between peer agencies in the development of good practice. For more information visit http://www.aldp.ie/services/quality_standards_support_project or contact nicola.corrigan@aldp.ie



Coolmine Therapeutic Community annual report 2013



The Coolmine Therapeutic Community (CTC) annual report for 2013 was launched by journalist and TV and radio presenter Matt Cooper, on 17 October 2014.¹ The report contains reports and statistics on CTC's services, as well as information on its strategic partners, funders and supporters.

The year 2013 saw CTC celebrate its 40th year of providing treatment and rehabilitation services in Ireland. During the year Coolmine worked with over 1,000 people, supporting them and their families to overcome addiction.

The annual report notes the continuing increased demand for CTC's services, and the growth of homelessness and drug use. While there was evidence of an improving economic outlook, the benefit of this improvement had yet to reach those individuals most in need. In the course of 2013 Coolmine Lodge increased its occupancy rate to an average of 28 men, a 27% increase from an average of 22 men in 2012. Ashleigh House catered for an average of 18 women, a 50% increase from an average of 12 women in 2012.

Throughout 2013 CTC maintained its emphasis on evidence-based treatments which serve to enhance the therapeutic community model. The two residential centres – Coolmine Lodge and Ashleigh House – offer a range of interventions including therapeutic groups, health promotion, relapse prevention, social skills, self-peer evaluation groups, art classes, computer courses, horticultural projects and complementary therapies. CTC staff completed training in mindfulness-based relapse prevention, mindfulness-integrated cognitive behavioural therapy and the 'Parenting under Pressure' programme, in addition to ongoing skill development and training in their core competencies.

CTC stresses that it is through this ongoing commitment to knowledge transfer, skills development and maintenance of evidence-based treatments, together with an increase in front-line staff, that it saw an average increase of 9% in client retention in its rehabilitation programme during 2013.

CTC strengthened its commitment to formal research by presenting the initial findings of a longitudinal outcomes study at the European Federation of Therapeutic Communities (EFTC) conference in September 2013. During this conference, CTC successfully bid to host both the European Working Group on Drugs Oriented Research symposium (EWODOR) in May 2014 and the EFTC conference in 2017.

Table 1: Services offered by CTC, number of participants and outcomes, 2013¹

Service	Total number of participants	Outcomes
Ashleigh House	63 women	<ul style="list-style-type: none"> ■ 13 clients completed a methadone detox placements ■ 40 mothers were worked with in Ashleigh House ■ 19 mothers had their child (children) on site on a permanent basis ■ 21 (+ 2 not attending crèche) children were worked with and attended the full-time crèche
Coolmine Lodge	139 men	<ul style="list-style-type: none"> ■ 10 clients had a methadone detox and 8 completed the detox

Coolmine in 2013 *(continued)*

Service	Total number of participants	Outcomes
Outreach	291 clients were worked with in our pre-entry groups.	<ul style="list-style-type: none"> ■ 22 clients were seen by outreach services from Ashleigh House ■ 93 clients seeking methadone detoxification admission ■ 388 clients attended Ana Liffey pre-entry groups ■ 52 individual assessments completed locally by Coolmine Outreach Team ■ 56 family three-way assessments completed
Drug-free Day Programmes	51 clients	
Welcome Stabilisation Programme	29 clients	
Family Support Services (either in group or 1-to-1)	56	
Career Guidance Service	828 individual sessions with Career Guidance Officer	<ul style="list-style-type: none"> ■ 320 clients seen in group career guidance sessions ■ 88 clients applied for education/training ■ 24 internal and external placements on Community Employment (CE) Schemes ■ 90 clients provided with literacy support ■ 10 clients took part in Business in the Community programme ■ 63 clients gained placements or volunteer work
Contingency Management Programme	32 clients	

(Vivion McGuire)

1. Coolmine Therapeutic Community (2014) *Annual report 2013*. Dublin: CTC. <http://www.drugsandalcohol.ie/22805/>

Cuan Mhuire Lumen Initiative

On 15 September 2014 President Michael D. Higgins opened the Cuan Mhuire Lumen Initiative and the newly refurbished Teach Mhuire, located in Dublin's Gardiner Street, which provides short-term accommodation for 55 homeless men who have completed a drug, alcohol, or gambling programme and who are in early recovery.

The Lumen Initiative offers residents of Teach Mhuire treatments such as group therapy, one-to-one counselling, assessment and referral, family support and relapse prevention groups.

President Higgins spoke about the work of Cuan Mhuire, the importance of their work, and about homelessness. He noted that 'lumen' is the Latin word for light and that he hoped that the project would shine some light in to the lives of those who were most vulnerable. He spoke of the complexity surrounding homelessness, and how it is often linked to many other challenges and difficulties:

They are people who know, from lived experience, that without a home, an address, citizens are also deprived in many ways of a voice in society; of the right to participate, to seek and obtain employment, to offer their skills and talents to their communities and their wider society. They are denied a sense of place, of home, of neighbourhood, and of shared solidarity and responsibility, which is critical to our living together.¹

President Higgins also spoke about addiction and the damage that it has done to both individuals and families in Ireland. In conclusion, he unveiled a plaque to commemorate the occasion.

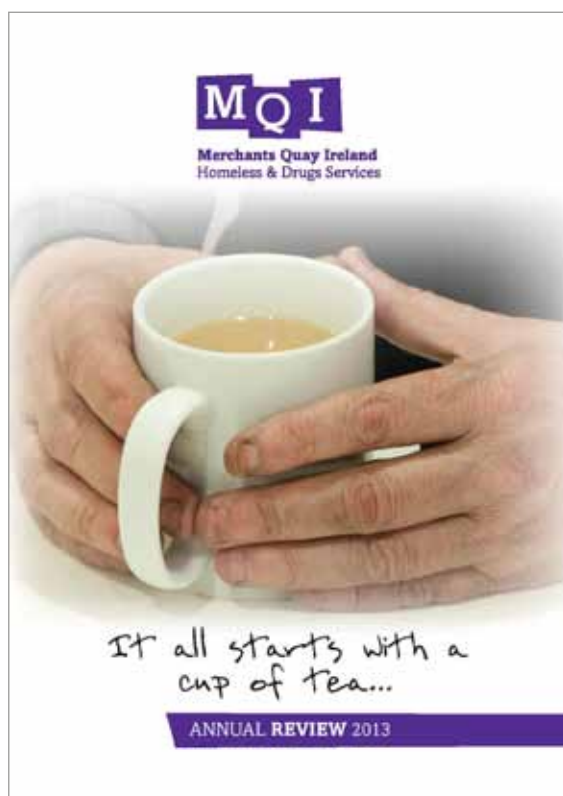
Sr Consilio, who founded Cuan Mhuire in 1966, thanked President Higgins for attending and acknowledged his long-standing friendship and support for the project. She spoke about the importance of valuing everyone equally and trying to ensure that those who are homeless are treated fairly. She acknowledged all the help and support that has been received over the years, without which Cuan Mhuire would not be able to exist.

The opening was attended by many supporters of Cuan Mhuire: the Lord Mayor, members of the Oireachtas and local councillors, current and past staff members, representatives of other agencies working in the area of homelessness and addiction, and donors, including staff of State Street Bank who had supported the refurbishment of Teach Mhuire.

(Suzi Lyons)

1. <http://www.president.ie/speeches/speech-at-the-official-opening-of-the-cuan-mhuire-lumen-initiative-gardiner-street-dublin/>

MQI annual review 2013



The Merchants Quay Ireland (MQI) annual review for 2013 was launched on 11 September 2014 by the Lord Mayor of Dublin, Christy Burke.¹

MQI's 17th annual review notes the continuing growth of homelessness and drug use. Whilst there is evidence of an improving economic outlook, the benefit of this improvement has not yet reached those individuals most in need.

The New Communities Support Service provided one-to-one support to 250 service users mostly from Eastern European countries. The largest numbers of new community clients were from Poland.

MQI's needle-exchange service recorded approximately 22,898 client visits in 2013. The report highlights a continuing high level of demand for homelessness services: 85,170 meals were provided by the day and evening services, and 4,467 health-care interventions were provided.

The year 2013 saw MQI continue to provide the national prison-based addiction counselling service to 13 prisons. Demand for this service continues to grow: 11,452 individual counselling sessions were provided, representing an 8% increase over 2012; 4,646 group attendances were recorded, representing a 27% increase. In Mountjoy Prison, MQI's counselling service co-ordinates an inter-agency programme at the medical unit.

MQI in 2013 *(continued)*

MQI in association with the Midland Regional Drugs Task Force and the HSE administers the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. In 2013:

- The family support service provided 230 group sessions and 762 individual sessions, and 771 supportive phone calls.
- The harm reduction service provided on average 257 needle exchanges each month.
- Athlone Open Door Centre had 148 clients during 2013, recording 3,264 visits and providing 2,796 meals.
- The Midlands Rehabilitation and Aftercare service worked with 41 individuals, providing 555 one-to one-sessions and 58 group sessions.

Table 1: Services/interventions offered by MQI, number of participants and outcomes, 2013

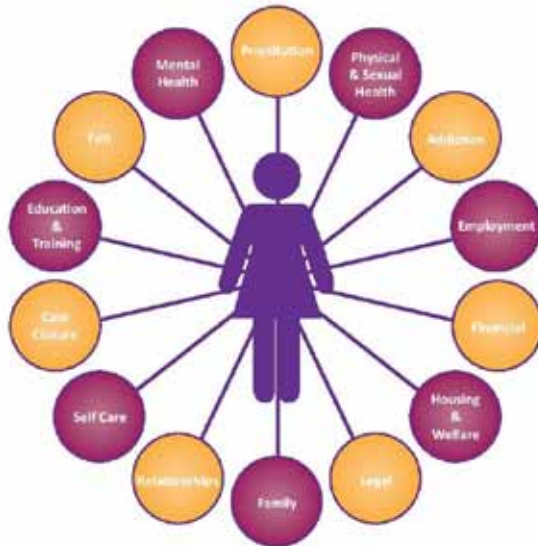
Service	Type of intervention	Total number of participants	Outcomes
Needle-exchange and health-promotion services	<ul style="list-style-type: none"> • Promotes safer injecting techniques • HIV and hepatitis prevention • Safe sex advice • Information on overdose • Early referral to drug treatment services 	3260 used needle-exchange services, of whom 614 were new clients	
Stabilisation services	Methadone substitution	20	
	Gateway programme	1251 service visits	
Integration programmes	<ul style="list-style-type: none"> • Ballymount House • Leixlip House with Respond Housing Association 	19 admissions to Aftercare Housing	Occupancy rate for Ballymount and Leixlip was 90%.
Training and work programmes	Community Employment scheme	81	Of the 28 who completed placements at MQI, 12 secured permanent employment; 1 moved to another course.
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	42 (of whom 9 were admitted for detoxification)	100% of clients completed the full programme.
St Francis Farm	Therapeutic facility offering a 14- week programme.	46	
	Detox facility	70	

(Vivion McGuire)

1. Merchants Quay Ireland (2014) *Annual review 2013*. Dublin: MQI. <http://www.drugsandalcohol.ie/22627/>

Ruhama annual report 2013

Chart 2. Care Planning Tool to assist conversation around needs and goals



On 5 November 2014 at the Alexander Hotel in Dublin, Senator Ivana Bacik launched Ruhama's annual report for 2013.¹ The launch also marked the 25th anniversary of Ruhama's work supporting women affected by prostitution and sex trafficking. Ruhama provides front-line services to these women and also advocates and lobbies for legislative and policy change to reduce the exploitation and harms associated with prostitution and sex trafficking. This article summarises the main reported activities from Ruhama's front-line services during 2013.

Street outreach

Ruhama provides practical support and information to women in street-based prostitution through its street outreach van. When Ruhama was set up in 1989, the first service it provided was this outreach support from a mobile van. The van now operates up to four nights a week: in 2013 the service was provided on 130 nights and supported 70 women, 10 of whom were referred on to Ruhama's casework service. According to Ruhama, '...addiction to drugs and/or alcohol is one of the main presenting issues for women in street prostitution...' (p. 9). In addition, women present with issues around financial debt, homelessness, poor mental and physical health, suicide ideation and domestic violence. Ruhama provides information to women on its own services and those of other agencies which may be able to assist with the problems that women present with.

Casework and care planning

The casework model that Ruhama uses involves a person-centred care plan that responds to the holistic needs of the women. As such, each care plan is tailored to the unique circumstances of each woman. In 2013, 219 women were engaged in casework with Ruhama, 96 for the first time and 123 continuing on from the previous year. The 219 women came from 36 different countries, and 83 of them were suspected of being victims of sex trafficking. According to Ruhama, '...the main focus of the care planning process

is empowerment [of the women]....This process assists women in taking control of their lives...the process also endeavours to ensure that women make informed choices out of the options available to them...' (p. 10). By the end of 2013, 63 women had completed their care plans and moved on to new opportunities.

Education and development

According to Ruhama, 'Many of the women who access Ruhama's services do not initially have the confidence for, or face barriers that restrict their uptake of, mainstream education and development opportunities...our Education and Development programme... offers practical supports which equip women with the skills they need to proceed to further education or the employment market' (p. 12). In 2013, 68 women engaged with the education and development programme, which included group activities and one-to-one sessions.

Housing and social welfare

In 2013, 42 women were supported by Ruhama to secure housing, 32 were assisted to develop budgeting skills to manage their households, and 35 were supported with processing paperwork and completing forms relevant to the housing and budgeting processes. The women presenting to Ruhama reported difficulties in accessing suitable accommodation, in particular securing accommodation through the private rental market. Ruhama reports that '... 2013 saw a marked increase in the number of Irish women accessing emergency or homeless accommodation in Dublin. For some the combination of homelessness and chaotic drug use further complicated women's positions of vulnerability and drove them further into street prostitution' (p. 15).

Conclusion

Ruhama's annual report for 2013 is a useful insight into the nature and extent of the work undertaken by the organisation. However, work of this kind with such vulnerable and marginalised women can rarely be captured by reference to numbers and categories. In the words of the chairperson of Ruhama:

...This report contains many statistics, but behind each statistic is an individual woman's story with her personal experience of prostitution. When women access our service they know they have no need to hide their experiences of prostitution; they will not be judged and will receive support to gain autonomy and make real choices (p. 3).

(Martin Keane)

1. Ruhama (2014) *Ruhama annual report 2013*. Dublin: Ruhama. <http://www.drugsandalcohol.ie/22900/>

From Drugnet Europe

New review on drugs and driving

Cited from *Drugnet Europe* No 87, July–September 2014

An estimated 28,000 lives are lost on Europe's roads every year and a further 1.34 million people are injured. Many of these accidents and deaths are caused by drivers whose performance is impaired by a psychoactive substance. Alcohol remains the number one substance endangering lives on European roads, but use of drugs and medicines behind the wheel, particularly when combined with alcohol, is a major challenge for policymakers. A new EMCDDA report — *Drug use, impaired driving and traffic accidents* — reviews the latest research in this field.¹

Released to mark International day against drug abuse and illicit trafficking (26 June), the report updates an EMCDDA literature review released in 2008. The new edition includes the results of the European Commission-funded DRUID project (2006–11), which contributed key evidence to road safety policy by mapping Europe's drink- and drug-driving problem across 13 countries. Also examined are over 500 studies, published in Europe and internationally up to 2013, with a greater emphasis placed on meta-analyses and systematic reviews, which combine and summarise the latest findings.

The report explores methodology, prevalence and the effects of substances on performance. It concludes: 'The chronic use of all illicit drugs is associated with some cognitive and/or psychomotor impairment and can lead to a decrease in driving performance, even when the subject is no longer intoxicated'. Among concerns raised in the report is the variety of drugs available today: 'The range of psychoactive substances available for illicit use is increasing, and recent studies are finding evidence of their use among drivers.'

¹ Verstraete AG, Legrand SA and EMCDDA Project Group (Vandam L, Hughes B and Griffiths P) (2014) *Drug use, impaired driving and traffic accidents* 2nd edition. Lisbon: EMCDDA. Available at www.emcdda.europa.eu/publications/insights

WHO–Europe launches new guide on prisons and health

Cited from *Drugnet Europe* No 87, July–September 2014

On 27 May, the World Health Organization's Regional Office for Europe (WHO–Europe) launched its latest guide for professionals working in the area of prison healthcare. The manual, entitled *Prisons and health*, was presented in Strasbourg at an expert meeting, co-organised by the Council of Europe's Pompidou Group and the WHO's Health in Prisons Programme, on the theme: 'Prison health in Europe: missions, roles and responsibilities of international organisations'.²

The manual is based on contributions from a large number of experts and international partners, including the EMCDDA. The guide outlines important proposals to improve the health of those in prison and to reduce the risks posed by imprisonment to health and society. In particular, it aims to facilitate better prison health practices in the fields of human rights and medical ethics; communicable diseases; non-communicable diseases; oral health; risk factors, vulnerable groups; and prison health management.

Based on the principle of prison health being a key factor of public health, the meeting also adopted the 'Strasbourg conclusions'. These highlight, among others: the right for prisoners to enjoy the same level of healthcare as others in society and the effectiveness of placing prison health services

under the jurisdiction of health (rather than justice) ministries. In the text, international organisations pledge their support for prison health reform by strengthening and coordinating their efforts to ensure implementation of these conclusions.

² Enggist S, Moller L, Galea G and Udesen C (eds) (2014) *Prisons and health* Copenhagen: WHO Regional Office for Europe. Available at www.euro.who.int/en/publications/abstracts/prisons-and-health

New study on HCV infection

Cited from *Drugnet Europe* No 87, July–September 2014

'Hepatitis: Think again' was the theme of this year's World Hepatitis Day commemorated on 28 July. To mark the occasion, the open-access online journal PLoS ONE published a new EMCDDA systematic review of data for scaling up treatment and prevention among injecting drug users infected with hepatitis C in the EU.⁴ People who inject drugs (PWID) are a key population affected by the hepatitis C virus (HCV). Treatment options are improving and may enhance prevention; however, access for PWID may be poor. The new study, one of the largest conducted on this topic and involving over 80 collaborators, concludes that data on HCV epidemiology, care and disease burden among PWID in Europe, while sparse, suggest many undiagnosed infections and poor treatment uptake. The burden of disease, where assessed, was high and is expected to rise in the next decade.

⁴ Wiessing L, Ferri M, Grady B, Kantzanou M, Sperle I, Cullen KJ, EMCDDA DRID group, Hatzakis A, Prins M, Vickerman P, Lazarus JV, Hope V and Mathei C (2014) *Hepatitis C virus infection epidemiology among people who inject drugs in Europe – A systematic review of data for scaling up treatment and prevention* PLoS One 28 July 9(7): e103345. Available at www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0103345.

The role of take-home naloxone in reducing overdose deaths

Cited from *Drugnet Europe* No 87, July–September 2014

The role of take-home naloxone (THN) in reducing opioid-related fatalities will be the focus of an EMCDDA meeting held in Lisbon on 14 October. Leading experts on the issue will come together at the event to focus on the scaling up of interventions using this medication across Europe.

The WHO will present at the meeting its new *Guidelines on the management of suspected opioid overdose* while the EMCDDA will review its upcoming paper on the *Effectiveness of take-home emergency naloxone to prevent heroin overdose*.

For more, see www.emcdda.europa.eu/topics/pods/preventing-overdose-deaths

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). It is available at www.emcdda.europa.eu.

If you would like a hard copy of the current or future issues, please contact:

Health Research Board, Grattan House, 67–72 Lower Mount Street, Dublin 2.

Tel: 01 2345 148; Email: drugnet@hrb.ie

Recent publications

Journal Articles

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

Gamma-hydroxybutyrate (GHB): a scoping review of pharmacology, toxicology, motives for use, and user groups

Brennan R and van Hout MC, *Journal of Psychoactive Drugs*, 2014, 46(3): 243–251

<http://www.drugsandalcohol.ie/22862/>

Gamma hydroxybutyrate (GHB) is a central nervous system depressant with euphoric and relaxant effects. Documentation of GHB prevalence and the under-reporting of abuse remains problematic, given the availability of GHB and its precursors γ -butyrolactone (GBL) and 1,4-butanediol (1,4-BD) and the ease of synthesis from kits available on the Internet. The continued abuse of and dependence on GHB, and associated fatalities, present an on-going public health problem. As the drug GHB remains an under-researched topic, a scoping review was chosen as a technique to map the available literature into a descriptive summarised account. PRISMA was used to assist in data retrieval, with subsequent data charting into three key themes (pharmacology and toxicology, outcomes, and user groups). Administered orally, GHB is dose-dependent and popular for certain uses (therapeutic, body enhancement, sexual assault) and amongst user sub-groups (recreational party-drug users, homosexual men). Despite the low prevalence of use in comparison to other club drugs, rising abuse of the drug is associated with dependence, withdrawal, acute toxicity, and fatal overdose. Clinical diagnosis and treatment is complicated by the co-ingestion of alcohol and other drugs. Limitations of the scoping review and potential for further research and harm reduction initiatives are discussed.

Life-time prevalence and psychosocial correlates of adolescent direct self-injurious behavior: a comparative study of findings in 11 European countries

Brunner R, Kaess M, Parzer P, Fischer G *et al.*, *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 2014, 55(4): 337–348

<http://www.drugsandalcohol.ie/22792/>

This study investigates the prevalence and associated psychosocial factors of occasional and repetitive direct self-injurious behaviour (D-SIB), such as self-cutting, -burning, -biting, -hitting, and skin damage by other methods, in representative adolescent samples from 11 European countries.

Cross-sectional assessment of adolescents was performed within the European-Union-funded project, Saving and Empowering Young Lives in Europe (SEYLE), which was conducted in 11 European countries. The representative sample comprised 12,068 adolescents (F/M: 6,717/5,351; mean age: 14.9 \pm 0.89) recruited from randomly selected schools. Frequency of D-SIB was assessed by a modified 6-item questionnaire based on previously used versions of the Deliberate Self-Harm Inventory (DSHI). In addition, a broad range of demographic, social, and psychological factors were assessed.

These results suggest high lifetime prevalence of D-SIB in European adolescents. Prevalence as well as psychosocial correlates seem to be significantly influenced by both gender and country. These results support the need for a multi-dimensional approach to better understand the development of SIB and facilitate culturally adapted prevention/intervention.

A newly identified group of adolescents at 'invisible' risk for psychopathology and suicidal behavior: findings from the SEYLE study

Carli V, Hoven CW, Wasserman C, Flaminia C *et al.*, *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 2014, 13(1): 78–86

<http://www.drugsandalcohol.ie/22790/>

This study explored the prevalence of risk behaviours (excessive alcohol use, illegal drug use, heavy smoking, reduced sleep, overweight, underweight, sedentary behaviour, high use of Internet/TV/videogames for reasons not related to school or work, and truancy), and their association with psychopathology and self-destructive behaviours, in a sample of 12,395 adolescents recruited in randomly selected schools across 11 European countries.

Latent class analysis identified three groups of adolescents: a low-risk group (57.8%) including pupils with low or very low frequency of risk behaviours; a high-risk group (13.2%) including pupils who scored high on all risk behaviours; and a third group ('invisible' risk, 29%), including pupils who were positive for high use of Internet/TV/videogames for reasons not related to school or work, sedentary behaviour and reduced sleep. Pupils in the 'invisible' risk group, compared with the high-risk group, had a similar prevalence of suicidal thoughts (42.2% vs 44%), anxiety (8% vs 9.2%), sub-threshold depression (33.2% vs 34%) and depression (13.4% vs 14.7%).

The prevalence of suicide attempts was 5.9% in the 'invisible' group, 10.1% in the high-risk group and 1.7% in the low-risk group. The prevalence of all risk behaviours increased with age and most of them were significantly more frequent among boys. Girls were significantly more likely to experience internalising (emotional) psychiatric symptoms. The 'invisible' group may represent an important new intervention target group for potentially reducing psychopathology and other untoward outcomes in adolescence, including suicidal behaviour.

Recent publications (*continued*)

Risk-behaviour screening for identifying adolescents with mental health problems in Europe

Kaess M, Brunner R, Parzer P, Carli V *et al.*, *European Child and Adolescent Psychiatry*, 2014, 23(7): 611–620

<http://www.drugsandalcohol.ie/22789/>

Indicated prevention of mental illness among youth is an important public health concern. The aim of this study was to establish a European school-based professional screening among adolescents, which included variables on a broad range of risk-behaviours and psychopathology, and to investigate the indicative value of adolescent risk behaviour and self-reported psychopathology on help-seeking and psychological problems that required subsequent mental healthcare.

A two-stage professional screening approach was developed and performed within the multi-centre study 'Saving and Empowering Young Lives in Europe' (SEYLE). The first stage of screening comprised a self-report questionnaire on a representative sample of 3,070 adolescents from 11 European countries. In the second stage, students deemed at-risk for mental health problems were evaluated using a semi-structured clinical interview performed by healthcare professionals. 61 % of participants (n = 1,865) were identified as being at-risk in stage one. In stage two, 384 participants (12.5 % of the original sample) were found to require subsequent mental healthcare during semi-structured, clinical assessment. Among those, 18.5 % of pupils were identified due to screening for psychopathology alone; 29.4 % due to screening for risk-behaviours alone; and 52.1 % by a combination of both. Young age and peer victimisation increased help-seeking, while very low body mass index, depression, suicidal behaviour and substance abuse were the best predictors of referral to mental healthcare.

Screening of risk behaviours significantly increased the number of detected students requiring subsequent mental healthcare. Screening of risk behaviours added significant value in identifying the significant amount of European pupils with mental health problems. Therefore, attention to adolescent risk behaviours in addition to psychopathology is critical in facilitating prevention and early intervention. Identifying factors that increase compliance to clinical interviews are crucial in improving screening procedures.

Modeling the impact of place on individual methadone treatment outcomes in a national longitudinal cohort study

Murphy E and Comiskey CM, *Substance Use & Misuse*, 2015, 50(1): 99–105

<http://www.drugsandalcohol.ie/22782/>

From 2003 to 2006, 215 clients were recruited to a cohort study of methadone treatment. Participants had their address and clinic geocoded. Treatment outcomes were measured at intake, at one and three years post treatment using the Maudsley Addiction Profile instrument. Spider diagrams and buffer rings were used to visually map clinics and clients. Regression models were used to measure the effect of place.

Results: Clients' accommodation and social and criminal problems in the region had a medium to large effect on heroin use. Analysis of buffer rings revealed that clients located within a 10-km radius of a major clinic demonstrated poorer outcomes in terms of heroin use.

Conclusion/Importance: Findings illustrated the relevance of geography to drug treatment outcomes and the planning of services.

Regulatory approaches to new psychoactive substances (NPS) in the European Union

Hughes B and Griffiths P, *Addiction*, 2014, 109 (10):1591–1593

<http://www.drugsandalcohol.ie/22745/>

As in New Zealand, three European countries (Ireland, Poland, Romania) have chosen to reverse the established control model, using effect-based definitions; the supply of any unregulated psychoactive substance that meets certain criteria is banned unless specifically permitted.

The association between family affluence and smoking among 15-year-old adolescents in 33 European countries, Israel and Canada: the role of national wealth

Pförtner T, Moor I, Rathmann K, Hublett A *et al.*, *Addiction*, 2014, Early online

<http://www.drugsandalcohol.ie/22734/>

This study examines the role of national wealth in the association between family affluence and adolescent weekly smoking, early smoking behaviour and weekly smoking among former experimenters. Data were used from the Health Behaviour in School-aged Children (HBSC) study conducted in 2005/2006 in 35 countries from Europe and North America that comprises 60,490 students aged 15 years. Multi-level logistic regression was conducted using Markov Chain Monte Carlo (MCMC) methods to explore whether associations between family affluence and smoking outcomes were dependent on national wealth.

Upcoming events

March

March 2015

58th session of the Commission on Narcotic Drugs (CND): Special segment on preparations for the special session of the General Assembly (UNGASS) on the world drug problem to be held in 2016

Venue: Vienna

Further information: <https://www.unodc.org/unodc/en/commissions/CND/index.html?ref=menuaside>

Provisional agenda includes:

- General debate on the special session of the General Assembly on the world drug problem to be held in 2016.
- Interactive discussions on high-level workshops to be held during the special session of the General Assembly on the world drug problem:
 - (a) Workshop 1: demand reduction and related issues — drugs and health;
 - (b) Workshop 2: supply reduction and related measures and countering money-laundering and promoting judicial cooperation — drugs and crime;
 - (c) Workshop 3: crosscutting issues — drugs and human rights, and youth, women, children and communities;
 - (d) Workshop 4: drugs, sustainable development and international cooperation.

April

April 2015

Annual conference: Girls, women and alcohol

Organised by: Alcohol Action Ireland

Further information: <http://alcoholireland.ie/>

Girls, women and alcohol will be the focus of Alcohol Action Ireland's annual conference. During the conference, expert speakers will examine the factors influencing alcohol consumption and drinking patterns among Irish girls and women, the health risks involved, as well as what we need to do to bring about a positive change to the current situation. Women will also share their personal experiences of alcohol with conference attendees.

May

20–22 May 2015

9th Annual Conference of the International Society for the Study of Drug Policy (ISSDP)

Venue: Ghent, Belgium

Hosted by: Institute for Social Drug Research (ISD), Department of Criminal Law and Criminology, Faculty of Law, University of Ghent

Further information: <http://issdp.org/>

Information: The ISSDP conference is held in May each year. The aims of the conference are to present original scientific research on drug policy; create opportunities for vigorous discussion and debate about findings and methods; provide an environment conducive for networking and the establishment of new collaborations; and provide a stimulus for delegates to publish their work in journals. Besides the plenary sessions, the 2015 ISSDP conference will offer space for panel discussions, poster sessions, and workshops.

September

23–25 September 2015

First European conference on addictive behaviours and dependencies

Venue: Lisbon

Organised by: Portuguese General Directorate for Intervention on Addictive Behaviours and Dependencies (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências — SICAD), the journal *Addiction*, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the International Society of Addiction Journal Editors (ISAJE).

Web: <http://www.lisbonaddictions.eu/html.cfm/index231960EN.html>

This conference will be a comprehensive and multi-disciplinary event, showcasing leading European addiction research in the specialist areas of illicit drugs, alcohol, tobacco, gambling and other addictive behaviours. It will address new challenges and cover developing fields such as new psychoactive substances, online sales and gambling, cannabis legalisation and alcohol pricing. This conference will provide a unique networking opportunity for researchers, practitioners and policy experts across countries and disciplines to discuss latest findings on the prevention, treatment and control of addiction. It is the ideal venue to forge collaborative partnerships and explore funding opportunities.

Just out

New 'policy tool' supports transparency and open debate

Identifying effective approaches to creating coherent policies regarding licit and illicit drugs has been the priority of the Pompidou Group during its 2010–14 work programme. It has produced four reports on the subject. The third report, published in 2012, proposed six markers around which the concept of coherency may be said to develop:¹

1. conceptualisation of the policy problem
2. policy context
3. legislative and regulatory frameworks
4. strategic frameworks
5. responses/interventions
6. structures and resources

In using these six markers the aim is to establish to what extent different drugs policies are in line with the concept of 'well-being', which is part of the World Health Organization's overarching goal in relation to licit and illicit drugs as well as other addictive behaviours such as gambling or the Internet. At the very least, the six aspects of policy highlighted by the six markers should not be in conflict with the overarching goal, and at best should contribute to its realisation.

In 2013 and 2014 researchers refined the six markers and tested them in their countries, namely Croatia, the Czech Republic, Hungary, Ireland, Israel, Italy, Norway and Portugal, to verify whether they provided a valid tool to measure the coherency of policies on psychoactive substances with the overarching goal of the well-being. For each marker, the authors were asked to assess the level of coherency in their country, and this was then converted into a numerical value – thus, high=3, medium=2 and low=1. The results were entered in a spreadsheet and converted into a spider diagram, with the high measure on the outer perimeter. This simple graphic representation shows at a glance the strengths and weaknesses of different policies and points the way to identifying options for strengthening policy coherency.

The results published in the most recent report, Coherency policy markers for psychoactive substances, indicate that such markers may indeed be used as a basis for discussion on the issue of coherence and in some cases as a means to better implement coherent policies in respect of psychoactive substances and also possibly other forms of addictive behaviour.²

Case study – Croatia

The spider diagram contained in the report written by the Croatian Office for Combating Drug Abuse (see Figure 1) demonstrates how Croatia's illicit drugs policy is by far the most coherent of all their policies relating to addictive behaviours, while gambling policy is the least coherent; alcohol and tobacco policies fall somewhere in between, although the strategic

framework for implementing tobacco policy is substantially stronger than that developed for alcohol.

Looking at the markers rather than the policies, it is evident that Croatia's legislative/regulatory frameworks for each policy area are the most coherent in terms of contributing to the well-being of the Croatian population as a whole, while structures/resources and responses/interventions are the areas showing least coherency. This assessment can form the basis for an open and transparent debate on how to address the shortcomings.

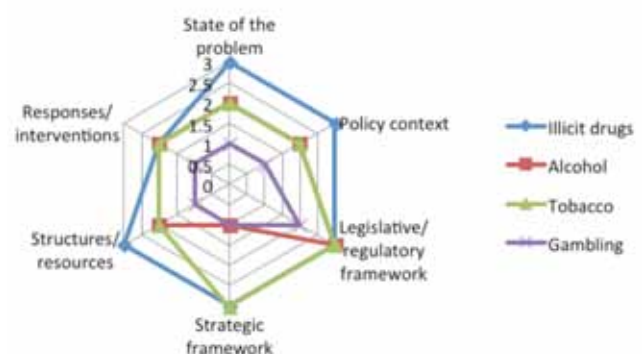


Figure 1: Summary of the assessment of six markers for coherence of policies on illicit drugs, alcohol, tobacco and gambling, Croatia

The authors of the Croatian report describe how they facilitated discussion. After the relevant bodies and experts in charge of the co-ordination and implementation of policies on psychoactive substances and addictive behaviour had assigned values (high, medium or low) for each of the six markers, these same people were invited to form a focus group in order to give more detailed insights into the issues and to clarify any ambiguities. In addition, there was a detailed analysis of the key strategic documents. On the basis of this 'triangulation', the authors were able to identify a series of specific actions to strengthen the coherency of addiction policies.

(Brigid Pike)

1. Muscat R, Pike B and Members of the Coherent Policy Expert Group Pompidou Group (2012) Reflections on the concept of coherency for a policy on psychoactive substances and beyond. Strasbourg: Council of Europe.
2. Muscat R, Pike B and Members of the Coherent Policy Expert Group Pompidou Group (2014) Coherence policy markers for psychoactive substances. Strasbourg: Council of Europe.