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Issue 46
Summer 2013

Alcohol and Drug Research Newsletter

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EU National Drug Co-ordinators meet in Dublin

Alex White TD, Minister of State at the Department of Health, hosted a meeting of the EU National Drug Co-ordinators in Dublin Castle on 8–9 April 2013 as part of the Irish Presidency of the Council of the European Union. The meeting brought together drug policy formulators from member states and EU institutions.

Speakers at the EU National Drug Co-ordinators meeting:

Front row: l to r, Dr Austin O'Carroll, general practitioner; Detective Sergeant Brian Roberts; Michael Conroy, Drug Policy Unit DOH; Minister Alex White TD; Dr Suzi Lyons, HRB; Professor Catherine Comiskey, NACDA chair.

Middle row: l to r, Ms Geraldine Hartnett, manager of family services Aislinn; Dr Denis O'Driscoll, chief pharmacist HSE Addiction Services; Ms Megan O'Leary, development worker Family Support Network; Mr Fergal Black, director of health care Irish Prison Services; Mr Tony Geoghegan, CEO Merchants Quay Ireland.

Back row: l to r, Mr Joe Doyle, national planning specialist, HSE Social Inclusion; Ms Brid Walsh, national rehabilitation co-ordinator, HSE; Mr Tony Duffin, director Ana Liffey Drug Poject; Mr Ger Twohig, project worker RADE; Mr Joe Kirby, rehabilitation co-ordinator, HSE Cork/Kerry.

While referring to the complexities and difficulties of the drug phenomenon, which he said is truly global in nature, Minister White also spoke of the problems being experienced by individuals, families and communities on the ground. He spoke of his responsibility for the implementation of the Irish National Drugs Strategy (NDS), and the structures established to maximise the chances of the 63 actions of the NDS being implemented. He also told delegates:

> At EU level we must address the challenge of ensuring that there is a focus on the implementation of agreed Actions, particularly through the Horizontal Working Party on Drugs, but also through robust links with other EU bodies and through meetings of the EU National Drug Co-ordinators. On the international level he added: If we as the EU can speak with one strong voice at international fora we can really make an impact on the overall global drugs situation.

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EU National Drug Co-ordinators meet *(continued)*

The theme of the two-day meeting was 'From Use to Recovery: Experiences and Future Approaches in Drug Policy'. Speakers from Ireland's statutory, community and voluntary sectors addressed the meeting on a range of topics including drug prevalence in Ireland, drug treatment provision, recovery and rehabilitation, as well as legislation to tackle drugs supply in Ireland – all with a focus on policy issues.

Delegates from across EU member states and the EU institutions also provided contributions and responses covering aspects of drugs policy across the EU. The meeting concluded with a presentation on the drugs situation in Croatia, with the accession of that country to EU membership due to take place in July 2013.

As part of the effort to ensure the relevance and timeliness of the national drug co-ordinators conference, the Irish Presidency took the innovative step of choosing recovery as the theme of the conference as it is a key policy area of the forthcoming EU Action Plan on Drugs. The Irish Presidency made a presentation on the outcomes of the conference to a subsequent meeting of the Horizontal Working Party on Drugs (HDG), highlighting four issues that featured prominently in discussions during the two-day conference:

- access to treatment for marginalised groups;
- the benefits of interagency working;
- the need to address the holistic needs of people; and
- the challenges and possible responses in developing drugs policy in a time of recession.

The HDG will be encouraged to focus further on these issues and to continuously monitor and review progress on the implementation of the Action Plan when it is finalised.

Ireland's 7th EU Presidency and drug policy[1]

Ireland has earned a reputation for energetically pursuing drug policy issues when holding the Presidency of the Council of the European Union. For example, the first joint European action on drugs was adopted in December 1996 when Ireland held the Presidency.[2] In 2004, during its next tenure of the Presidency, Ireland kicked off the development of the EU Drugs Strategy 2005–2012 with a major EU drugs conference in Dublin.[3] During the first six months of this year, Ireland has presented a draft EU Action Plan on Drugs 2013–2016 to the other 26 member states and the EU institutions. Since then Ireland has worked steadily as 'neutral arbiter' to win agreement on its contents.[4] It is anticipated that all outstanding issues will have been resolved by the time of the June meeting of the Council of Justice and Home Affairs Ministers and that the Council will adopt the Plan.

Leading on EU drug policy gives Irish policy makers unique first-hand experience of the international dimensions of the drug problem. They gain a deepened awareness of the similar challenges faced by different countries, the interconnectedness of the issues not only between different countries around the globe but also between the global, EU, national and local levels. So observes Michael Conroy, head of the Drug Policy Unit in the Department of Health, who has also headed the Irish Presidency Steering Group on Drugs Issues, which comprises a small number of officials drawn from his own department and from the departments of Foreign Affairs and Trade, and Justice and Equality. Set up in early 2012, this steering group has itself been drawn from the larger International Drug Issues Group (IDIG), which meets every quarter to co-ordinate Ireland's drug policy responses on the international stage.[5] Members of the larger group, including representatives of An Garda Síochána, Revenue's Customs Service and the Irish Medicines Board, have also contributed to the work of the steering group when requested.

EU policy

Work on drugs policy at EU level proceeds via the Horizontal Working Party on Drugs (HDG), a working party of the European Council, comprising representatives from each of the 27 member states and based in Brussels.[6] The Presidency chairs the monthly meetings of the HDG, organises presentations and seeks decisions. Professor Des Corrigan, formerly chair of Ireland's National Advisory Committee on Drugs, has chaired the HDG during Ireland's Presidency.

As well as focusing on the EU Action Plan on Drugs, the Irish Presidency has sought to advance a proposal for EU-wide legislation on new psychoactive substances. At this stage many member states have gone further than the EU in progressing legislation controlling new psychoactive substances at national level. For example, under the Misuse of Drugs Acts, Ireland has banned approximately 260

Ireland's 7th Presidency and drug policy *(continued)*

substances and a further 40 are in the pipeline, and the Criminal Justice (Psychoactive Substances) Act 2010 has led to the closure of most headshops in Ireland. By contrast, under current EU legislation only three new psychoactive substances have been banned across all 27 member states and a further two are in the pipeline. Thus, there is not a uniform approach to the control of new psychoactive substances across the member states and it is not possible to effectively control the availability of these substances within the EU. The proposal is expected to revise the 2005 EU legislation,[7] and to speed up the process for bringing new substances under control. At the time of going to press, the proposals were still being finalised by the European Commission.[8]

The Presidency also organises meetings of various EU expert and NGO groups. In April the EU's national drug co-ordinators met in Dublin for their regular six-monthly meeting (see separate article on this meeting). In February representatives of the EU's Civil Society Forum on Drugs (CSF) met with the HDG to give their views on the draft EU Action Plan on Drugs. The member organisations of the CSF are appointed for two-year periods, and in June 2013 the members of the newly appointed CSF, including representatives from Merchants Quay Ireland and CityWide Drugs Crisis Campaign, will meet in plenary session with the HDG. This further engagement under the Irish Presidency will be the first ever such meeting between the entire membership of both bodies.[9]

International policy

Beyond its borders, the EU plays an influential role in drug policy at international level, and Ireland has been to the forefront of this work for the first half of 2013. At the 56th Session of the Commission on Narcotic Drugs (CND), the UN's drug-policy-making body, which brings together representatives from all over the world to debate drugs policy and its implementation, Minister of State Alex White TD delivered the opening EU Statement at the first Plenary Session. The Minister commented: 'This is a vitally important conference providing an opportunity to debate policies and strategies to combat the drugs problem worldwide. I had an opportunity to hear the views and experiences of countries from every region of the world. As we address the enormous challenges associated with drugs misuse in Ireland, we must also continue our work in the international context, particularly through the Irish Presidency of the European Council.' Ireland with the European External Action Service (EEAS) co-ordinated the European input to the CND, including five resolutions sponsored by the EU (see separate article in this issue on the 56th Session of the CND). In a hectic schedule, Minister White also availed of the opportunity at the CND to hold bilateral meetings with New Zealand and Ecuador.

The EU is also engaged in dialogues on the drugs problem with regions and individual countries around the world. In conjunction with the EEAS, Ireland has led the EU representation in meetings with the Community of Latin American and Caribbean States (CELAC), the Western Balkans, and the United States.

CELAC: Ireland is leading EU efforts to agree a joint Declaration on drugs between CELAC and the EU, to be concluded at a High-Level Meeting between the two regions in Quito, Ecuador, in June 2013, which Minister White will co-chair with his counterpart from Ecuador. The first Technical Meeting involving the 27 EU member states and 33 CELAC member states, and co-chaired by Degorah Salgado Campana (Ecuadorian Ambassador to the EU) and Michael Conroy of Ireland's Department of Health, took place on 17 April. A further such meeting took place in May leading up to the High-Level Meeting in June. This High-Level Meeting will feature a number of thematic debates on current global drugs issues.

This High-Level Meeting follows the ratification of the Political Dialogue and Cooperation CAN–EU Agreement and Joint Declaration at the 11th meeting of the High-Level Specialised Dialogue on Drugs CAN-EU, held in Quito in October 2012,[10] and the Santiago Declaration jointly issued in January 2013 by the EU and CELAC and renewing their 'strategic partnership'.[11] Paragraphs 35 and 36 of the Santiago Declaration commit the two regions to strengthening co-operation on aspects of the drugs issue, including preparations for the 2016 Special Session of the UN General Assembly (UNGASS) on the world drug problem.

Western Balkans: Since 2003 the EU has had a joint action plan with the six countries of the Western Balkans to address drug-related problems in the region. These include the issue of the 'Balkan route' used by drug traffickers between Afghanistan and south-eastern Europe. Ireland led the EU delegation at a meeting in February and agreement was reached that the action plan that expires this year would be renewed by means of a Declaration to be signed at a High-Level Meeting in November under the Lithuanian Presidency.[12] Work on the Declaration is progressing at the HDG under the Irish Presidency.

United States: The EU meets formally with the United States every six months to discuss drug-related matters. A meeting under the Irish Presidency was scheduled for May. The availability and abuse of prescription and over-the-counter drugs were anticipated to feature in the discussions.

Dublin Group: This is an informal consultation and co-ordination mechanism for global, regional and country-specific problems of illicit drugs production, trafficking and demand. Its participants include the 27 member states of the EU, Australia, Canada, Japan, Norway, the United States, the European Commission and the UN Office on Drugs and Crime (UNODC). The group first met in Dublin in 1990, during the fourth Irish Presidency of the EU. It now meets in Brussels every six months. Discussion at the meetings focuses on the production and trafficking of drugs on a regional basis and ways of curbing these activities.[13] The Dublin Group is due to meet in Brussels during the Irish Presidency in June.

(Brigid Pike)

1. Thanks to Michael Conroy, Dairearca Ní Néill and Brendan Ryan of the Drug Policy Unit in the Department of Health for generously taking the time to give a briefing on the work of Irish Presidency. This briefing formed the basis for this article.
2. Decision No 102/97/EC of the European Parliament and of the Council of 16 December 1996 adopting a programme of Community action on the prevention of drug dependence within the framework for action in the field of public health (1996–2000) [Official Journal L 019 , 22/01/1997 P. 0025 – 0031]. See also T Boekhout van Solinge (2002) *Drugs and decision-making in the European Union*. Amsterdam: Mets and Schilt. www.drugsandalcohol.ie/3671/
3. Note from the Council of 22 November 2004 on the EU Drugs Strategy for the period 2005–2012 [15074/04]. See also B Pike (2004) Groundwork for new EU Drugs Strategy to be laid during Irish presidency. *Drugnet Ireland* (10): 1. www.drugsandalcohol.ie/11353/

Ireland's 7th Presidency and drug policy *(continued)*

4. Note from the Presidency to the Horizontal Drugs Group on 3 April 2013 on Draft EU Action Plan on Drugs (2013–2016) [5418/2/13 REV 2]. Ireland began drafting the drug action plan in late 2012, and built on the work already put in by the previous holder of the EU Presidency, Cyprus.
5. For the establishment of the IDIG, see Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*, Dublin: Department of Community, Rural and Gaeltacht Affairs, paras. 6.92–6.100 and Action 61. www.drugsandalcohol.ie/12388/
6. Agendas for 'Meeting of the Horizontal Working Party on Drugs' are available at http://register.consilium.europa.eu
7. Council Decision 2005/387/JHA (10 May 2005) on the information exchange, risk-assessment and control of new psychoactive substances. *Official Journal of European Union*, L 127/32 (20 May 2005)
8. For details of the European Commission's work, see Pike B (2012) EU drug policies under review in 2012. *Drugnet Ireland*, (41): 8. www.drugsandalcohol.ie/17269/
9. For further information on the CSF, visit http://ec.europa.eu/justice/anti-drugs/civil-society/index_en.htm The CSF's views on the EU drugs strategy 2012–2020 are summarised in Pike B (2012) Alternative ways forward for EU drugs policy. *Drugnet Ireland*, (43): 8–9. www.drugsandalcohol.ie/18458/
10. CAN comprises four countries in the Andean region – Bolivia, Columbia, Chile and Peru. The EU-CAN High-Level Specialised Dialogue on Drugs was established in the mid-1990s to bring together high-level experts from both sides to exchange views on how best to address the drugs phenomenon and how to co-ordinate efforts.
11. Council of the European Union (27 January 2013) Santiago Declaration. [5747/13. PRESSE 31]
12. Council of the European Union (17 July 2009) Draft Action Plan on drugs between the EU and the Western Balkan countries (2009–2013). [12185/09]
13. T Boekhout van Solinge (2002) *Drugs and decision-making in the European Union*. Amsterdam: Mets and Schilt, pp. 114–117. www.drugsandalcohol.ie/3671/

Commission on Narcotic Drugs meets for 56th Session

Between 11 and 15 March 2013 over 1,000 representatives from UN member states and civil society met in Vienna for the 56th Session of the Commission on Narcotic Drugs (CND). The CND is the central policy-making body within the UN system dealing with illicit drugs and is the governing body for the work of the UN Office on Drugs and Crime (UNODC), which is based in Vienna. The CND provides member states and civil society with the opportunity to exchange expertise, experiences and information on drug-related matters and to develop a co-ordinated response.

Holding the EU Presidency (see separate article in this issue), Ireland co-ordinated with the European External Action Service (EEAS) the EU input to the Session. The CND adopted a total of 18 Resolutions, five of which were tabled by the EU – forensic drug profiling, HIV/AIDS, Western Africa, an electronic import and export authorisation system and drug precursors. A Resolution on new psychoactive substances tabled by the United Kingdom was co-sponsored by Ireland and supported by the majority of EU member states.[1]

Preparations were also put in train for the high-level review of the implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (2009),[2] which will be undertaken during next year's Session. This political declaration and action plan sets 2019 as the target date for member states to eliminate or reduce significantly and measurably the diversion of and trafficking in substances frequently used in the illicit manufacture of narcotic drugs and psychotropic substances. Thought was also given by participants to preparing for the Special Session of the UN General Assembly (UNGASS) on the drug problem, to be held in 2016, the first such session since 1998 when the UN resolved to achieve a drug-free world by 2008. It is anticipated that these two reviews will help refine the international community's approach to illicit drugs.

The view from civil society

Non-governmental organisations (NGOs) and civil society organisations (CSOs) are encouraged to participate in the annual sessions of the CND, both before, during and after the conclusion of the proceedings.[3] This year representatives of over 160 CSOs participated. The feedback from two CSOs indicate that there has been a sea-change in the approach being taken by member states with regard to drug policy.

Canadian Drug Policy Coalition: 'As the meeting commenced it became clear that there was something different in the air this year. … My take is that there is an implicit if not explicit recognition that the drug policy landscape is indeed changing, new approaches are being considered, and countries are beginning to demand a wider debate on policy. For the CND to remain relevant these debates should be welcomed as an important opportunity at future meetings of the Commission.'[4]

International Drug Policy Consortium: 'These annual meetings have long provided frustration for civil society, which has fought hard to have a voice in the debates. Broadly speaking, however, this year represented an improvement on previous events – a further sign that things are slowly changing within the United Nations drug control structures.'[5]

(Brigid Pike)

1. For Session agenda, reports and resolutions, see www.unodc.org/unodc/en/commissions/CND/session/56.html
2. High-level segment of Commission on Narcotic Drugs, Vienna,11–12 March 2009. *Official Records of the Economic and Social Council, 2009, Supplement No. 8* (E/2009/28), chap. I, sect. C. available at www.unodc.org/documents/commissions/CND-Uploads/CND-52-RelatedFiles/V0984963-English.pdf
3. Vienna NGO Committee on Drugs (2013) *The Commission on Narcotic Drugs (CND): A briefing for NGOs and CSOs*. Available at www.vngoc.org
4. From blog 'Reading between the lines at the 56th Commission on Narcotic Drugs' by Donald Macpherson, Executive Director of Canadian Drug Policy Coalition, posted on 27 March 2013 at http://drugpolicy.ca/blog/
5. From news alert 'Feedback from the UN Commission on Narcotic Drugs' posted on 23 March 2013 on web site of the International Drug Policy Consortium at http://idpc.net/alerts/2013/03/feedback-from-the-un-commission-on-narcotic-drugs

Annual review of the drug situation in Europe

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published their ***European drug report 2013: trends and developments*** on the 28th May.[1] This year the centre's annual overview of the European drug situation is presented in a new information package designed to be 'more timely, interactive and interlinked', and which replaces the former annual report. The shorter, graphic-rich report summarises the latest trends across the 27 EU member states, and Norway, Croatia and Turkey. Accompanying the 2013 report is a series of online interactive **Perspectives on drugs (PODs)** providing deeper insights into important issues.

The EMCDDA reports that the numbers initiating heroin use are falling, there is less injecting and the use of cocaine and cannabis is declining in some countries. While these are positive developments, the emergence of new synthetic drugs and new patterns of use presents new challenges. Today's drug market is less reliant on the long-distance movement of plant-based substances into Europe. Globalisation and new technologies have driven significant changes in the manufacturing, supply and distribution of drugs.

Commenting on the report, **European Commissioner for Home Affairs Cecilia Malmström** says: 'I am heartened by the fact that, thanks to robust drug policies and record levels of treatment, use of heroin, cocaine and cannabis appears to be waning in some countries and drug-related HIV continues to decline.' Despite these advances, the fact that drug use in Europe remains high is a cause of continuing concern. Commissioner Malmström continues: 'Emerging challenges add to my concerns – we are faced with an ever more complex stimulant market and a relentless supply of new drugs which are increasingly diverse. The fact that over 70 new drugs have been detected in the last year is proof in itself that drug policies need to stay on target.'

The EMCDDA estimates that at least 1.2 million Europeans received treatment for illicit drug use in 2011. Opioid users constitute the largest group undergoing treatment, followed by cannabis and cocaine users. Substitution treatment remains the 'first choice' for treating opioid dependence. Some 730,000 Europeans now receive substitution treatment for opioid dependence – up from 650,000 in 2008 – representing around half of the estimated 1.4 million problem opioid users in Europe today. Although the number of heroin users entering treatment for the first time continues to fall, the long-term nature of opioid use means that many of those in treatment are likely to require services for many years to come.

Cannabis

- Cannabis is still Europe's most commonly consumed illicit drug. However, most countries report stable or downward trends among young people. Around 15.4 million adults aged 15–34 years (11.7% of this age group) used cannabis in the last year; 9.2 million of them were aged 15–24 years (14.9% of this age group).
- The use of cannabis by school students aged 15–16 years increased between 1995 and 2003, decreased slightly in 2007 and has remained stable since then. Around 1% of adults, over two-thirds of whom are aged 15–34, use cannabis daily or almost daily.
- Among **all clients** entering treatment, cannabis is the second most frequently reported main problem drug, after heroin. Among **new clients** entering treatment for the first time, cannabis is now the most frequently reported main problem drug.
- Between 2006 and 2011 the numbers of first-time clients increased from 45,000 to 60,000.
- Herbal cannabis is becoming more common in Europe, with almost all countries reporting some domestic cultivation of cannabis plants. In 2011 herbal cannabis accounted for 41% of all drug seizures, and cannabis resin for 36%.

EMCDDA annual review *(continued)*

Opiates (mainly heroin)

- Around 197,000 (48%) clients who entered drug treatment in 2011 reported opioids, mainly heroin, as their primary problem drug.
- Eleven European countries reported that 11% or more of new opioid clients entering treatment were using opioids such as fentanyl, methadone and buprenorphine without a prescription
- European data on opioid users entering treatment for the first time show a fall in numbers from a peak of 59,000 in 2007 to 41,000 in 2011.
- Treatment data provides evidence of a long-term decline in opiod injecting. The proportion of first-time entrants to drug treatment who are opioid injectors fell from around 58% in 2001 to 38% in 2011.
- The number of opiate-induced deaths increased from 2003 up to 2008, stabilised in 2009 and began a decline in 2010. The downward trend continued in 2011, when 6,500 overdose deaths were reported, compared to 7,000 cases in 2010 and 7,600 in 2009.
- The EMCDDA warns that 'a large burden of advanced liver disease can be expected over the next decade' among injecting drug users (IDUs) infected with hepatitis C. Injecting drug use accounts for an average of 58% of all hepatitis C virus cases and 41% of the acute cases notified across the countries that provided data in this area. Three of the countries with national trend data for 2006–2011 (Italy, Portugal and Norway) reported declining HCV prevalence, while Greece and Cyprus reported an increase during this period.
- There were 1,507 newly report cases of HIV/AIDS attributable to drug use in the EU in 2011, a slight increase on the 2010 figures. There are significant differences in prevalence between countries, with Greece and Romania between them accounting for 23% of the total. Other countries showed slight increases, while in Ireland, Spain and Portugal infection rates have declined steadily since 2004.
- Latest figures for seizures and drug-law offences point to an overall decrease in heroin supply. There were 40,500 seizures of the drug in 2011, down from around 55,000 in 2010. The 6.1 tonnes of heroin seized in 2011 was the lowest reported in a decade and was equivalent to about half that seized in 2001.

Cocaine

- Cocaine remains the most commonly used illicit stimulant drug in Europe, although high levels of cocaine use are observed in only a small number of western European countries. It is estimated that about 2.5 million young adults (15–34 years) used cocaine in the last year.
- Recent surveys have shown a fall in the use of cocaine by young adults (15–34 years) in countries where use among this age group has been highest in earlier years. Fewer young adults are using cocaine in Denmark, Ireland (2.8%), Spain, Italy and the UK and fewer people are entering treatment for the first time with cocaine as their main problem drug.
- At least 475 deaths related to cocaine use were recorded in 2011.
- The number of cocaine seizures has fallen steadily in recent years. In 2011, 62 tonnes were seized, down from 120 tonnes in 2006. There have been some recent signs of diversification in cocaine trafficking routes, with a drop in interceptions of the drug in the Spain and Portugal and increases in Bulgaria, Greece, Romania and the Baltic

Other stimulants and new psychoactive substances

- The European Early Warning System (EWS) identified 24 new psychoactive substances in 2009, 41 in 2010 and 49 in 2011. In 2012, 73 new psychoactive substances were officially notified for the first time, 30 of which were synthetic cannabinoids and 14 new substituted phenethylamines.
- An estimated 1.7 million (1.3%) of young adults (15–34 years) used amphetamines during the past year. Recent data show use of the drug to be stable or declining among this age group.
- It is estimated that 1.8 million young adults used ecstasy (MDMA) in the last year. Most countries report stable or declining levels of ecstasy use between 2006 and 2011. Ecstasy was the primary drug used by less than 1% of those entering treatment for the first time.
- Between 2006 and 2011 the number of drug supply offences related to ecstasy fell by about two-thirds and these now represent about 1% of all reported supply offences. There is, however, some recent evidence of increased availability of MDMA, including high-purity MDMA powders.

(Brian Galvin)

1. European Monitoring Centre for Drugs and Drug Addiction (2013) *European drug report 2013: trends and developments*. Luxembourg: Publications Office of the European Union. Available at: www.drugsandalcohol.ie/19915/

Irish and Portuguese drug policies profiled

Drug policy in Ireland goes back nearly 150 years. In 1870, when Ireland was still part of the United Kingdom, legislation (the Poisons [Ireland] Act) was introduced to control the sale of various substances, including opium and morphine. Some sixty years later the Dangerous Drugs Act 1934 was passed in order to fulfill Ireland's obligations under the League of Nations Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs of 1931. So says a profile of Ireland's drug policy recently published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).[1]

In just 20 pages this drug policy profile examines the evolution of Ireland's drug policy through four historical periods: 1921–1979, 1980–1995, 1996–2008 and 2009–2012. The report explores the country's national strategies, the legal context within which they have operated, the public funds spent, or committed, to implement them, and the political bodies and mechanisms set up to co-ordinate the responses to the problem. The profile sets this information in context by outlining the size, wealth and economic situation of the country as a whole. Also described is the manner in which events in Ireland resemble, or differ from, developments in other European countries.

Distinctive features of Ireland's drug policy, according to the profile, are the nature of the drug problem that emerged in the 1980s and the way in which the government responded. The drug problem, which grew rapidly from the early 1980s, was mainly located in poor areas of the capital city and was, at times, linked with violence and public demonstrations. Initially, this led to action at local level which was only endorsed considerably later, in a national policy document published in 1991. The changes that took place after 1996 are attributed partly to the work of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, which recommended the establishment of local drugs task forces, but also to external stimuli. The adoption of the Strategic Management Initiative (i.e. new public management) across government led to the publication in 2001 of a national drugs strategy with clear objectives and the use of indicators. Similarly, the government's social partnership approach to governing saw stakeholders with different views on the drugs issue involved in implementing the national drugs policy.

In line with its international obligations, Ireland has a 'balanced' drugs policy. The profile describes how this 'balance' has been achieved:

> Consensus among policymakers and other stakeholders on the direction of the action taken in supply reduction appears to have resulted in the development of specialised police forces and new laws to fight organised crime. Drug-demand reduction interventions, however, especially the more controversial harm reduction measures, have often arisen from initiatives at the local level, only becoming endorsed and institutionalised at national level many years later. The achievement of a balance, where supply and demand reduction (including harm reduction) have, at least symbolically, similar weight, took time to develop… . (p. 31)

The profile notes that the public health approach that drove some of the changes in Ireland's drugs policy in recent decades is now giving rise to the question – how can drug and alcohol policies in Ireland be better linked? Additionally, the development of the 'legal highs' phenomenon has triggered new legislative developments, which the profile comments 'often focus on those who sell these substances and not on those who use them'.

This profile is the second in a series. The first profiled Portugal's drug policy, which has been under the spotlight since Portugal decriminalised drug use in 2000.[2] This policy profile concluded with three observations:

1. The policy reform that occurred in Portugal between 1999 and 2001 was the result of more than two decades of drug policy debate in which there was ongoing tension between the criminalisation of drug use and the desire to help drug users. Over time the debate moved towards a model that prioritises early intervention and treatment over any form of sanction.
2. The decriminalisation of drug use was only one element in a larger policy change that progressively transferred responsibilities from the Ministry of Justice to the Ministry of Health, led to more integrated and detailed plans, highlighted the importance of evaluation as a policy management tool, and brought alcohol and drug policy closer together. These changes have a strong public health orientation and the profile suggests that this might be the best way to characterise Portugal's drug policy. Rather than representing the Portuguese model as a first step towards the legalisation of drug use or as the new flagship of harm reduction, the model may best be described as a public health policy founded on values such as humanism, pragmatism and participation.
3. Portugal's drug policy is not proving to be a 'magic bullet'. The profile notes that the country still has high levels of problem drug use and HIV infection, and does not show specific developments in its drug situation that distinguish it from other European countries that have a different policy. According to the profile, however, Portugal has developed a policy that appears internally consistent and that tries to respond to drug problems in a pragmatic and innovative way.

(Brigid Pike)

1. European Monitoring Centre for Drugs and Drug Addiction (2013) *Drug policy profiles: Ireland*. Luxembourg: Publications Office of the European Union. www.drugsandalcohol.ie/19396
2. European Monitoring Centre for Drugs and Drug Addiction (2011) *Drug policy profiles: Portugal*. Luxembourg: Publications Office of the European Union. www.emcdda.europa.eu/publications/drug-policy-profiles/portugal

How are the children?

In recent months three reports on the state of Ireland's children, including assessments of their use of tobacco, alcohol and illicit drugs, have been published. The statistical analyses, undertaken by UNICEF and by the Department of Children and Youth Affairs, report that overall levels of substance use have declined over the past decade. However, the annual review by a group of non-governmental organisations of the government's progress in implementing policy suggests that further effort is needed to deliver on policy commitments in relation to alcohol policy and the effects of alcohol on children.

Irish children compared to those in other countries, 2009/2010

UNICEF's Office of Research has published a comparative overview of child well-being in developed countries, including Ireland.[1] Drawing on statistical data relating to 2009–2010, the report ranks Ireland 10th out of 29 countries. Well-being is based on an aggregate of five separate dimensions, on some of which Ireland scores very well and on others not so well: material well-being (17th), health and safety (15th), education (17th), behaviours and risks (7th) and housing end environment (2nd). The 'risk' dimension comprises four indicators – smoking, alcohol and cannabis use, and teenage fertility rate.

Regarding risk behaviours, the following three graphs from the UNICEF report indicate that smoking and cannabis use, and getting drunk, among young people in Ireland, as in most other developed countries, have all declined.

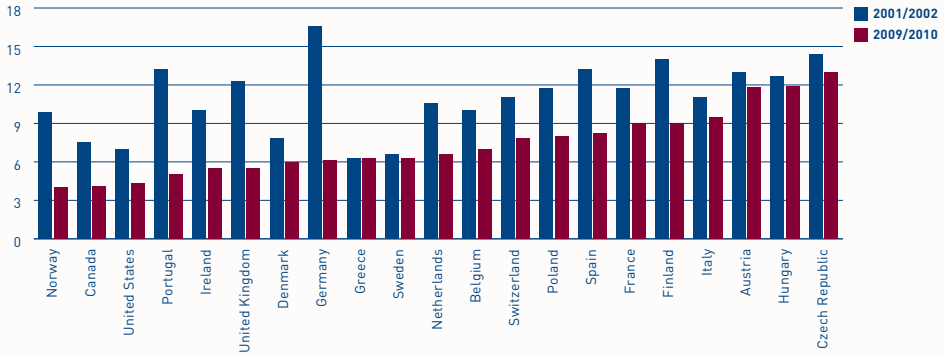


Figure 7.3a Changes between 2001/2002 and 2009/2010 in the percentage of young people aged 11, 13 and 15 who reported smoking at least once a week

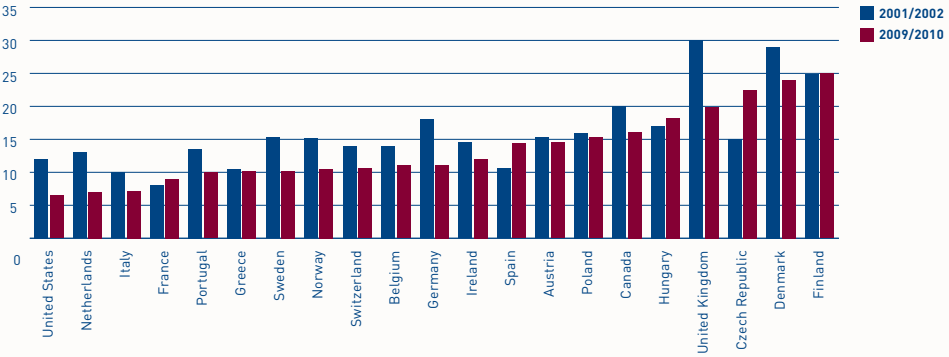
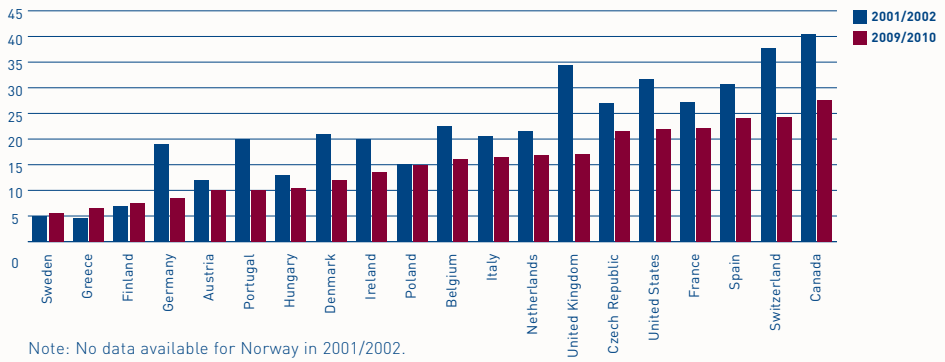


Figure 7.3b Changes between 2001/2002 and 2009/2010 in the percentage of young people aged 11, 13 and 15 who reported having been drunk on more than two occasions



Note: No data available for Norway in 2001/2002.

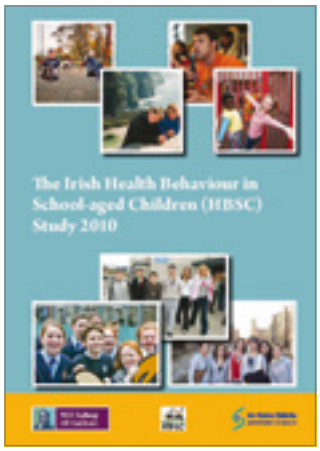
Figure 7.3c Changes between 2001/2002 and 2009/2010 in the percentage of young people aged 11, 13 and 15 who reported having used cannabis in the last 12 months

How are the children? *(continued)*

State of the Nation's Children, 2012

Released in March 2013, this fourth biennial *State of the Nation's Children* report,[2] published by the Department of Children and Youth Affairs, presents data in four sections:

1. Socio-demographics – the child population, child mortality, family structure, parental education level, Traveller children, foreign national children, children with a disability and children as carers.
2. Children's relationships – with their parents and peers, including levels of reported bullying and children's friendships.
3. Children's outcomes – relating to health, education, and social, emotional and behavioural outcomes, including smoking, alcohol and cannabis use.
4. Formal and informal supports – including school, housing, antenatal care, immunisation and economic.



Data on smoking and alcohol and cannabis use were derived from *The Irish health behaviour in school-aged children (HBSC) study 2010*, and the results compared with the data from previous iterations of the HBSC.[3] The report highlighted the decrease in the use of all three substances by children aged 10–17 in Ireland:

- The percentage who reported never having smoked increased from 50.8% in 1998 to 73.5% in 2010.
- The percentage who reported never having had an alcoholic drink increased from approximately 40% in 2002 to 54% in 2010.
- The percentage who reported having taken cannabis at least once in their lifetime decreased from 15.7% in 2006 to 10.5% in 2010.

The report points out that Traveller children and children with a disability and/or chronic illness were less likely than other children to report having never smoked cigarettes or drunk alcohol. They were also more likely, along with immigrant children, to report having taken cannabis at least once in their lifetime.

With regard to age, gender and social class, the report notes that older children and boys were less likely to report never having smoked cigarettes, had an alcoholic drink or taken cannabis. Children from lower social class categories were similarly less likely to report never having smoked cigarettes or taken cannabis. However, the percentages of children never having had an alcoholic drink were broadly similar across all social class categories.

Is government keeping its promises to children?

The Children's Rights Alliance (CRA) has published its fifth annual report on the state of the nation's children.[4] The report assesses the government's performance in honouring its promises to the over one million children living in Ireland. Awarding 'Ds' for each of the first three years, 2008–2010, the CRA gave the government a 'C+' in 2011, reflecting 'the Government's commitment to children's rights, evidenced in the appointment of a Minister for Children and Youth Affairs with full cabinet status; the creation of a new Department of Children and Youth Affairs; and the commitment to hold a referendum on children's rights'. In the latest report, for 2012, the CRA has given an overall 'C' grade, reflecting 'a satisfactory attempt to date, though children remain wanting'.

Notwithstanding the improvement in the overall rating, under the subheading 'Right to Health', the report gives the government a 'D' for progress in 2012 in relation to alcohol, drugs and smoking, pronouncing progress 'unsatisfactory'. The report states that despite the commitment that every government department, agency or task force responsible for implementing elements of the National Addiction Strategy would be required to account to the minister for their budget annually and to demonstrate progress on achieving targets, a *National Addiction Strategy* has not been published and 'is not expected until 2016'. The report goes on to comment that 'there is no Government policy on tackling alcohol misuse; no Government decision has been made on recommendations of the Steering Group'. It calls for the following actions in 2013:

- Urgently adopt a national strategy to tackle alcohol misuse and ensure it is coherent with the Interim National Drugs Strategy 2009–2016. The strategy should have a clear focus on the impact of alcohol and drugs on children, including to reduce children's access to alcohol and drugs; curb the widespread availability of cheap alcohol; restrict the promotion of alcohol; raise awareness of the potential harmful effects of alcohol and drugs and develop youth appropriate addiction treatment services. It must also address harmful parental drinking and its impact on children. The Strategy must be accompanied by a clear plan, with targets, timeframes and accountability structures.
- Introduce a legislative ban to protect children from alcohol marketing.

How are the children? *(continued)*

- Sustain investment in non-alcohol and drug free spaces for young people.
- Enact the Protection of Children's Health from Tobacco Smoke Bill 2012.

(Brigid Pike)

1. UNICEF (2013) *Child well-being in rich countries: a comparative overview*. Innocenti Report Card 11. Florence: UNICEF Office of Research. www.drugsandalcohol.ie/19663
2. Office of the Minister for Children and Youth Affairs (2012) *State of the nation's children report: Ireland 2012*. Dublin: Stationery Office. www.drugsandalcohol.ie/19449
3. Kelly C, Gavin A, Molcho M and NicGabhainn S (2012) *The Irish health behaviour in school-aged children study 2010*. Dublin: Department of Health and National University of Ireland, Galway. www.drugsandalcohol.ie/17360. For a detailed account of the HBSC 2010 data relating to alcohol and cannabis use, see Long J (2012) Alcohol and cannabis use among school-aged children in Ireland. *Drugnet Ireland*, (42): 1–2. www.drugsandalcohol.ie/17680
4. Children's Rights Alliance (2013) *Report card 2012*. Dublin: Children's Rights Alliance. www.drugsandalcohol.ie/19332

The President gets young people talking...

In his inauguration speech on 11 November 2011 President Michael D Higgins said that as part of his presidency he would host a number of seminars on themes that went beyond immediate legislative demands but which were important to the shared life of the Irish people. He decided that the first of these seminars would be about 'Being Young and Irish'.

President Higgins invited young people to think about the way we wish to live with others; the way our institutions must work and serve their purpose for the welfare of all; the way we define what is valuable; and how the economy should connect with society.

A total of 775 people aged between 17 and 26 years contributed their ideas and opinions by participating in regional workshops, making separate submissions and/or participating in the final seminar. The published report highlighted nine areas of concern:[1]

- Employment, enterprise, social security, concern with the economy
- Political reform
- Education
- Equality
- Involve young people
- Being positive
- Health
- Community and civil society
- Identity as Irish

A summary of the issues raised in relation to alcohol, drugs and smoking, which were reported under the heading of Health, is given below.[1]

Alcohol

Most saw the role of alcohol in Irish society, and in relation to young people in particular, as problematic. For example: 'Alcohol is the drug of choice among youth. Many young people are experiencing the consequences of drinking too much, at too early an age. As a result, underage drinking is a leading public health problem in this country.' Alcohol was seen as affecting all areas of people's lives – work, socialising, sport, addiction and mental health. One participant blamed those selling alcohol for the under-age availability: 'Alcohol is so widely available these days that employees don't ask the customers for ID anymore.'

Measures identified to tackle the alcohol problem included the provision of alternative and affordable options for socialising. For example: 'If I'm completely honest it's not fun living here. There is a great lack of facilities for young people and more often than not most of us resort to drink to fool ourselves into thinking that we are having fun. In reality we spend much of our time on the computer developing a sort of artificial social life, devoid of face-to-face interaction.' Other suggestions included more education, for example sending secondary school students into hospitals to see the effects of alcoholism and substance abuse, or student campaigns about the effects of alcohol. Higher taxes on spirits, wines and shots were mentioned. Conversely, cutting taxes on alcohol sold in drinking establishments such as pubs, night clubs and restaurants was recommended, as well as simultaneously raising taxes on alcohol sold in off licences: it was argued that this would both support the declining pub trade and reduce the sale of alcohol in off-licences and shops, which were seen as the main problem since consumption of drink is then unsupervised.

Drugs

Only a small number of participants commented on drugs, with very little consensus. Some submissions related to the harm caused by drugs while some focused on the harm caused by the illegal status of drugs. The participants gave a number of different arguments for legalising drugs, especially cannabis. Overall, it was argued that if drugs were legalised, they would be safer: 'If legalised there "would not be as much of a black market", therefore, "less organised crime related to drugs … crimes like robbery and the likes because prices would be lower without the criminals involved".'

One participant claimed that cannabis 'has no reported deaths or illness', and that the laws governing cannabis use need to be changed because, 'it's disgraceful that a toxic

The President gets young people talking... *(continued)*

substance [alcohol] which is the cause of a lot of domestic and social problems as well as mental and physical illnesses is legal while a non toxic substance which many Irish people chose to smoke is illegal. It's a waste of tax payers money … [which is] negatively effecting many young people … receiving a criminal record for possession of this relatively harmless drug.'

While the call for legalisation focused mainly on cannabis, a couple of participants called for 'complete legalisation of all drugs', with strict regulation especially for 'hard drugs'. Some young people were firmly of the belief that the 'system' was 'enabling … evil people by having the drug illegal'. The need for regulation was emphasised, including a strictly controlled minimum age for use and the use of photo ID or swipe cards.

Smoking

A small number of 'passionate' comments, all negative, were provided about smoking. One participant proclaimed, 'I believe in the 21st century it is a failure of a nation that young people still smoke', while another stated, 'the goal should be to completely eradicate smoking from Ireland'. Participants expressed frustration that smoking has not been tackled effectively by society: 'campaigns based on "MPOWER"[2] may marginally reduce the number of smokers, but is … extremely inefficient based on the number of smokers in the country'. One participant suggested that smoking could be completely phased out in a generation.

(Brigid Pike)

1. Centre for Social and Educational Research, Dublin Institute of Technology (2013) *Being young and Irish 2012: take charge of change*. Report on President Michael D Higgins' consultation 'Being Young and Irish' with young people. Dublin: Office of the President. www.president.ie/youngandirish/
2. MPOWER is a package of six evidence-based tobacco control policies promoted by the World Health Organization which has been incorporated by the HSE in its Tobacco Control Framework.

…and the Minister replies

On 21 March 2013 the Minister for Health, James Reilly TD, gave his thoughts on the report published by the Office of the President *Being young and Irish: take charge of change*, and explained what he was doing to help realise the young peoples' vision for Ireland. He said that he shared the young people's concerns and listed the initiatives being progressed by his department.[1]

Alcohol

The minister reported that 'real and tangible proposals' were being finalised on foot of the recommendations in the report of the Steering Group on a National Substance Misuse Strategy 2012, mainly in the areas of legislation on minimum unit pricing, access to and availability of alcohol, advertising and sponsorship. He noted that the Cabinet Committee on Social Policy had also considered the matter and was to bring forward specific proposals for consideration by government as soon as possible. In the meantime, work on developing a framework for the necessary Department of Health legislation was continuing.

Legalising cannabis

The Minister's reply is given here verbatim:

> International research shows that significant physical and mental health risks are associated with long-term cannabis use. These include increased risks of developing lung and throat cancer (smoke from cannabis contains more carcinogenic tars than does tobacco smoke) and risks associated with the development of mental illness, such as schizophrenia and depression. The potency of cannabis products can also vary greatly. The 2011 NACD study The potency of THC in cannabis products reported the growing concern about the significant rise in the potency levels in some cannabis products over the last number of years, particularly in herbal cannabis. Concerns have also been raised that cannabis produced in Ireland, and used relatively quickly, has a higher potency than imported varieties. There is also evidence that cannabis plants generally are being genetically engineered to ensure they produce high levels of THC (tetrahydrocannabinol). Legalisation would be likely to lead to greatly increased levels of experimentation, leading to significantly increased levels of sustained long term use causing increased health problems in our society. Indeed, the situation that pertained only a few years ago in Ireland in regard to the volume of new psychoactive substances sold in headshops illustrates this point. People were prepared to experiment with readily available legal products, despite the publicity regarding the consequences. Legalisation would be unlikely to significantly reduce the level of criminality surrounding the broader market in illicit drugs. Also, if cannabis was legalised, it would most likely be strongly regulated and probably heavily priced to influence demand (as in the case of tobacco). This in turn could lead to the continuation of an illicit market on similar lines to the black market of cigarettes. Overall, the amount of money likely to be raised in tax would be small in relation to the health and other implications arising. Cannabis was re-classified from a Class C drug to a Class B drug in the UK in 2009. This decision was taken in the light of the "real public concern about the potential mental health affects [sic] of cannabis use, in particular the use of stronger forms of the drug.
>
> Finally, any possibility of legalising cannabis has to be looked at in a European and global context. A unilateral decision to legalise its use here would most likely lead to Ireland becoming a destination for those from other countries who wish to use cannabis. In view of the evidence available I am not in favour of legalising the use of cannabis at this time.

Tobacco

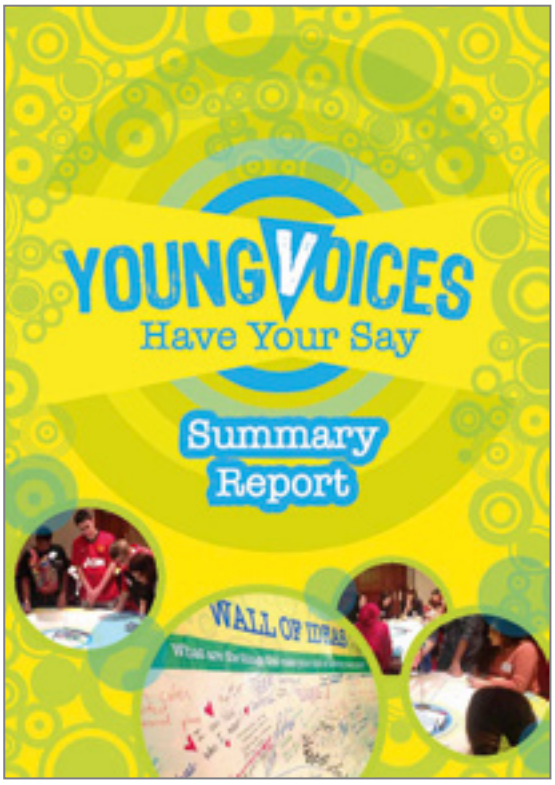
The Minister stated that his department was developing a new tobacco policy with the aim of 'denormalising' tobacco smoking and so leading to a tobacco-free society. The new policy will have a particular emphasis on children. It is envisaged that the policy will be completed by mid-2013.

(Brigid Pike)

1. Reilly, J (2013, 21 March) *Parliamentary Debates Dáil Éireann (Official report: unrevised): Written answers.* Presidential reports. Vol. 797, No. 2, p. 561. Question(s) 253. http://oireachtasdebates.oireachtas.ie/Debates%20A...

Young people appeal for a more inclusive society

The Department of Children and Youth Affairs (DCYA) recently published a summary of the main issues to arise from a regional consultation with 239 young people in Sligo, Cork and Dublin; 57% were female and 73% were aged under 18 years.[1] The consultations were undertaken as part of a European programme called 'Structured Dialogue', a process established by the Council of the European Union in its resolution for a renewed framework for co-operation in the youth field (2010–2018). The consultations centred on the theme of 'social inclusion' among young people and the main issues are presented here under a number of sub-headings.



What does being included mean?

A synopsis of the issues covered in Table 1 show that young people feel included when their uniqueness as individuals is recognised and respected, when their opinions are actively sought and responded to, when they are afforded equal dignity and respect as that shown to others and when the can form attachments and bonds with significant others.

Table 1 Components of social inclusion for young people

Site of inclusion	Illustrative examples of being included
Among your family and friends	Being respected and not treated like a child in the family Being accepted and loved for who you are Having a safe space to be yourself Having a say and being included in decisions Having someone to talk to and rely on
In your area (local community)	Being consulted for your opinion Being treated the same as older people Getting involved in community events Having a sense of belonging and feeling included Having a fun and safe place to hang out with friends
Employment	Being treated equally regardless of age, gender, sex and race Fair wage and reward Having equal opportunities for training and promotions Being trusted and given responsibility Being involved in decision-making
Education	Equal access and funding for education regardless of social class Equality – no racism, bullying, discrimination or judgement regardless of sexuality, race, religion or background Having a voice on important things in school Being treated fairly by teachers
Clubs and activities	A sense of belonging and feeling welcome Being consulted, listened to and involved in decision-making on activities Being treated equally and not judged, discriminated against or bullied Meeting new people and making friends Working as part of team

Young people's voices *(continued)*

What stops young people being included?

As illustrated in Table 2, young people feel excluded when their significant others do not afford them trust and respect and do not legitimately recognise their differences, and when they experience bullying and discrimination due to their differences.

Table 2 Components of social exclusion for young people

Site of exclusion	Illustrative examples of not being included
Among your family and friends	Negative relationships with parents due to lack of trust and respect Negative relationships with friends and peers due to peer pressure, alcohol and drug misuse and different values, beliefs and interests Discrimination – being judged on your looks or your sexual orientation
In your area (local community)	Stereotyping of and discrimination against young people by older people, e.g. the media, Gardaí Bullying Lack of facilities, e.g. a place to hang out and lack of information on existing facilities Peer pressure to drink alcohol, take drugs and get involved in crime
Employment	Lack of work for young people and lack of opportunities to gain experience Lack of opportunities to get necessary, qualifications, education and skills Discrimination on age, gender, race, ethnicity, disability, sexuality, religion, mental health and criminal record
Education	Bullying by other students due to looks, race, religion or sexuality Discrimination and lack of understanding of sexuality e.g. religion class teaches that 'being gay is wrong' Bad teachers e.g. strict and controlling Too expensive
Clubs and activities	Bullying and cliques, e.g. 'Group closure' Not being made welcome – due to sexuality, social background, and cultural differences Club can be intimidating, have narrow range of activities and be expensive to attend Lack of confidence and self-esteem Rural isolation due to lack of transport

What times in their lives are young people most at risk of being excluded?

Table 3 illustrates that at important milestones in their lives young people can experience elevated risks which can contribute to their feeling excluded.

Table 3 Significant life events and risk among young people

Significant life events	Illustrative examples of being at-risk of exclusion
Starting primary school	Leaving parents for the first time, meeting new teachers and friends and adapting to the playground
Starting secondary school	Meeting new teachers and new people and adapting to new schools and systems
Teenage years	Puberty, discovering sexuality and identity, dealing with fractured relations with family and friends and dealing with peer pressure and alcohol and drugs, bullying and being judged
Transition year	An 'in-between' stage and staring a social life
Exam time	Pressure from parents to get points and fear of failure
Starting college	Lack of financial support, new relationships, thinking about the future, leaving home and becoming independent

The report documents a large number of achievements that young people claim they secured through participation in youth-related clubs and activities. These are listed under three broad categories (i) personal development and happiness (ii) skills and experiences needed for life and (iii) feeling more included. Young people talked about how participating in youth-related clubs and activites helped them 'to discover who they are, "what they want from life", and to accept themselves for who they are by building self-confidence and self-esteem. In addition, "young people feel that clubs give you an opportunity to talk to people you wouldn't talk to otherwise", resulting in respect, tolerance and acceptance of others and their differences' (p.9).

When young people were asked for their views on how the existing activities could be improved, and new ideas for clubs and activities, the main responses centred on young people having a more active say in running clubs and activities, more interaction with similar groups outside the clubs, greater diversity of activities in clubs and an emphasis on providing a welcome to new members and a safe space in clubs to address specific issues, such as disability, sexual health and orientation.

This is useful snapshot of the lives of young people which illustrates their strong desire to be recognised for their unique individuality and their enthusiasm and willingness to build a more relevant and meaningful understanding of the main issues confronting young people in contemporary society. Their appeals for a respect for difference and for justice and equality are striking and their testimony to the value of participation in youth sector related activities is encouraging.

(Martin Keane)

1. Department of Children and Youth Affairs (2013) *Young voices: have your say. Summary report*. Dublin: Department of Children and Youth Affairs. www.drugsandalcohol.ie/19479

Guidelines for promoting mental health and suicide prevention in post-primary schools

A comprehensive set of guidelines promoting positive mental health and well-being among post-primary students was recently launched.[1] The guidelines were developed by an inter-departmental group of representatives from the Department of Education and Skills, the Health Service Executive and the Department of Health. The guidelines were developed in three phases: (i) a national consultation process with key stakeholders from health, education and other relevant sectors; (ii) a review of national and international literature on good practice in health promotion and suicide prevention and (iii) developing the guidelines using information gathered from the consultation process and the literature review through on-going discussion with key partners. The purpose of developing the guidelines is to support schools to develop a whole-school approach to promoting positive mental health and preventing suicide.

The guidelines are based on the theoretical assumptions that developing positive mental health and well-being, linked to a sense of attachment and bonding to school, will foster improved resilience and social skills among students. Schools are encouraged to promote positive mental health and well-being through adopting a whole-school approach; this means permeating all aspects of school-life from the curriculum to relations between staff and students and via the school environment. The guidelines provide some examples of models of good practice in this area.

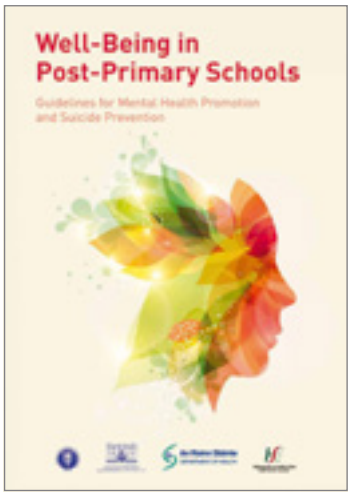
One such model is the Health Promoting School (HPS) model which include four areas of action within which schools can promote positive health; the school environment, including social relations and physical characteristics; the school curriculum by including health promotion modules and learning e.g. SPHE; school policies, e.g. anti-bullying and substance use policies; and forming partnerships between the school and the wider community. The guidelines clearly outline the eleven stages that schools adopting the HPS model can commit to. The guidelines also state that 'the full implementation of Social, Personal and Health Education (SPHE) and Relationships and Sexuality Education (RSE) provides a framework for educating young people about their health and well-being in a planned and structured way' (p.21). The guidelines also recommend that schools should adopt the three-tiered continuum of support model for promoting mental health: support for all (universal), support for some (selective) and support for a few (indicated).

School support for ALL

Section three sets out guidelines on how schools can implement a whole-school approach to promoting positive mental health for all members of the school community, providing early identification and intervention for young people showing mild or transient signs of difficulty. Schools are encouraged to undertake self-evaluation to establish what is working well, where improvement is needed, and to evaluate and report on outcomes.

School support for SOME

Section four sets out guidelines on how schools can identify young people who are at risk of developing unhealthy patterns of behaviour or who are already showing early signs of mental health difficulties. Issues that can place young people at an elevated risk level include bereavement, bullying, family problems, discrimination, sexuality and substance use. Schools are encouraged to gather sufficient relevant information on the issue/s that concern the young person, plan and execute an appropriate intervention and undertake a regular monitoring and review of the overall situation.



School support for a FEW

Section five sets out guidelines on how schools can support young people with complex or enduring needs relating to their mental and emotional well-being. Supports at this level will be more intensive and individualised and may include the use of external professionals and services. This section provides guidance on how to support young people to return to school following an absence for mental-health-related issues,as well as those at-risk of suicidal behaviour and those who need support in the aftermath of a death by suicide.

Overall, this is a very useful resource for post-primary schools to draw upon when devising plans to prevent or tackle existing mental health difficulties among students. The resource is conceptually rich in identifying the key risk factors that may compromise a young person's mental health and the protective factors that can develop resilience to counteract pressures on their mental health. By situating potential responses within the three-dimensional classification of universal, selective and indicated prevention, there is ample scope for schools to develop responses to tackle issues that affect the whole school population, in addition to putting in place measures to support young people who may have a higher risk profile around their mental health. Using these guidelines to develop frameworks of understanding of the pressures that can impact on young people's mental health and how schools can respond in a timely and effective manner is key to their successful implementation. Indeed, in the concluding section, the report states that 'it is vital that school management and staff review and build on existing good practice and implement the processes described in these guidelines to support the emotional health of young people' (p.51).

(Martin Keane)

1. Department of Education and Skills, Health Service Executive, and Department of Health (2013) *Well-being in post primary schools: guidelines for mental health promotion and suicide prevention.* Dublin: Department of Education and Skills, Health Service Executive & Department of Health. www.drugsandalcohol.ie/19228

Healthy Ireland – implementation matters

On 28 March 2013 the government launched *Healthy Ireland: a framework for improved health and wellbeing 2013–2025*.[1] *Healthy Ireland* sets out a framework of actions to improve health and wellbeing and reduce the health risks posed to future generations. The government has developed the policy in response to rising levels of chronic illness, lifestyle trends that threaten health and persistent health inequalities.

The economic justification for the policy is clear. It is estimated that in Ireland the economic cost per year associated with obesity, smoking, alcohol use and mental health issues is around €18 billion. (The economic cost of the illicit drugs market in Ireland has never been calculated.)

Obesity: Two in every three adults in Ireland are overweight or obese, and 20% of children in all socio-economic groups are overweight.

Smoking: Around 1 million people in Ireland smoke tobacco products, and 12% of children aged between 11 and 17 years are current smokers. Smoking rates are highest (56%) among women aged 18–29 years from poor communities, compared to 28% of young women from higher social classes. One in every two smokers will die of a tobacco-related disease; 5,200 preventable deaths occur each year from tobacco.

Alcohol: The alcohol consumption rate for Ireland is one of the highest in Europe, at 11.9 litres per capita. Alcohol is responsible for approximately 90 deaths every month, and is a factor in half of all suicides.

Drugs: Use of illegal drugs in the last year is reported at 7% of adults aged between 15 and 64 years, and drug use was the direct or indirect cause of 534 deaths in 2008.

Mental health: Mental health is a growing health, social and economic issue and it is expected that depressive mental illnesses will be the leading cause of chronic disease in high-income countries, including Ireland, by 2030. Currently, in Ireland, the mortality rate from suicide in the 15–24-year age group is the fourth highest in the EU. One in 20 participants in an Irish longitudinal study on ageing (TILDA) reported a doctor's diagnosis of depression, with a similar number reporting a diagnosis of anxiety. Levels of depression and admission to psychiatric hospital are higher among less affluent socio-economic groups.

Evidence and experience from around the world show that in order to make a positive change in population health and wellbeing a whole-of-government approach is needed, as well as involving local communities and society as a whole. *Healthy Ireland* lists 64 broad inter-sectoral actions, with initial partners including government departments, statutory agencies, civil society organisations, the community and voluntary sector, the private sector, and employee representative organisations.

The authors of the policy framework recognise that ensuring effective implementation of the policy, making sure it does not get left on a shelf, is the biggest challenge.[2] The framework of actions emphasises five activities – leadership, measurement, partnership, empowerment, and resource management – designed to ensure the policy remains on the front burner.

Leadership: The Cabinet Committee on Social Policy, chaired by An Taoiseach, will oversee implementation. It will oversee and monitor targets and action plans to improve health and wellbeing and will address the cross-cutting policy issues that arise. A national Healthy Ireland Council will be established to represent all stakeholders. This Council will build a network of advocates at national and local level to actively promote and pursue the goals of *Healthy Ireland*.

Measurement: Rigorous planning, reporting and evaluation will be assured through an Outcomes Framework with key indicators and measurable targets. Indicators will be set to measure improvements in population health. These will include health status, weight, diet and activity levels. It will also include indicators to measure health inequalities and the broader determinants of health, such as the proportion of young people completing second level education, access to green spaces and other environmental influences; and indicators that measure how we are protecting the health of the population, e.g. uptake of immunisation programmes.

Partnership: Responsibility for action on health determinants and health behaviours will be distributed across the State, private sector and employers, communities, families and individuals. Local structures will be identified and supported to work on common implementation agendas. It is at this level that individuals, community and voluntary groups and projects, sporting partnerships, local schools, businesses, primary care teams, community gardaí etc. will be able to work together.

Empowering people and communities: To achieve the goal of a 'healthy Ireland', it is essential to empower people and communities to improve and take responsibility for their own health and wellbeing. Actions to empower individuals and communities will need to be balanced with a broader range of provisions influencing the choices people have, e.g., regulatory and legislative options to adapt or change the decision-making environment or to provide for quality and safety standards. Social interaction and social connectedness and involvement in community life are also keystones to empowering people at the individual level and building strong communities for health and wellbeing, and will be addressed.

Healthy Ireland *(continued)*

Resource management: *Healthy Ireland* will be implemented using existing resources; existing programmes and priorities will be reviewed to ensure they are directed toward community-based programmes for those most at risk or experiencing the greatest disparities, and to ensure selection of those programmes with the greatest opportunity for impact.

How *Healthy Ireland* will work in with the National Drugs Strategy remains to be seen. With regard to alcohol, citing the 2012 report of the Steering Group on a National Substance Misuse Strategy, *Healthy Ireland* identifies a decrease in alcohol consumption across the population as an indicator and sets a target of reducing the amount of alcohol consumed by people over the age of 15 years to an annual per capita consumption of 9.2 litres of pure alcohol. No date is set for this target.

(Brigid Pike)

1. Department of Health (2013) *Healthy Ireland: a framework for improved health and wellbeing 2013–2025*. Dublin: Department of Health. Available at www.drugsandalcohol.ie/19628
2. The challenge of effective implementation has been recognised and written about elsewhere. For example, see Pike B (2010) How effectively is policy being implemented? *Drugnet Ireland*, (33): 15–16 (www.drugsandalcohol.ie/13029), and Burke K, Morris, K and McGarrigle L (2012) *An introductory guide to implementation: terms, concepts and frameworks*. Dublin: Centre for Effective Services. Available at www.effectiveservices.org/knowledge-exchange/ces-publications

Alcohol Forum national conference

As part of National Alcohol Awareness Week, which took place from 18–22 March, the Alcohol Forum hosted a conference in the Convention Centre, Dublin, on 20 March entitled *The Power of Local Community in Reducing Harmful Drinking*. Pat Harvey, Chairman of the Alcohol Forum provided the opening address and outlined the costs associated with alcohol-related harm in Ireland. He spoke about the influence of the alcohol industry, describing it as 'a "Goliath" in terms of muscle and funds nurturing a society that has alcohol consumption at dangerous and harmful levels'. He called on the government to implement the National Substance Misuse Strategy as a matter of urgency.[1]

Mr Alex While TD, Minister of State for Primary Care, opened the conference and spoke about the power of community and the need to mobilise communities, schools, sports and law enforcement and to pool resources. He said that the alcohol problem in Ireland was too big and too entrenched to be dealt with on an individual or even a community level and that, despite the arguments being made against every single measure that has been proposed, some form of regulation was necessary. He confirmed that the government was considering the measures contained in the Steering Group report on a National Substance Misuse Strategy and would announce its conclusions and decisions shortly.[2]

Other speakers included Dr Ann Hope, Department of Public Health and Primary Care, Trinity College Dublin; Dr Walter Kern Scheffeldt, Clinical Psychologist, Zurich University of Teacher Education; Anne Timony, Community Mobilisation Officer with the Alcohol Forum; and Claire Dineen, Chair of the National Forum of the Family Resource Centre Programme. There was also a 'Soapbox' session where speakers were given three minutes to present their arguments on how to effect changes. The participants in this session were Fiona Ryan, CEO, Alcohol Action Ireland; John Waters, *Irish Times* columnist; John Logue, President of the Union of Students in Ireland; Denis Bradley, former Vice Chair of the Northern Ireland Policing Board; and Eamon O'Kane, Director of Derry Healthy Cities.

Minister Alex White TD with Alcohol Forum chairman Pat Harvey at the opening of the conference (photo by Conor O'Mearain)

(Deirdre Mongan)

1. Alcohol Forum (2013, 20 March) *Alcohol Forum challenges government, the drinks industry & parents*. News item posted on the Alcohol Forum website. Accessed 8 May 2013 at www.alcoholforum.org/index.php/news/103
2. White A (2013, 20 March) *The power of local community in reducing harmful drinking*. Speech delivered at the opening of Alcohol Forum conference, 20 March 2013, Convention Centre, Dublin. Accessed 8 May 2013 at http://alexwhitetd.wordpress.com/2013/04/11/

Education, addiction services and workforce development

Ms Marion Rackard, chair of Health Service Executive National Addiction Training Programme, speaking at the NDC conference (photo by JJ Berkeley)

A recent National Documentation Centre conference[1] heard researchers, educators and service managers speak on the role of education in the development of the addiction services workforce. Education and training are essential elements in the development of a skilled, competent and motivated workforce. Employing organisations must recognise the value of this learning and encourage their staff to use it in an innovative and progressive environment. The NDC conference speakers addressed these issues from different perspectives and a number of broad themes emerged during the course of the day. These themes are set out below.

1. Using evidence in addiction work

An evidence-based approach must involve a critical assessment of current and proposed practices and a thorough analysis of the context of the particular problem that needs to solved. Interventions can then be chosen on the basis of the evidence of efficacy, their suitability for the population requiring the intervention and the capacity of the service to implement the intervention using established protocols. Education and training programmes should include some element of critical appraisal training to encourage a questioning attitude and to challenge the establishment of new orthodoxies.

2. The role of educational institutions in developing the addiction workforce

A number of educators working in third-level institutions in different parts of the country described the courses which these institutions supported and the outlook on which they had been established. Learning in this setting allows students to benefit from the accumulated educational knowledge of the university or college and from the intellectual resources built up across a range of disciplines. Availing of these resources enables the learner to develop a keener awareness of the social, political and economic contexts in which their new skills will be applied. It is also beneficial to study in an environment in which a spirit of enquiry and multi-disciplinary approaches to problem solving are the norm and critical abilities and intellectual development are encouraged.

One course director noted that it is now common for universities to assert their responsibility to the broader community and to highlight their work in outreach and adult education work.

A significant proportion of the cohort undertaking courses in drugs and alcohol studies would otherwise be unlikely to study at third level. By supporting these courses, and the tutors and academic staff that provide them, the university gives real expression to the values of inclusiveness and equal opportunity it officially supports.

3. Developing competencies

It was suggested that an over emphasis on collecting quantifiable and comparable data brings with it the risk of masking less tangible but still vital knowledge. An academic who has worked in adult education for many years distinguished three separate types of knowledge relevant to addiction work: the biological sciences; knowledge based on psychological theory; and the type of 'sense-making' which requires an ability to absorb another's dilemmas, values and experience into one's own frame of reference. Practical skills are improved through self-reflection on work practice and decisions. The successful practitioner, by looking beyond the phenomenon of a client's dependency, has developed communication skills which can reveal traits, attitudes and needs and provide a fuller personal picture.

Tacit skills and judgement complement research-based competencies and theoretical knowledge. These are important considerations for both educators and workplace managers. Effective education and training programmes not only impart skills but also facilitate the intellectual and personal development of the individual learner. These programmes increase the capacity of the practitioner to use their listening and observational abilities and to deal empathetically and skilfully with complex situations. It may not be possible to codify what is learned through this practice in the same way that clinical practice can be recorded and made available for analysis by others. But, as one researcher pointed out, we have techniques to manage and transfer this knowledge and, through research tools such as meta-ethnography, we have access to the evidence that others have provided. Practice should be informed by a pluralistic approach to the use of evidence which does not elevate a particular discipline but is nonetheless rigorous and soundly based in theory.

4. Structural change and systems focus

Responding to today's substance use situation involves very different challenges to those of 2001, when the first National Drugs Strategy was published. New drugs require new approaches and polydrug use presents particular problems for services. Technological advances have transformed the manufacture, sale and distribution of both licit and illicit drugs. Alcohol is being integrated into a broader substance use strategy. Of equal significance will be a shift in drugs policy towards a recovery approach. It is not possible yet to envisage the full implications of this policy development. We can say that it will call for closer integration of services and will present new challenges as clients develop their personal pathways to complete and fulfilling lives.

These changes will have implications for workforce planning. In many respects Ireland is in a strong position to deal with these changes. A services manager described the many highly successful training programmes that are currently under way. Training, especially in treatment and

Addiction services workforce *(continued)*

rehabilitation services, is being co-ordinated by teams comprising highly motivated managers, practitioners, community workers and health professionals. These partnerships can be strengthened and new links established between these teams and researchers and educators. The Scottish experience provides plentiful evidence of how these types of link can inform innovative and adaptable workforce development. The STRADA organisation, based in the University of Glasgow (www.projectstrada.org/ems/live), has used its knowledge of research, policy making and services to develop a comprehensive and coherent suite of addiction training programmes. In turn, policy, practice and research is informed by the work of STRADA. The STRADA experience is very relevant to the task of building an adaptable, skilled and motivated addiction workforce in Ireland.

We know from studies in other countries that the successful integration of new knowledge into work practice must be part of a systemic approach to dealing with workplace issues. There will need to be a comprehensive analysis of the addiction workforce in Ireland. This analysis would place individual learning alongside recruitment, planning, worker well-being, management and leadership and other organisational and structural considerations. This will be a formidable task but progress in this sector requires a commitment to an integrated approach to workforce development. From the evidence of this conference, there is a willingness to work together to ensure that education and learning transfer are central to this development.

We are grateful to all the speakers for their contribution to the day:

Prof Catherine Comiskey, Trinity College Dublin, chair of the National Advisory Committee on Drugs and Alcohol (Opening address)

Prof Shane Butler, Trinity College Dublin

Mr Martin Keane, Health Research Board

Dr Patricia Mannix McNamara, University of Limerick

Prof John Wells; Dr Marie Claire Van Hout, Waterford Institute of Technology

Dr Derek Barter, National University of Ireland, Maynooth

Dr Ted Fleming (formerly of NUI Maynooth)

Ms Joy Barlow, strategic advisor, Scottish Training on Drugs and Alcohol (STRADA)

Ms Marion Rackard, chair of Health Service Executive National Addiction Training Programme

(Brian Galvin)

1. The conference was titled *Putting knowledge to work through education: substance use workforce development in Ireland.* It was held in Dublin on 18 April 2013. The conference presentations are available in video and pdf format at www.drugsandalcohol.ie/19737/ and www.drugsandalcohol.ie/19723/

Launch of Galway City alcohol strategy

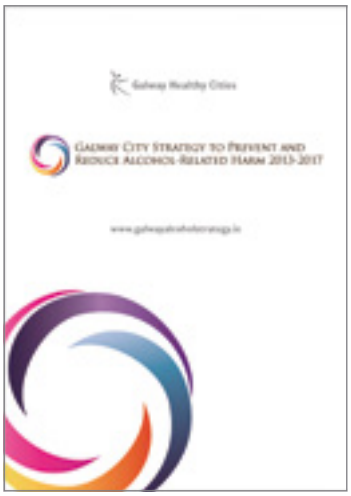
Galway City strategy to prevent and reduce alcohol-related harm 2013–2017 was launched on 18 February by Mr Alex White TD, Minister of State for Primary Care. The five-year strategy seeks to prevent and reduce alcohol-related harm in Galway City and was prepared by Galway Healthy Cities Alcohol Forum in partnership with a range of organisations and groups. These include HSE West, An Garda Síochána, Western Region Drugs Task Force, City of Galway VEC, NUI Galway, Galway Mayo Institute of Technology, Galway City Council and Galway City Community Forum.

The strategy is informed by research on effective approaches to preventing and reducing alcohol-related harm and focuses on four key areas:

1. Prevention – the aim is to communicate and engage with policy makers, stakeholders and the general public.
2. Supply, access and availability – the aim is to ensure that key factors influencing alcohol supply such as price, availability and marketing are regulated and controlled.
3. Screening, treatment and support services – the aim is to provide a range of services and supports.
4. Research, monitoring and evaluation – the aim is to use information and research in decision making.

It is anticipated that the outcomes of implementing the strategy will include:

- Improved health, wellbeing and quality of life of people living in Galway City;
- Reduced harmful use of alcohol;
- Reduced alcohol-related harm;
- Reduced incidents of alcohol-related crime and anti-social behaviour;
- Increased access to support services for those affected by another's alcohol consumption;
- Increased access to alcohol treatment services;
- Reduced prevalence of alcohol at community events/activities; and
- Reduced alcohol marketing in local areas.



The Galway City Alcohol Forum will develop a yearly action plan to achieve the outcomes of the strategy and an update on progress made will be completed each year. This progress update will enable the Forum to adapt the action plan to reflect developments and changes in the local or national context. This will also ensure energy and momentum for the implementation of this strategy.

A copy of the strategy and the 2013 action plan may be accessed at www.drugsandalcohol.ie/19344.

(Deirdre Mongan)

Government policy on homelessness

On the 21 February 2013, Ms Jan O'Sullivan TD, Minister for Housing and Planning, launched a policy statement on homelessness.[1] In her speech, the minister restated her personal commitment to tackling homelessness as a priority. She also acknowledged that 'homelessness is not a label or category; it is a destructive social condition that can wreak havoc on human dignity and well-being. As a social condition it requires a social response – from Government, from the voluntary sector, from citizens'.[2]

The policy statement follows a review of government policy towards homelessness which was undertaken by Eoin O'Sullivan in 2012.[3] O'Sullivan is critical of the value for money obtained from state expenditure on tackling homelessness. He argues that 'it is now clear that the historically high levels of statutory funding for homelessness services are not delivering satisfactory outcomes for homeless households…' (p.24). This funding has traditionally being channelled into the provision of emergency-type shelter or resource-intensive interventions with various forms of ancillary support to prepare individuals to become 'housing ready'. In the case of individuals with alcohol and drug problems, this has meant that evidence of abstinence or sustained stabilisation was often required prior to their being considered for more sustainable accommodation.

O'Sullivan reviewed a number of studies that reported outcomes from both the broad church of the housing-ready / treatment-first approach and the housing-first (or housing-led) approach. The latter does not require people to demonstrate abstinence or provide evidence that they are ready to be housed. The housing-led approach seeks to place homeless people in sustainable rented accommodation first, and provides 'floating supports' at the request of the person being housed. Such supports may include assistance with social welfare enquiries, developing independent living skills or seeking help for addiction problems. O'Sullivan concludes that 'the overwhelming evidence points to the effectiveness of a Housing Led approach rather than one that seeks to promote Treatment First' (p.35).

The policy statement on homelessness endorses this view of the evidence base and declares that the policy's primary purpose is to make explicit the government's commitment to ending homelessness by implementing the housing-led approach. The policy statement asserts the government's aim to end long-term homelessness by the end of 2016 and encapsulates the government's response to homelessness to include the following components:

1. Preventing homelessness
2. Eliminating the need to sleep rough
3. Eliminating long-term occupation of emergency accommodation
4. Providing long-term housing solutions
5. Ensuring effective services
6. Better co-ordinated funding arrangements.

At the launch, the Minister announced that an oversight group has been established to monitor and review the housing-led approach being advocated in the policy statement. To assist the group in monitoring the measures and approach outlined in the policy, the minister announced a set of seven indicators that will be used to 'demonstrate the dynamics' of homelessness as it is addressed:

1. Number of new homeless presentations on a daily basis
2. Number of persons in emergency accommodation for longer than six months
3. Number of persons leaving emergency accommodation
4. Occupancy rate in emergency accommodation
5. Number of persons moving on into independent living with support
6. Number of persons moving on into independent living without support
7. Number of persons sleeping rough voluntarily and involuntarily

The publication of this policy statement is a welcome development and makes explicit the government's commitment to implement the housing-led approach, a model grounded in consistent evidence on efficiency and effectiveness. However, if the model is to be applied and the government's target of ending long-term homelessness by 2016 is to be realised, then sufficient numbers of housing units must be made available. In the current climate of austerity and fiscal restraints, these outputs may be compromised. Indeed, a recent article by Mary Regan, political correspondent for the *Irish Examiner*, reports Minster O'Sullivan's acknowledgement that 'her department is "struggling" with ensuring it has enough accommodation to meet demand. [But]…her department hopes to secure 3,000 units from Nama'.[4]

(Martin Keane)

1. Department of the Environment, Community and Local Government (2013) *Homelessness policy statement*. Dublin: Department of the Environment, Community and Local Government. www.drugsandalcohol.ie/19346
2. O'Sullivan J (2013, 21 February) Speech by Ms Jan O'Sullivan TD, Minister for Housing and Planning on the launch of the homeless policy statement. Available at www.drugsandalcohol.ie/19346
3. O'Sullivan E (2012) Ending homelessness: a housing-led approach. Dublin: Department of the Environment, Community and Local Government. www.environ.ie/en/Publications/DevelopmentandHousing/Housing/FileDownLoad,32437,en.pdf
4. Regan M (2013, 22 February) 'Hope is not enough' to end long-term homelessness. *Irish Examiner*. Accessed 8 May 2013 at www.irishexaminer.com/ireland/hope-not-enough-to-end-long-term-homelessness-223411.html

Legal proceedings for drug offences 2004–2011

This article looks at trends in legal proceedings for drug offences in the years 2004–2011. It should be noted that drug offence data are primarily a reflection of law enforcement activity. Consequently, they are affected in any given period by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of drug users and drug traffickers to law enforcement activities. Having said that, when compared with other data sources such as drug treatment for example, they can provide a useful indicator of overall drug trends. Alternatively, where law enforcement trends differ from those of other data sources in a given period they may reveal something about specific law enforcement strategies or activities at that time, something that can be further investigated through research.

Figures 1 and 2 show trends in proceedings for drug offences from 2004 to 2011. As can be seen from Figure 1, the number of legal proceedings for the possession of drugs for personal use (simple possession) decreased in 2009 for the first time since 2004. The number continued to fall in the following two years. Simple possession offences accounted for almost 69% of total drug offence proceedings in 2011. Proceedings for drug supply have also decreased marginally since 2009.

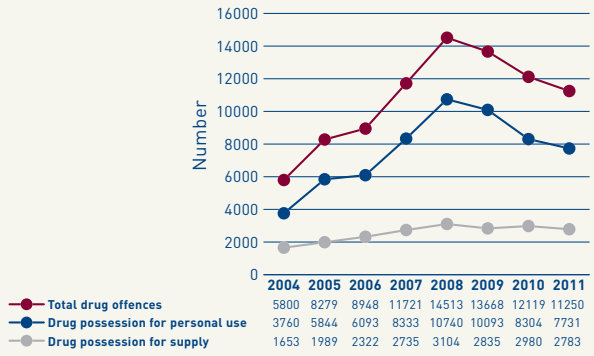


Figure 1 Trends in relevant legal proceedings for total drug offences, and for possession for personal use and for supply, 2004–2011

Source: Central Statistics Office (2013) Interactive tables online[1]

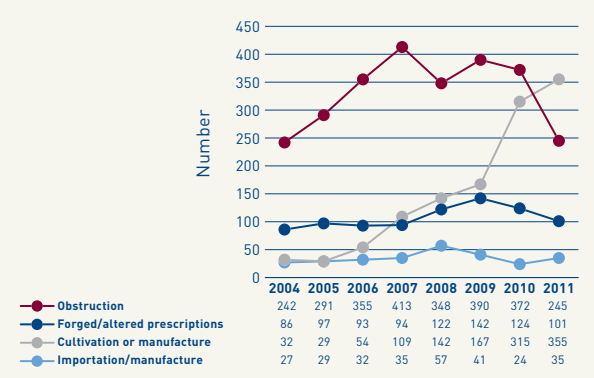


Figure 2 Trends in relevant legal proceedings for selected drug offences, 2004–2011

Source: Central Statistics Office (2013) Interactive tables online[1]

Obstruction offences often involve an alleged offender resisting a drug search or an arrest or attempting to dispose of drugs to evade detection. Such offences continue to account for the largest number of prosecutions, although numbers declined from a high of 415 in 2007 to 245 in 2011, approaching the 2004 figure of 242. Proceedings for the offence of forged/altered prescriptions have also remained fairly constant since 2004. Another noteworthy development has been the continued increase in the offence of cultivating/manufacturing controlled drugs. Proceedings for this offence have continued to increase since 2005, when there were 29 related proceedings, reaching 167 in 2009 and then more than doubling to 355 in 2011. It is unclear whether this increase reflects a genuine growth in the commission of such offences or a sustained concentration of law enforcement on their detection. For example, in 2010, the Garda Síochána conducted Operation Nitrogen, a nationwide investigation into cannabis cultivation sites by district and divisional drug units.[2] Although the specific focus of this operation may have had an impact on the data presented here, a recent report jointly published by the EMCDDA and Europol highlighted the increased involvement of organised crime groups in cannabis cultivation in many European countries, including Ireland.[3]

Drug driving offences

Figure 3 shows the trend in prosecutions for driving or being in charge of a vehicle while under the influence of drugs (DUID) between 2004 and 2011. Between 2006 and 2009 the number of prosecutions for DUID increased from 74 to 703, an increase of 850%. It is unclear why this increase occurred. It could be due to an increase in the incidence of DUID or, the more likely possibility, to an increase in targeted police activity in this area. Since 2009, the number of such offences has decreased significantly, with 337 reported prosecutions in 2011.

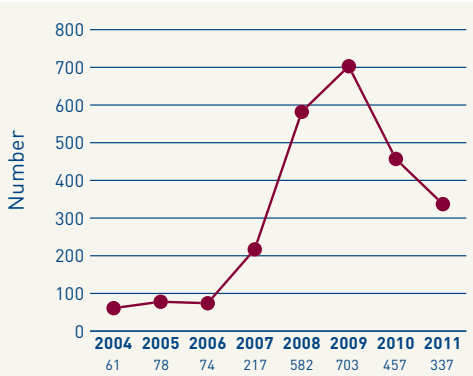


Figure 3 Trend in relevant legal proceedings for driving in charge of a vehicle while under the influence of drugs, 2004–2011

Source: Central Statistics Office (2013) Interactive tables online[1]

Drug offences 2004–2011 *(continued)*

Drug offence data can assist us in understanding aspects of the operation of the illicit drug market in Ireland. Data on drug offence prosecutions by Garda division are a possible indicator of national drug distribution patterns. While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, when compared with other sources, such as drug treatment data, for example, they can show us trends in market developments throughout the State. Such data can also indicate trafficking patterns by showing whether there is a concentration of prosecutions along specific routes. Figures 4 and 5 show trends in relevant legal proceedings for possession of drugs by Garda region. It should be noted that possession offences include both possession for personal use and possession for the purpose of supply. It is not possible to distinguish between these two offences in the data reported by Garda region. However, in the country as a whole, possession for personal use accounted for between 65% and 75% of all possession cases in the years 2004–2011 (Figure 1).

As shown in Figure 4, an upward trend since 2004 in relevant legal proceedings for possession (for personal use and for supply) continued until 2008, and then decreased between 2008 and 2011. The majority of such proceedings were in the Dublin Metropolitan Region (DMR), where the number increased steadily from 1,515 in 2004 to 5,270 in 2008. The number has fallen since then, with 3,773 such offences prosecuted in 2011, below the figure of 4,077 reported for 2007.

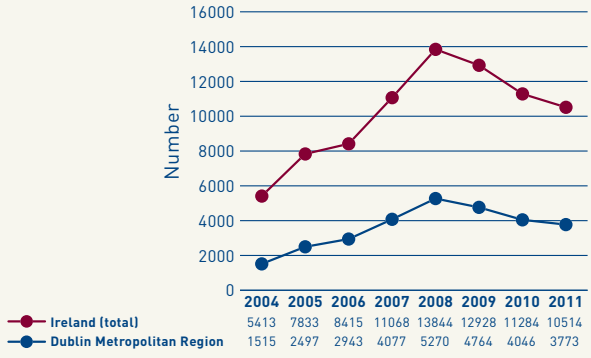


Figure 4 Trends in relevant legal proceedings for possession of drugs for personal use and for sale or supply, nationally and in the Dublin Metropolitan Region, 2004–2011

Source: Central Statistics Office (2013) Excel tables online[4]

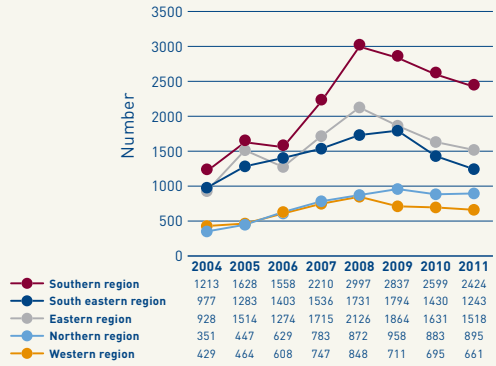


Figure 5 Trends in relevant legal proceedings for possession of drugs for personal use and for sale or supply, by region, excluding the DMR, 2004–2011

Source: Central Statistics Office (2013) Excel tables online[4]

Figure 5 shows trends in supply offences by Garda region, excluding Dublin. Numbers have increased in all regions since 2004. This reflects the reality that drug markets are no longer primarily a Dublin-based phenomenon. Following this general increase throughout the country since 2004, the number of relevant legal proceedings for drug possession (for personal use and for supply) decreased in all regions between 2008 and 2011, with the exception of the Northern Region where the figure fluctuated slightly in that period.

(Johnny Connolly)

1. Central Statistics Office (2013) Interactive tables online. Table CJA02: Offences by type of offence, year and statistic. www.cso.ie/px/pxeirestat/Statire/SelectVarVal/Define.asp?maintable=CJA02&PLanguage=0
2. An Garda Síochána (2012) *Annual report 2011*. Dublin: An Garda Síochána. www.drugsandalcohol.ie/17953
3. European Monitoring Centre for Drugs and Drug Addiction, Europol (2013) *EU drug markets report: a strategic analysis*. Luxembourg: Publications Office of the European Union. www.drugsandalcohol.ie/19227
4. Central Statistics Office (2013) *Garda recorded crime satistics 2003–2011*. Excel tables online, Table 4 complete. www.cso.ie/en/releasesandpublications/crimeandjustice/gardarecordedcrimestatistics2003–2011exceltables/

INCB annual report 2012

The International Narcotics Control Board (INCB) is responsible for overseeing the operation of the international drug treaties, management of markets in medicines controlled by the treaties, and ensuring the supply of opioids for pain and other medical uses.[1] The Board, which comprises 13 experts elected by the United Nations Economic and Social Council, deems itself the guardian of the treaties and is often critical of countries it judges as having violated their provisions. For example, in its annual report for 2012,[2] Denmark comes in for criticism for proposals to establish drug consumption rooms, and 'coffee shops' in the Netherlands are considered by the Board to be in violation of the international drug control conventions (pp.99–100). The report highlights the publication of the National Substance Misuse Strategy in Ireland. It also refers to the 'heroin drought' identified in Ireland in late 2010 and relates this to a decrease in heroin being trafficked to the United Kingdom via Turkey (p.103). Another interesting drug market feature noted in the report relates to the trafficking of amphetamine-type stimulants (ATS) into Australia. Ireland, along with Canada, China (including Hong Kong) and India are the main embarkation points for those detected bringing ATS into Australia (p.112).

(Johnny Connolly)

1. For a recent article on the international drug conventions, see Room R and Reuter P (2012) How well do international drug conventions protect public health? *The Lancet*, 379(9810): 84–91.
2. International Narcotics Control Board (2013) *Report of the International Narcotics Control Board for 2012*. Vienna: United Nations Office. Available at www.drugsandalcohol.ie/19428

Recent publications

Books

Books recently acquired by the National Documentation Centre on Drug Use.

Drugs 2.0: the web revolution that's changing how the world gets high
by Mike Power
Portobello Books (2013)
ISBN: 9781–1–84627–459–6

Journal articles

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

Cannabis misinterpretation and misadventure in a coroner's court

Tormey WP

Medicine, science, and the law, 2012, 52(4): 229–230.

www.drugsandalcohol.ie/19527

A 37-year-old, one-pack-per-day tobacco smoker collapsed and died at home. At autopsy, he had an occluded left anterior descending coronary artery. Δ(9)-Tetrahydrocannabinol-carboxylic acid was found in his urine but no cannabinoids were detected in his blood. Misadventure was the inquest verdict on the basis of the urinary cannabis, with acute myocardial infarction as the primary cause and cannabis as the secondary cause of death. Such a conclusion is a misinterpretation of the evidence when the time duration for cannabis as a trigger for myocardial infarction is at most two hours. The absence of cannabis in the blood likely places the time since inhalation at more than two hours. The role of tobacco smoking as a trigger was ignored. Cotinine, the biochemical marker of tobacco smoke, should be added to the standard toxicological screen in the guidelines on autopsy practice of the Royal College of Pathologists.

The epidemiology of assault-related hospital in-patient admissions and ED attendances

O'Farrell A, de la Harpe D and Geary U

Irish Medical Journal, 2013, 106(3).

www.drugsandalcohol.ie/19503

The aim of this study was to describe the epidemiology and impact of serious assault warranting in-patient care over six years and its impact on ED attendances in a large teaching hospital in Dublin over 2 years. There were 16,079 emergency assault-related in-patient hospital discharges reducing from 60.1 per 100,000 population in 2005 to 50.6 per 100,000 population in 2010. The median length of stay was 1 day (1–466) representing 49,870 bed days. The majority were young males (13,921, 86.6%; median age 26 years). Overall crime figures showed a similar reduction. However, knife crimes did not reduce over this period. Data on ED attendances confirmed the age and gender profile and also showed an increase at weekends. Alcohol misuse was recorded in 2,292/16079 (14%) of in-patient cases and 242/2484 (10%) in ED attendances. An inter-sectoral preventative approach specifically targeting knife crime is required to reduce this burden on health services.

Silk Road, the virtual drug marketplace: a single case study of user experiences

Van Hout MC and Bingham T

International Journal of Drug Policy, 2013, 1 March, Early online.

www.drugsandalcohol.ie/19490

Background: The online promotion of 'drug shopping' and user information networks is of increasing public health and law enforcement concern. An online drug marketplace called 'Silk Road' has been operating on the 'Deep Web' since February 2011 and was designed to revolutionise contemporary drug consumerism.

Methods: A single case study approach explored a 'Silk Road' user's motives for online drug purchasing, experiences of accessing and using the website, drug information sourcing, decision making and purchasing, outcomes and settings for use, and perspectives around security. The participant was recruited following a lengthy relationship building phase on the 'Silk Road' chat forum.

Results: The male participant described his motives, experiences of purchasing processes and drugs used from 'Silk Road'. Consumer experiences on 'Silk Road' were described as 'euphoric' due to the wide choice of drugs available, relatively easy once navigating the Tor Browser (encryption software) and using 'Bitcoins' for transactions, and perceived as safer than negotiating illicit drug markets. Online researching of drug outcomes, particularly for new psychoactive substances was reported. Relationships between vendors and consumers were described as based on cyber levels of trust and professionalism, and supported by 'stealth modes', user feedback and resolution modes. The reality of his drug use was described as covert and solitary with psychonautic characteristics, which contrasted with his membership, participation and feelings of safety within the 'Silk Road' community.

Conclusion: 'Silk Road' as online drug marketplace presents an interesting displacement away from 'traditional' online and street sources of drug supply. Member support and harm reduction ethos within this virtual community maximises consumer decision-making and positive drug experiences, and minimises potential harms and consumer perceived risks. Future research is necessary to explore experiences and backgrounds of other users.

Effectiveness of motivational interviewing in influencing smoking cessation in pregnant and postpartum disadvantaged women

Hayes C, Collins C, O'Carroll H, Wyse E, Gunning M, Geary M and Kelleher CC

Nicotine & Tobacco Research, 2013, 15(5): 969–977.

www.drugsandalcohol.ie/19420

Introduction: Systematic assessments of Motivational Interviewing (MI) in smoking behavior have been rare to date. This study aimed to determine whether an integrated approach, involving staff training in MI techniques, was sufficient to affect change in smoking status or intensity in low-income pregnant and postpartum women.

Methods: Overall, 500 consecutive smokers were recruited at first prenatal visit to public antenatal clinics. Following staff training, 500 more were recruited (intervention group). Data were recorded at 28–32 weeks gestation, after birth, at 3–4 and 7–9 months postpartum. The primary outcome measure was self-reported continued abstinence from smoking verified by urinary cotinine analysis. Changes in smoking intensity were also measured.

Results: There was no significant difference in the proportion of smokers in the intervention and control groups who reported stopping smoking at 28–32 weeks gestation (8.2% vs. 8.8%; p = .73), 1 week after birth (8.6% vs. 11.4%; p = .14), 3–4 months after birth (5.8% vs. 4.8%; p = .48), or 7–9 months after birth (5.2% vs. 4.0%; p = .36). Although more cases were nonsmoking at the second visit, 14.8% [95% CI = 11.8–18.5] vs. 13.1% controls [95% CI = 10.3–16.6], this was not statistically significant.

Conclusions: MI delivered at a number of time points during pregnancy and up to 9 months postpartum failed to affect quit rates. It may have had a small effect in preventing relapse among spontaneous quitters in late pregnancy though the validity of this remains uncertain.

Attitudes of women from five European countries regarding tobacco control policies

Dresler CM, Wei M, Heck JE, Allwright S, Haglund M, Sanchez S *et al.*

Scandinavian Journal of Public Health, 2013, 41(2): 126–133.

www.drugsandalcohol.ie/19419

Aims: Tobacco-related cancers and, in particular, lung cancer still represent a substantial public health epidemic across Europe as a result of high rates of smoking prevalence. Countries in Europe have proposed and implemented tobacco control policies to reduce smoking prevalence, with some countries being more progressive than others. The aim of this study was to examine factors that influenced women's attitudes in five European countries relative to comprehensive smoke-free laws in those countries.

Methods: A cross-sectional landline telephone survey on attitudes towards tobacco control laws was conducted in France, Ireland, Italy, the Czech Republic and Sweden. Attitudinal scores were determined for each respondent relative to questions about smoke-free laws. Logistic regression models were used to obtain odds ratios with 95% confidence intervals.

Results: A total of 5,000 women were interviewed (1,000 women from each country). The majority, regardless of smoking history, objected to smoking in public buses, enclosed shopping centers, hospitals, and other indoor work places. More women who had quit smoking believed that new tobacco control laws would prompt cessation, compared with women who still smoked.

Conclusions: In general, there is very high support for national smoke-free laws that cover bars, restaurants, and public transport systems. As such laws are implemented, attitudes do change, as demonstrated by the differences between countries such as Ireland and the Czech Republic. Implementing comprehensive smoke-free laws will gain high approval and will be associated with prompting people to quit.

Reductions in cardiovascular, cerebrovascular, and respiratory mortality following the national Irish smoking ban: interrupted time-series analysis

Stallings-Smith S, Zeka A, Goodman P, Kabir Z and Clancy L

PLoS ONE, 2013, 8(4).

www.drugsandalcohol.ie/19756

Background: Previous studies have shown decreases in cardiovascular mortality following the implementation of comprehensive smoking bans. It is not known whether cerebrovascular or respiratory mortality decreases post ban. On 29 March 2004, the Republic of Ireland became the first country in the world to implement a national workplace smoking ban. The aim of this study was to assess the effect of this policy on all-cause and cause-specific, non-trauma mortality.

Methods: A time-series epidemiologic assessment was conducted, utilizing Poisson regression to examine weekly age and gender-standardized rates for 215,878 non-trauma deaths in the Irish population aged 35 years and over. The study period was from 1January 2000 to 31 December 2007, with a post-ban follow-up of 3.75 years. All models were adjusted for time trend, season, influenza, and smoking prevalence.

Results: Following ban implementation, an immediate 13% decrease in all-cause mortality (RR: 0.87; 95% CI: 0.76 0.99), a 26% reduction in ischemic heart disease (IHD) (RR: 0.74; 95% CI: 0.63–0.88), a 32% reduction in stroke (RR: 0.68; 95% CI: 0.54– 0.85), and a 38% reduction in chronic obstructive pulmonary disease (COPD) (RR: 0.62; 95% CI: 0.46–0.83) mortality was observed. Post-ban reductions in IHD, stroke, and COPD mortalities were seen in ages 65 years and over, but not in ages 35–64 years. COPD mortality reductions were found only in females (RR: 0.47; 95% CI: 0.32–0.70). Post-ban annual trend reductions were not detected for any smoking-related causes of death. Unadjusted estimates indicate that 3,726 (95% CI: 2,305 4,629) smoking-related deaths were likely prevented post-ban. Mortality decreases were primarily due to reductions in passive smoking.

Conclusions: The national Irish smoking ban was associated with immediate reductions in early mortality. Importantly, postban risk differences did not change with a longer follow-up period. This study corroborates previous evidence for cardiovascular causes, and is the first to demonstrate reductions in cerebrovascular and respiratory causes.

A comparative analysis of health policy performance in 43 European countries

Mackenbach JP and McKee M

Journal of Public Health, 2013, 23(2): 195–344.

www.drugsandalcohol.ie/19744

Background: It is unknown whether European countries differ systematically in their pursuit of health policies, and what the determinants of these differences are. In this article, we assess the extent to which European countries vary in the implementation of health policies in 10 different areas, and we exploit these variations to investigate the role of political, economic and social determinants of health policy. Data and Methods: We reviewed policies in the field of tobacco; alcohol; food and nutrition; fertility, pregnancy and childbirth; child health; infectious diseases; hypertension detection and treatment; cancer screening; road safety and air pollution. We developed a set of 27 'process' and 'outcome' indicators, as well as a summary score indicating a country's overall success in implementing effective health policies. In exploratory regression analyses, we related these indicators to six background factors: national income, survival/self expression values, democracy, government effectiveness, left-party participation in government and ethnic fractionalization.

Results: We found striking variations between European countries in process and outcome indicators of health policies. On the whole, Sweden, Norway and Iceland perform best, and Ukraine, Russian Federation and Armenia perform worst. Within Western Europe, some countries, such as Denmark and Belgium, perform significantly worse than their neighbours. Survival/self-expression values and ethnic fractionalization were the main predictors of the health policy performance summary score. National income, survival/self-expression values and government effectiveness were the main predictors of countries' performance in specific areas of health policy.

Conclusions: Although many new preventive interventions have been developed, their implementation appears to have varied enormously among European countries. Substantial health gains can be achieved if all countries would follow best practice, but this probably requires the removal of barriers related to both the 'will' and the 'means' to implement health policies.

Upcoming events

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

August

21–23 August 2013

***Contemporary Drug Problems* Conference**
Complexity: Researching alcohol and other drugs in a multiple world
Venue: Aarhus University, Denmark
Organised by / Contact: Aarhus University Conference organisers
Email: CDP@curtin.edu.au
Web: psy.au.dk/en/research/research-centres-and-units/centre-for-alcohol-and-drug-research/research/conferences/contemporary-drug-problems/
Information: An interdisciplinary conference for international researchers in drug use and addiction studies from a range of research disciplines. This conference offers a forum in which the issues and dilemmas of complexity in alcohol and other drug research can be explored. It welcomes research based on quantitative and qualitative methods, and encourages innovative use of methods, concepts and theoretical approaches. Following the conference, Contemporary Drug Problems, an interdisciplinary quarterly and one of the driving forces behind the conference, will publish a special issue featuring selected papers from the conference.

September

17–20 September 2013

Rehabilitation and Drug Policy
14th EFTC Conference
Venue: Prague, Czech Republic
Organised by / Contact: European Federation of Therapeutic Communities (EFTC)
Email: eftc@conference.cz
Web: www.conference.cz/EFTC2013/index.htm
Information: This Conference will be hosted by Magdalena, a non-governmental organisation, and the Clinic of Addictology at Charles University. Its purpose is to discuss the pressing issues we all face in this changing world of addiction: development trends in the therapeutic community; research and education; and special populations and approaches. This topic not only invites us to reflect upon the basic and classical therapeutic ideas from a contemporary perspective, but also to discuss their current transformation, modification, and new developments.

18 September 2013

The EU Drugs Strategy 2013–2020: Combating Illicit Trafficking and Substance Misusee
Venue: The Silken Berlaymont Hotel, Brussels
Organised by / Contact: Public Policy Exchange
Email: parvin.madahar@publicpolicyexchange.co.uk
Tel: +44 (0) 20 3137 8630
Web: www.publicpolicyexchange.co.uk
Information: This special International Symposium provides a timely opportunity for practitioners and stakeholders across Europe to discuss the latest challenges and consider the next steps needed to win the fight against illicit drug trafficking and substance misuse through holistic, multi-level and cross-border approaches. Public Policy Exchange welcomes the participation of all key partners, responsible authorities and stakeholders.

21 September 2013

2nd Annual Recovery Walk
Venue: Civic Offices, Wood Quay, Dublin
Organised by / Contact: The Recovery Foundation
Email: info@recoverywalkireland.com
Web: www.recoverywalkireland.com
Information: Addiction is a community-wide problem – recovery should be a community-wide celebration. The recovery walk is a free, fun-filled, family event with food and music. Register on our website.

October

31 October 2013

Digital Alcohol Marketing – Online Conference
Organised by / Contact: European Centre for Monitoring Alcohol Marketing (EUCAM)
Email: eucam@eucam.info
Web: www.eucam.info
Information: Developments in digital alcohol marketing have gone rapidly as alcohol marketers adapt to keep up with the latest trends and technologies. Consequently, there is a need for up-to-date evidence based policy measures. To ring the alarm bell, close the gap in the literature and publicize much needed policy recommendations, EUCAM is dedicating its first online conference on the subject of digital alcohol marketing. The conference will result in the publication of the EUCAM Manifesto on Digital Alcohol Marketing. NGOs, policy officials and scientists are welcome to participate.

November

6 November 2013

Game on: drug and alcohol services and the new local players
Venue: Connaught Rooms, Great Queen Street, London WC2B 5DA
Organised by / Contact: DrugScope
Email: conferences@drugscope.org.uk
Web: www.drugscope.org.uk/events
Information: It has been a long time coming, but now it is here. As the National Treatment Agency rides off into the sunset, over the hill comes Public Health England and with it a whole new landscape in which drug and alcohol services need to operate. PHE will be much more 'hands off' than the NTA and for some that will be welcome. But it does mean that the voice for services inside Whitehall will be quieter – and we will all need to get smarter at making the case for services at the local level. So we have speakers who reflect the new dynamic as well as those reporting on developments in drug use which may well impact on services.

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