acjrd

Preventable Harm

SIXTEENTH ANNUAL CONFERENCE

Camden Court Hotel, Dublin 2. Friday 4th October 2013

Mission Statement

ACJRD informs the development of policy and practice in justice

Vision Statement

Innovation in justice

CONTENTS

Foreword from the Chairperson

Maura Butler, Chairperson ACJRD Ltd

As Chairperson of the Association for Criminal Justice Research and Development (ACJRD) it is very rewarding to have had another successful annual conference.

As many public service delegates were present the Chatham House Rules were evoked as in the previous years. The Chatham House Rules state:
"When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed".

Presentations at this conference reflected the diversity of our membership to include academics, professional and voluntary practitioners from the criminal justice system, and other disciplines. In choosing the theme for its 16th Annual Conference '*Preventable Harm: Criminal Justice, Communities and Civil Society*' this diversity of membership was also a factor. This theme facilitated the construction of knowledge towards better understanding for all, through our usual plenary presentations and workshop structures.

Learning through the shared research and experience of conference contributors, as outlined in this Conference Report, highlights those spaces where criminal law breaches affect the communities in which they occur. The responses to those breaches by members of those communities and civil society groups, delineated in this publication, demonstrate the constructive impact of such interventions. In particular this conference 'takes pause' to consider those intersections which take place when decisions are taken within communities to work with offenders and offending and where civil society groups offer services to facilitate crime reductions, desistance from crime and reintegration of the offender back into the community whilst also engaging with issues arising for victims of crime.

Specifically the plenary sessions presented discourse and considered papers on the nature of voluntary and community sector service provision in criminal justice and its dynamics. The conference took note of the diversity of Irish society in 2013 and the necessity to incorporate that into our policing policy. Two separate and thought provoking presentations opened up the Harm Reduction/Abstinence from drugs debate, in the context of policy in this area.

Focusing on communities, the conference benefited from a presentation on the development of a Restorative Community in Tallaght West and consideration of the new Victims' Rights Directive.

All of the large group sessions then peeled off into eight workshops where these ideas and discussions were further elaborated, discussed and debated, utilising the expertise of the workshop speakers but also the expertise of the participants who generously shared their experiences.

Specific issues arising for juvenile offenders were given particular focus during some of these workshops where the development of behavioural skills, family support and reintegration were explored, thereby augmenting individual knowledge through group interaction.

The 16th Annual Conference was launched by Nora Owen. Nora is a former Minister for Justice (1994-1997), having commenced a career as a TD in 1981. Nora's service to Irish society outside politics includes work with the Irish Aid Expert Advisory Group, the Railway Preservation Society of Ireland, The Special Olympics, and national TV presentations.

ACRJD sincerely thanks Nora Owen and all of the expert speakers who made this conference a most vibrant and informative one and hopes that the papers now collated in this report will be of benefit to those who work in the sector.

"Looking a gift horse in the mouth: voluntary and community sector service provision in criminal justice[i]"

Professor Anthea Hucklesby, University of Leeds, UK

Introduction

The direction of travel of the UK government in terms of the provision of criminal justice services in England and Wales is clear. Successive policy documents have demonstrated a commitment to opening up the criminal justice sector to competition (MoJ, 2010). The vision is to have a mixed economy of provision provided by a tripartite structure of statutory agencies, voluntary and private sector organisations. The latest plans involve the deconstruction of the probation service as it operates currently (MoJ, 2012; 2013). This will be replaced by a new National Probation Service responsible for servicing the courts and managing high risk offenders. The remainder of its current work will be put out to competitive tender with providers potentially being individual organisations from one sector or consortiums from one or more sectors (MoJ, 2013). Despite much opposition and warning signs (including allegations of fraud against two of the primary private providers of criminal justice services) about the planned approach, the government seems intent on carrying through its policy which is motivated at least as much by ideology as the need to reduce costs.

The drive for a mixed economy of criminal justice presents a major opportunity for the voluntary sector as a whole and the individual organisations within it. It could signal a significant watershed in their long-standing involvement in criminal justice and resolve enduring issues about their reliance on short contracts, soft money and the largess of the state sector to facilitate their work. For the Government, the voluntary sector provides an acceptable mechanism to further reduce the (almost) state monopoly on managing punishment and privatise, or at least deregulate, the governance of criminal justice. There is no doubt that the voluntary sector contributes significantly to criminal justice services currently and historically and has plugged gaps in state provision, providing essential and complementary services for offenders (Hucklesby and Worrall, 2007). One of its main advantages is its separation from the state and its community roots which engender high levels of trust facilitating work with 'hard to reach' groups. Its strong connections with local communities promote social capital which can be drawn upon by service users (Brown and Ross, 2010). An important element of the services it provides is the involvement of volunteers who add a positive dimension to services which is not present when individuals are paid to do a job. The sector claims to bring distinctive values with it which are, to a greater or lesser extent, based on altruistic values. It is also viewed as independent, innovative, flexible and risk-

taking. There is an economic imperative to policy change and the voluntary sector is viewed as a cheaper way of providing services. It also has access to additional funding sources (for example, Trust and Foundation funding) to support their activities.

The plans for the greater involvement of the voluntary sector in criminal justice services appear to be a win-win situation for both parties. The government receive services which are as good, if not better, than statutory sector agencies provide, more cheaply, whilst the voluntary sector gains the opportunity to provide its services in an arguably more secure funding environment. This paper questions these assumptions, suggesting that not everything that appears to be a gift for both parties actually is, or indeed is worth having. The saying 'Don't look a gift horse in the mouth' suggests that one should be grateful for receiving a gift and that you should not try and quantify the value of the gift. It apparently has its origins in the fact that horses teeth continue to grow throughout their lives. Consequently, if you look in the mouth of a horse you have received as a gift you might find out that it is an 'old nag' rather than the sprightly working horse you had been lead to believe. The moral of this tale is to examine what appears to be a gift carefully and this is the argument set out in this short paper.

The voluntary sector in criminal justice

The voluntary sector has a long history of working in the criminal justice field as service providers, advocates and reformers. Today, the voluntary sector is diverse ranging from small organisations relying exclusively on volunteers to large organisations with many paid staff and high turnovers although small organisations predominate numerically. It also encompasses a range of fields within criminal justice although the focus of this paper is the penal voluntary sector. Even in this sub-sector, there is tremendous diversity and importantly many of the agencies involved in penal service provision would not define themselves by this work. Instead they are organisations working in broad areas of social welfare such as housing, employment, mental health and so on.

In the sector the quality of service provision is variable. Just because it is provided by the voluntary sector, often at minimal cost to the host organisation or the user communities, it does not necessarily mean that it is useful and/or effective. This matters for two main reasons. One, the user communities are fragile and often vulnerable. Offenders are some of the most damaged and marginalised members of society with multiple and long-standing problems. The criminal justice system often acts as a safety net for the offenders who have fallen through the gaps between services and/or had negative experiences of them and poor service provision can exacerbate these problems. It is also well known that the good intentions of offenders to go straight readily dissolve. Poor service provision can result in no change or even more damaged users with all the implications this has for reconviction rates

and so on. Secondly, interventions can be harmful as well as helpful. Integrity of programmes is important because outcomes are worst when offenders fail to complete programmes which they have started than if they do not start them (Harper and Chitty, 2005). Continuity and sustained relationships matter so outcomes are better if the same individuals work with offenders (Burnett, 2004; Lewis et al, 2007; Shapland et al, 2012; Rex, 1999). Procedural justice i.e. that service users view the service as legitimate, are treated justly, with respect and are given a voice is also an influential factor in outcomes (Shapland et al, 2012; Tyler, 1990; Tyler and Huo, 2002). Consequently, an important question for policy makers is how voluntary sector providers can ensure that they provide a stable and supportive environment to work with offenders. The question is pertinent because traditionally voluntary sector organisations have provided supplementary, 'nice to have' services rather than core services. They have often filled the gaps left by the statutory sector, for example, the provision of bail support services (Hucklesby, 2011), resettlement services for prisoners serving sentences of under 12 months who do not currently receive statutory supervision (Hucklesby and Wincup, 2007) and more generally taking on the role vacated by the probation service when it moved away from its role of 'advising, assisting and befriending' to more managerialist imperatives (Hucklesby and Wincup, forthcoming). Traditionally they have not been involved in the provision of core services, with serious offenders or with enforcement. They have primarily provided services which are accessed voluntarily and with the informed consent of the service users. They are now being expected to take on very different roles, many of which embed them into the coercive elements of the criminal justice process.

Positive futures?

Voluntary sector organisations have a choice about whether they become involved in contracting for core criminal justice services. However, some of the areas of activity in which they currently operate have become or are becoming mainstreamed into the core activities of the criminal justice process, therefore reducing the opportunities for working in partnership or in parallel with the state sponsored system. The voluntary sector has been successful both in terms of selling itself as legitimate and effective providers of criminal justice services and changing government policy. Its success has led to the encroachment of the statutory sector on the 'patch' where it has traditionally operated. For example, the UK Government has announced the setting up of a nationwide resettlement service to provide 'through the gate' services to all offenders leaving prison, even those serving sentences of under 12 months, and the provision of mentoring for all offenders (MoJ, 2013). These will be part of the new commissioning structure so areas of activity in which the voluntary sector have traditionally been involved are now core activities. This is a double edged sword. On the one hand, it

potentially provides a secure funding source for voluntary sector organisations to continue to provide such services. On the other hand, it may close off areas of activity in which they have considerable expertise and which may result in reducing the viability of organisations.

The lure of government contracts for voluntary sector organisations appears to be overwhelming. For them, it represents opportunities including more secure funding and access to an infrastructure which they have often lacked in the past, including information about defendants /offenders which has be carefully guarded by statutory agencies. It provides them with the opportunity to get involved in the provision of mainstream services and scaling up their innovative programmes and so on. In short, they can make a difference on a larger scale. It may also feel like they do not have a choice. However, there are questions about whether the voluntary sector can, or indeed should, become involved in delivering mainstream criminal justice services and it is to these issues that we now turn.

The evidence base on which claims about the effectiveness of services provided by the voluntary sector are made is weak (see for example Boaz and Pawson, 1995; Joliffe and Farrington, 2007). It is only relatively recently that the sector has undertaken robust evaluations of its work and these are still few and far between (Wincup and Hucklesby, 2007). Traditionally, voluntary sector organisations have been protective of their work using selective information to validate their approach. The 'feel good factor' (Colley, 2002) which surrounds the voluntary sector has often cushioned it from close scrutiny. This leaves many unanswered questions which are fundamental to providing a holistic view of the voluntary sector's contribution to the criminal justice landscape. This includes the extent of its involvement in all aspects of criminal justice services. Recent work by Gojkovic et al (2011) demonstrates how difficult it is to quantify its involvement in the criminal justice sector even to the extent of measuring how many voluntary sector organisations work with offenders, let alone the scope of its contribution to meeting criminal justice targets such as reducing reoffending.

Voluntary sector organisations tend to provide services which they wish to provide (and may have received funding for from independent sources) rather than what is needed or as part of any strategic coordinated plan. Services are often ideologically driven rather than evidence based. What is provided in one location is serendipitous rather than planned resulting in overlap in some areas and gaps in others. The questions which need to be asked but are often not, are whether the services being proposed or provided are necessary and appropriate and whether the most appropriate organisation is providing the service(s). This is important because the services have resource implications for the host organisations which might include the provision of space, coordination and so on

and inappropriate services may be harmful. It is also vital that questions are asked about how effective the services are. The answer depends on what they are trying to achieve. The objectives may not in any event coincide with Government and/or statutory sector targets perhaps because they were never intended to. Certainly, there is little evidence of the mechanisms by which the work of voluntary sector organisations is supposed to, or actually does, contribute to the major aims of criminal justice such as reducing reoffending. A much firmer evidence base is required which is reliant on a more questioning rather than accepting culture.

The evidence about the quality, integrity and consistency of services provided by voluntary sector organisations raises questions about their ability to deliver core services in the new competitive environment. For example, some organisations rely heavily on volunteers. This leads to questions about whether there is a sufficient supply of good quality, reliable volunteers. Research evidence suggests that, even for relatively small scale projects, ensuring that volunteers are always available when and where they are needed is extremely difficult and time consuming, and that problems do occur (Hucklesby and Wincup, forthcoming; Hucklesby, 2011). Unlike with paid employees, organisations have no leverage with volunteers, making it almost impossible to hold them to account for their behaviour or lack of commitment. Finding the right volunteers is also difficult and raises particular problems in a criminal justice environment. Volunteers are predominantly white and female when offenders tend to be young males and a significant number are from minority ethnic groups. Additional capacity issues are raised in relation to infrastructure. The statutory sector has access to buildings in multiple locations, trainers and training facilities, secure e-mail and so on. Many of these facilities are not readily available to voluntary sector organisations, especially in several different locations. Currently, they are often hosted by statutory agencies /institutions utilising their existing buildings and facilities at no cost to the organisation (Hucklesby, 2011). The procurement of such facilities is costly and is likely to increase the costs of voluntary sector operated services.

The voluntary sector has been very good at innovating and piloting new ways of working. Its current position as an addition to the criminal justice process has enabled it to fulfil this function. However, there is less evidence to suggest that it is able to operate services for a sustained long-term basis, mainly because it currently relies on short-term funding streams. The pitfalls of scaling up projects beyond pilots are well known. Even if it was successfully achieved, the voluntary sector is likely to be less flexible and less innovative as it becomes embroiled in the machinery of the criminal justice process, resulting in the loss of the environment which nurtures new ideas.

The new environment of a mixed economy of criminal justice will be a lot

more complicated and complex. Significant costs will be associated with coordinating, monitoring and auditing the work being undertaken. It is difficult to envisage how voluntary sector organisations (except perhaps the very large ones) will be able to respond to the requirements. In order to do so, they are certainly going to have to scale up many of the backroom functions and become akin to the agencies/organisations which they replace or are partners with. Whether this is what they want is open to question but it will potentially change the landscape of voluntary sector provision and reduce its ability to retain the attributes which make it attractive and distinctive.

Concluding comments

The voluntary sector has always been an important partner in the criminal justice system. Its independence is a key aspect of its current role as one of the alternative providers of criminal justice services. Furthermore, whilst service provision is one part of its role, its advocacy and reform voices are equally, if not more, important. The voluntary sector certainly has something to lose by its greater involvement in criminal justice and it may be that service users and society as a whole may lose even more if it becomes akin to statutory agencies or private sector organisations in all but name. On the other hand, questions remain about whether the services provided by the voluntary sector are quantifiably different and more effective than those provided by the statutory sector and whether they have the capacity to provide large scale financially sustainable services which 'work'. The voluntary sector is not inherently better than the alternatives and careful consideration should to be given to its role and the services it provides in criminal justice.

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[i] This presentation draws on the ESRC funded seminar series *The Third Sector in Criminal Justice* details of which are available at: http://www.law.leeds.ac.uk/research/projects/research-projects-archive/the-third-sector-in-criminal-justice.php

"Policing diverse societies"

Sergeant Dave McInerney, Garda Racial Intercultural & Diversity Office

Introduction

Recalling the 2008 ACJRD conference held in Dublin, on the topic of *'Minorities, Crime and Justice',* Mr. Sean Aylward, Secretary General of the Department of Justice and Co-founder of the ACJRD stated that he saw our jobs as public servants in the justice sector *'to help, protect and vindicate people's rights, irrespective of colour or creed'.* Moving on to 2013 at a Citizenship ceremony held in the Dublin Convention Centre on the 28th August where four thousand people were granted citizenship, Mr. Alan Shatter, Minister for Justice and Equality stated that those receiving citizenship *'were joining a State that provides constitutional and general law protections against all types of discrimination'.* The new citizens at this particular ceremony originated from 170 countries. Despite the economic downturn, the census conducted in 2011 indicates that the number of non-Irish nationals has increased by 29.7% (124, 624 persons) since 2006 and now accounts for 12%, or 544,360 of the population (CSO, 2012). O'Sullivan and O'Donnell state that '*by the beginning of the 21st century, Ireland was being described as the most globalised country in the world*' (2003: 42). Civil society continues to change at a rapid pace.

As a national police force concerned with state security and security of citizens, it is not altogether apparent that our primary purpose as State agents is to uphold people's rights under the constitution, i.e. human rights being our primary policing concern, in that you cannot maintain law and order without respecting one's rights under the constitution, and one of those principal rights is the right to freedom from discrimination – a right that cannot be derogated from under any circumstances. This was laid down in Article 10 of the International Covenant on Civil and Political Rights 1965 – a convention ratified by Ireland. Further protections from discrimination are provided for in our ratifying of the International Convention on the Elimination of All Forms of Racial Discrimination, and the European Convention of Human Rights 1950, (Article 14).

Sergeant Dave McInerney

Cultural Awareness

The policing associated with the protection of people from discrimination was something that was not really heard of when I joined An Garda Síochána in 1980, and the question of policing a diverse society did not feature by any means. Our only minority group were the Traveller Community where the relations with this group would have been rather strained due to their pursuance of a nomadic way

of life, which was perceived by the majority to be alien to the way of life of the settled community. Black people in the community were mostly professionals and medical students. Ireland's Muslim population was beginning to grow in Ireland during that period while many Libyans and other North Africans arrived in Dublin to train as aircraft mechanics. However, these migrants were welcomed and were seen as an asset to the country.

As already stated, the mid 1990's began to bring about changes in this regard with the arrival into the country of thousands of migrants – asylum seekers, refugees and workers from all over the world. New challenges quickly arose for An Garda Síochána around immigrants and attendant security concerns. Issues around interaction between members of An Garda Síochána and immigrants, many of whom were linguistically challenged in an unfamiliar culture came to the fore. Irish society and the newly arriving immigrants experienced a sense of 'culture shock' as both groups were devolved of knowledge about each other's cultural protocols. The term 'culture shock' is described as '*anxiety, disorientation and stress that an individual may experience when in a new or unfamiliar cultural environment*' (Furnham, 2000: 316). Furnham goes on to state how behaviourally, both migrants and host nations "need to acquire specific skills to communicate with people of very different backgrounds" (*ibid:* 118). This was a factor for front-line Gardaí who were meeting migrants on a daily basis in the course of their work in the community.

How did An Garda Síochána negotiate such 'culture shock'? Notwithstanding this challenge, how was An Garda Síochána to engage on a daily basis with the more marginalised of those within the Black, Roma Gypsy and Muslim Communities – who were generally perceived in society as 'problem migrants' compounded by media reports depicting such individuals as 'spongers, criminals and terrorists'. To this end, Zizek describes how migrants, regardless of their status, face the wrath of racists, in his quote: *'to the racist the 'other' is either a workaholic stealing our jobs or an idler living on the labour'* (2000: 596).

The tainting of individual's perceptions in Ireland at this time could be deduced from comments by Kilcommins et al, who described how 'of 9,716 persons committed to prison in Ireland, 21% were non-nationals drawn from a total of 105 countries' (2004: 257). Furthermore, the overwhelming referendum result in favour of the limitation of rights to non-Irish citizens in Ireland in the Constitutional Citizenship Referendum of 2005 made it quite transparent that certain prejudices existed in all sections of society pertaining to the acceptance of the 'Other' in Ireland. This was also to be the juncture where the field of policing was encountering a variety of new challenges which in turn would impact considerably on the policing habitus. How was An Garda Síochána to negotiate this new policing environment?

Building Trust and Confidence with Minorities

To answer the aforementioned questions, I will outline steps that An Garda Síochána took to endeavour to break-down the negative barriers, perceived or otherwise, that existed at that time. In 1999, the Commissioner launched the Garda Racial and Intercultural Office which is now known as the Garda Racial, Intercultural and Diversity Office. To this end, the first

task of that office was to consult with representatives of the new migrant communities and our Traveller Community. The office identified relevant representatives of minority groups who could assist in developing relations with An Garda Síochána and invited them to Garda Headquarters for the purpose of an exchange of information – for An Garda Síochána to learn about the police service requirements of minorities and to impart information to minorities about the role of An Garda Síochána in policing multi-cultural Ireland. Fifty two representatives attended a formal meeting at hosted by the Chief Superintendent and staff of the Garda Racial and Intercultural Office. The minority attendees were asked three questions, as follows:

> *How would you like us to provide a police service to your community?*
> *What do we need to know about your unique cultural and religious protocols in terms of providing a police service to members of your community?*
> *What do we need to know in order to respect your human right of freedom from discrimination'?*

What did An Garda Síochána learn as a result of asking these questions from the group? Nothing new, simply: treat people with respect; slow down when you are talking; listen; treat our female community members with respect; if searching our dwelling house – treat our property with respect; treat all religious items with respect and at time of death try and accommodate various pertinent rituals.

From this initial consultation a formal consultation process was developed between An Garda Síochána and members of minority communities at national and local level. In a study conducted on experiences of policing within socially marginalised communities, Mulcahy and O'Mahony (2005) noted that negative perceptions of policing affect trust and engagement with the police and went on to acknowledge the fact that the existence of the Garda Racial and Intercultural Office went some way to assist members of marginalised communities access the services of An Garda Síochána.

Appointment of Garda Ethnic Liaison Officers

Another step initiated in order to build trust and confidence with minorities was taken by the Garda Commissioner who approved the appointment of Garda Ethnic Liaison Officers (ELOs) in order to liaise with local minority individuals and reassure them of the Garda services available. Jones and Newburn (2001) have written extensively on policing minority communities and especially recommend that police have positive engagement with hard-to-reach minority individuals. To this end, the role of the Ethnic Liaison officer was to improve confidence in policing among the more vulnerable hard-to-reach minority individual – especially those who would not have been part of the formal consultation process. These officers have employed different means to try and build trust and confidence with the more marginalised through organising events at local level; organising sporting events for marginalised children; organising Garda Station 'Open-Days' and encouraging the more marginalised to take part in such events through positive interaction with the police.

It is quite evident that measures seeking to ensure an all-encompassing strategy which integrates minority communities fully into society and away from violent radicalisation are essential. Lord Scarman

presiding over an inquiry into the Brixton Race Riots in the UK in 1980 declared that the '*Metropolitan Police Service had not understood the centrality of community relations to policing multi-racial society*' (1981: 66). Employing community policing with its range of techniques that An Garda Síochána and the public use in partnership at local level has so far proved to be the most effective strategic cohesive approach to instilling confidence and trust between An Garda Síochána and minority groups. In this regard, Neumann states that, *'structures have shown that communities which perceive themselves to have strong 'buy in' to the system of political power, are far less likely to be willing to risk losing this by turning towards violent action and radicalisation'* (2005: 966).

Lessons Learned.

As police we have witnessed from the United Kingdom (UK) experience, the fall-out from profiling, extensive use of stop and search and the mentalities of some officers, which bore out the definition of institutional racism as laid down in the Macpherson Report (1999) - an investigation into the police investigation of the murder of a black youth, namely, Stephen Lawrence. These issues were among a few of the issues in the report that led to mayhem over a prolonged period in the UK and destroyed trust and confidence building between the police and minority communities. Failure to consult and liaise at the outset with minority communities, and allow the 'buy in' Neumann refers to, permitted a situation to develop where those from minority communities perceived them-selves as 'unequals' and permitted the feeling of discrimination to fester leading to anger and resentment which eventually spilled out on to the streets.

Unfortunately, such sustained anger and resentment led to the more covert radicalising of individuals within minority communities which has led to incidences of violent extremism which persists today as a result of earlier discriminatory policing practices. A lesson learned for An Garda Síochána from the UK experience is that mere reactive responses to policing minority communities are wholly inadequate. A sustained approach that ensures continuing partnership between police and minorities in society provides the most meaningful method to securing peace and harmony in any society.

Hence, An Garda Síochána's instilling of the community policing model in order to satisfy the need for fairness in upholding the law while respecting cultural and ethical difference. Wright states that *'in deciding against these competing principles, policing must apply the principle of fairness by maximising recognition of citizens' rights in any decision'* (2002: 152). He goes on to say that, '*in this way community justice can draw upon the principles of human rights, upon the rule of law and the sensibilities of local communities* (*ibid:* 152).

Racism and Hate Crime

To date recorded racist crime in Ireland is at the lower end of the scale. Holdaway states in this regard that '*as racial harassment is not a specific offence and that a majority of incidents are of verbal abuse, it is not surprising to find low rates of reporting'* (1996: 62). An Garda Síochána adopted the definition of a racist incident defined in the Macpherson Report as *'any incident which is perceived to be racist by the victim or any other person'* (1999: 328). Any incident reported as racist will be mandatorily recorded as such by the Garda receiving the report. This

definition was intended to overcome concerns that police acted as gatekeepers, who often denied that offences were motivated by racism, hence removing the need for police to make decisions as to the recording of crimes as racist.

This definition can in itself cause problems though, in that it can be misinterpreted if the officer has not been trained in its application. Rowe refers to the conceptual ambiguities of hate crime in that the law *'focuses on the intent or mens rea and not the motive – which is a much more subjective factor'* (2004: 102). Police are not accustomed to considering what motivated the offender to commit the offence. The on-going rather than incident driven nature of hate crime is a further challenge to policing which is largely incident driven. It can also be said that the fact that the offender is generally not known to the victim like other types of crimes can lead to less detections but more intense investigation.

Conclusion

Recently, I have been asked by various individuals; *how come the Garda Racial, Intercultural and Diversity Office is still in existence – especially in the light of the cutbacks, second-generational development and the rapid acquisition of Irish citizenship by immigrants*? The answer I give is, that An Garda Síochána through its constant engagement with and listening to minority individuals in the community, realises the very fact that one is different requires An Garda Síochána to be always sensitive to the vulnerabilities pertaining to difference. Notwithstanding this, the constant threat of racism, xenophobia, homophobia and general criminal acts of hate require sensitised policing techniques that ensure that those different in our community do not feel in any way vulnerable when accessing the services of An Garda Síochána. The devastating impact on victims and members of the victim's community cannot be overstated. The office exists to ensure that racism is prevented and that any offences coming to light are constantly monitored. The office proffers advice to all Garda members on all matters relating to policing a diverse society. The office now engages with the nine strands of diversity as described in the Equal Status Act 2000.

Finally, the transmission of citizenship to second generation and subsequent generations is another key issue for the future. Castles and Miller (1998) refer to the fact that second generation members still generally have multiple cultural identities, but they also have a secure legal basis on which to make decisions about their life perspectives. One must regard the plethora of Irish citizenship ceremonies held in public in the last two years where 52,000 people have been granted citizenship. Those gaining citizenship rights will be more assertive in their demands from the police and will not tolerate questions based upon incorrect stereotypes, such as *'what country are you from? where were you born? when are you going back?'* One would hope that the initiatives employed by An Garda Síochána in delivering a police service built on the principles of fairness, respect, equity and non-discrimination will counteract against any possible future allegation(s) that An Garda Síochána merely prioritises crime social control issues over personal protection of individuals regardless of status, thereby maintaining and building upon the robust relationships built up over the previous thirteen year period with ethnic minorities throughout Ireland.

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"Harm reduction or abstinence from drugs?"

Professor and Senator John Crown

I must say by the way, I am a bit intimidated by the audience, because I strongly suspect I'm in an audience of professionals, many of whom are involved in a much more hands-on way with the drug problem, and the personal and social catastrophes which stem from the drug problem, than I am. I have a little perspective on it. I have a little interest in it. I have been aware of it for a long time. Some of it stems from my medical experience in the US and when I came to Seanad Éireann in 2011 I decided that I really wanted to try and focus on a few issues that were of healthcare interest, where there is the intersection between healthcare and public policy.

I mean, obviously, I've been involved in advocacy for the cancer services and I'm a very definite believer in the need for fundamental reform of our health service, which I do hope we get and I know we have a reforming Minister right now, who unfortunately inherited a real bad set of cards when he came into the job in 2011 and a crippled economy, a difficult time to have the zeal for reform and I really do wish him well in it.

I have been very interested in substance addiction, substance policy of different types, and the one thing that has dawned on me is, people have accused me of a certain inconsistency because I have apparently very different attitudes to different drugs and the truth is, I do, because one size doesn't fit all.

For different drugs the problems are different, and for the same drug the problems are different for different patients and I think having a blanket policy that all drugs should be illegal, all drugs should be legal, all drugs should be able to be sold, and whatever, and that within a drug, a particular type of drug, that all addicts should be treated the same way; either all with heroin, all with methadone, all with abstinence, all with cold turkey, is absurd, because we're in an era in medicine of what we call 'personalised medicine' where we do understand that broad sociological differences in this area, broad pathological differences in the area I was in, were perhaps relevant when we were less sophisticated in our ability to segregate individual components of individual problems.

Professor and Senator John Crown

So for this reason, just to digress for one little second: I as a former heavy cigarette smoker and nicotine addict, have an insight into what it's like to be a smoker, I have a certain set of ideas of how we should deal with this problem.

My own belief and with my associate from Leinster House, Shane Conneely, we are trying to pioneer an idea across Europe called SOS2030 which is that the various bodies involved in the Western world, in Europe, in North America, etc., and hopefully other countries, will come around to the way of thinking, that by about the year 2030 we should make it illegal to do for-profit commerce in tobacco. It won't be illegal to smoke, it won't be illegal to grow your own but it should be illegal to do for-profit commerce.

All those people who sit in the board rooms of London and Virginia and New York, in British American Tobacco and Imperial and Japanese Tobacco, all these folks, if they want to sell drugs, tobacco, after 2030 they'll be doing it in the same sort of business plan that the Medellin cartel do now. They will not be able to do it in cosseted respectful offices there.

We need to, I believe, develop an entire new policy of educating people that every aspect of drugs sales, from the 'Mom and Pop' retailer around the corner to the person who's manufacturing it, is engaged in a trade which is fundamentally immoral. And that's why I don't get too exercised about things like smuggling, whereas I get very exercised when the tobacco industry were able to get access to our Taoiseach and two of our senior Ministers to discuss their problems in a, I believe a genuine mistake on the part of our politicians and nothing else, but the companies were able to parlay influence through a very well-connected PR firm into getting the kind of access to a coterie of our senior Ministers that I would love to get, to discuss the problems with cancer services, but will never get. So I do think it's important that we have a culture shift in that.

We're all aware of our problems with alcohol but I won't go into them in any great detail today. We've had a really good national discussion starting around this issue in recent years but my one take-home message is, I enjoy a drink, I probably enjoy too many, but the reality is, this is a problem we have with culture in this country, we do collectively drink a bit too much. Every bit of our social policy should be aimed at getting people to drink less.

People who sell drink have as their number one, two and number three agenda item, selling more drink. We can treat them with respect but we should not be engaging them as partners in the effort to reduce alcohol consumption, they are our adversaries as they want to sell more, we want society to buy less, and until we understand that, it's going to be hard to tackle the problem.

But let's get to illicit drugs. When I was in Mount Sinai in New York, I was in a hospital that existed right on the interface of a very rough area of urban depravation in Northern Manhattan and right on the fringe of a very, very affluent area of the Upper East Side, so we had a very diverse group of patient problems.

As a young medical student I can recall we used to get lessons on complications in pregnancies and they were haemorrhage,

blood pressure and blood clots but in Mount Sinai Hospital some of the leading complications in pregnancies were gunshot wounds and drug overdoses. Drug overdoses were not an insubstantial problem in the obstetrics department there and in the cancer department where I worked many of our patients also had substantial drug problems.

There is no doubt that the cutting edge of the drug problem – the heroin problem, the crack cocaine problem, some of the newer drugs - has been with us for a long time and it is very depressing to see how little progress we've made, very depressing indeed.

I've been involved over the years in a few areas of medical research that didn't work out: we said, we're going try beat breast cancer by giving huge doses of chemo, it didn't work, we said, OK, stop, back to the drawing board and I guess the question is, do we need to do this right now in the case of heroin.

It was very telling to me when I saw statistics a little while ago that suggested that during this interesting, tragically interesting, sociological experiment we had in our rapidly rising and suddenly collapsing economy, that cocaine use shot up and dropped down again. Alcohol use which was rising shot up and actually levelled off a bit in the last couple of years. Heroin use has been dead flat all the way along. It really has. They'll tell you that it's different.

The problem with heroin, I believe, is a fundamentally different problem and I believe that the kind of solutions which may be relevant to cocaine, to nicotine, and to alcohol, may not be relevant to heroin. I am not a drug expert and I bow to the expertise of those in the audience who are but I'd just be interested to know their personal perspectives on this.

To me, by any stretch of the imagination, by any definition, heroin addiction, pure and simple, is an illness. It is an illness for which there is acute treatment. The acute treatment is to give people the drugs which prevent the withdrawal which can make them so terribly, terribly ill, which can threaten their health, which can threaten their life, which can make them desperate enough to do awful things to themselves, to their families and to society at large. We should have as our goal, the chronic management of opioid heroin addiction - getting people off it - that absolutely is what we should be aiming to do.

But the question you have to ask is - and this is not some kind of detached, upper middle class elitist saying 'oh look as long as they don't frighten the horses let them have their heroin' - to the heroin users themselves: we have got to ask, is their life better if they get medical heroin or if they do not. Is their family's life less disruptive if the addict gets medicalised heroin or if they do not?

I think the case that society would be somewhat better off has been to a large extent made. So in trying to do this, Shane and I set off about two years ago doing a little wander over a number of months through some of the drug treatment facilities in Dublin, meeting some of the fantastic professionals, volunteers, recovering addicts, support groups, help groups, etc. and I must say it was a very, very instructive, very, very humbling to meet some folks who, in very difficult circumstances, do a very unglamorous and a very good job.

The first thing that struck me was nobody actually really knows how many opioid addicts there are in Dublin or Ireland. We've heard statistics suggesting it may be as few as 15,000 and as many as 40,000. Depending on that, we're not exactly sure what percentage of the regular opioid users are actively engaged in the methadone and other rehabilitative services. It's not certain.

A few things did come out though. The services that exist, like other parts of the health service, have inadequate resources and waiting lists. In a sort of eerie parallel of what goes on with cancer services, people who live a good distance away from a major city find that they have quite a trek to make to get their methadone treatment, very often if they're not in one of the few major centres that does it.

It's just struck me that this is not a great way to approach an illness. If this illness was cancer, blood pressure, diabetes or heart disease, we'd have a very different set of attitudes to it. In attempting to deal with it, I think it is critically important that we, number one, first and foremost, say that we are dealing with an illness. Let there be no ambiguity about this, there shouldn't be any question of us thinking, you know, crime, moral failure etc., it's an illness.

So what's the right way to tackle it? Well, the first thing is, what are the problems? And again I was - I have, this awful sense that I'm probably giving a terribly superficial talk to an audience of experts but it is the common experience of people that do nothing more than read newspapers and people who know what the drug service is, that there is a colossal burden associated with compulsive addictive opioid use.

For the addict themselves, it is all there is in your life. There is nothing you won't do to avoid getting your next dose of the opioid to which you are addicted. There's no personal degradation you will not stoop to. There's no family squalor that you won't inflict. There's no theft, personal disappointment, relationship destruction that you won't do if the alternative is not getting your heroin. You'll steal anything, you'll cheat on anyone, you'll do what's necessary to get it. People have to understand that this is because it is an illness. The physical horrors of heroin withdrawal, opioid withdrawal, will compel you to do anything.

So, the second layer of horror then is to the family. Living with someone who's taking illegal heroin and is indulging in the drug-seeking behaviour associated with it can be a living hell. You have somebody who may be prowling the streets day and night, begging, foraging, trying to score the stuff, stealing, robbing, perhaps getting involved in violent crime, perhaps, horror of horrors, getting involved in prostitution. These are the levels of problems which non-addicted family members often, and this is disproportionately a problem in socio-economically disadvantaged strata of society, have to deal with, actually having to live with somebody whose life has been taken over by drug-seeking behaviour.

Finally there's the issue of society in general. This is where I guess, the more cosseted parts of society suddenly start noticing because if your car is broken into, if your car radio is stolen, if your house is broken into, if you have any manner of

personal crime or violent crime; there's a disproportionate, not always, but a disproportionate chance that it will in some sense be drug related. I think Gardaí figures say approximately a quarter of crime in Dublin now is drug-related.

So, into this mix we have methadone treatment and again I must say, please do not, for one second, infer any disrespect on my part for the wonderful nurses, doctors, social workers, volunteers, that I've met in several methadone-treatment clinics around Dublin. Clearly, this is where the one size fits all comes into it - for some people it works and for people in whom it works, it not only takes the craving, it engages them with people who actually care about them, as opposed to engaging with some of the worst, most anti-social elements of the drug dealing community, it puts them under professional supervision, it has a real reproduce-able recovery rate of people who actually will be weaned off drugs. Many of those who will not be weaned off drugs will still have all kinds of aspects of their lives improved, improved health outcomes, improved engagement with their families. Some of them will work, they get back to jobs. They'll be able to actually get their own life in order.

I must say that when I asked people in that area, 'well, what do you think about giving medicalised heroin or injectable opioids?' there was a real difference of opinion. There were some people who believed so strongly in what they were doing that they thought that this was it. I said so then, why is it - I kept trying to get to this question, maybe some of you can help me - 'why is it then that some people are still out scoring heroin, robbing, stealing and prostituting to get heroin, if they actually have their craving satisfied by methadone?'

There were two broad answers which were advanced forwards. One of them is well we don't have enough spots for them. The second one is, no, no, no, many of them want the high of living in the demi-monde of the drug world and they want Valium and they want alcohol, they want crystal meth. The heroin is only a small part of it. I said, are there some of them where it's just opioid, they want the opioid but the methadone doesn't do it for them? Who are those folks? And would injectable heroin or injectable morphine do it for them? I could never get a number on this but I would believe it's an appreciable minority. I guess the question we have to ask ourselves is, if we were to identify those people and make a more satisfying, medically-supervised, as safe as we can make it, alternative drug available to them, which prevents them wandering out into the illegal drug world, are we helping to reduce their harm, their family's harm and society's harm? I am not saying that every currently abusing IV-drug-user that's not currently satisfied with methadone would become rehabilitated if we do it. I don't know. I suspect some would.

So the question next is, have others tried it? and the answer is yes they have, and again I have this awful feeling that I'm going to give a very superficial troll through statistics and studies which are probably much better known to many people in this audience. One of the bigger studies was the one done in Switzerland, quite a while ago. The Swiss starting tackling the problem in a big way after they found the HIV rates shooting up in the late '80s and '90s, they suddenly instituted the first kind of wave of harm

reduction programmes which involved the cleanliness of needles, syringes, medical supervision, testing, things like that. Then they went a bit further and did a national study on injectable opioids and what they found in this study, which had a quite long follow-up, was that there was increased, increase in the recourse of addicts to the professional services; there was a decreased drop-out rate from the services compared to people who were on methadone; there was decreased use of illegal drugs.

Various health statistics for the cohort who were given clean, injectable, medically supervised opioids, were better. There was less HIV, less hepatitis, less tuberculosis, less of the various problems which can occur when people are really living very squalid lives, spending a lot of their time scratching around trying to get illegal drugs. There was better social integration. People had a greatly decreased chance of being homeless. There wasn't much effect on employment. There was a big increase in the integration back into their family lives. A very high percentage of them actually completed rehabilitation and went on to various other programmes.

Now, results have as you know, been part of a larger Cochrane Review. We in the medical world, get a little nervous when the Cochrane Review is mentioned, this wonderful meta-analytic process in which critical health issues from across the spectrum ranging from bone marrow transplant to leukaemia to heroin use to HIV testing are analysed. There are situations where there are different randomised trials, trials where patients were randomly assigned to receive a treatment A or treatment B, very often for reasons of the ego of people like me these studies were too small because we wanted to be the person who did the study, but if you actually want to get the really definitive answers, sometimes rather than just lump all the studies together, we use a statistical tool called meta-analysis which makes the various studies behave as if they are sufficiently similar, as if they're one large, very statistically authoritative, randomised trial.

What they found, in the study meta-analysis of studies from Switzerland, Canada, Spain, UK and Germany, was broadly similar results to the ones that were seen in the individual studies. There was a great stabilisation of people's lives. They became less homeless. Chaos was reduced. They were re-integrated into family life. Various health statistics improved, socialisation statistics improved and there was a dramatic decrease in the use of illegal drugs. There was also, across the studies, a decline in crime. People are involved less in crime. That's kind of simple I guess, if you need to do crime to get something which is illegal, you will to do it if the alternative is being terribly sick. If you don't need to do crime, because your doctor and your nurse are giving it to you in a societally supervised forum, you don't need to do it, so unsurprisingly, crime goes down. The costs associated with crime go down, the costs associated with incarceration go down.

In several of the studies where cost-benefit analyses were done it was cost neutral. The increased cost associated with having the increased medical sophistication to supervise people taking injectable drugs as opposed to taking oral methadone, was outweighed by the decreased cost of looking after people whose lives have been rendered so cruelly

chaotic where they're frantically trying to get street drugs. So, I think this is something we need to look at.

Portugal, as you know has gone a sort of a stage further. Portugal has taken the approach of effectively decriminalising drugs, or socialising, or medicalising much of the drug problem. When people first interact with the criminal justice system they're kind of channelled across to a parallel appraisal system which is quasi-judicial and which is also medical and social, where there's all kinds of incentives built into it for better behaviour. It effectively means, this method, is that if you use small amounts of personal drugs you're not going to end up in prison, you're not going to end up in the criminal justice system. What have they found is the number of people presenting for treatment is higher because when you interact with this other system, you must get treated. Decreased HIV; decrease in drug-related deaths; there's a slightly increased use of illicit drugs across your lifetime, that may be real, that may be due to increased candour in reporting it and that people are less afraid to say it if they're not actually admitting that they're breaking the law in doing so. There is a decrease in justice work and also you know, we live in an era of markets, the street value of drugs went down, which is, I guess, bad news for all those folks in the cartels and all of their intermediaries along the way.

So, my own sense is that many of you will not say 'yes' to the simple answers when it comes to drugs, that you will actually understand that it is critically important that we actually have a real mature focused discussion about drug policy. I attempted to do this on *The Late Late Show* a little while ago, again, I mean no disrespect to any of my co-panellists, the wonderful, wonderful Fr. Peter McVerry and I were basically on the same side, saying we should look at the possibility of changing the legal situation.

But I would just ask you, just to remember one thing - you know, I'm old enough to remember drugs when I was a little kid in Brooklyn and we'd have the odd drug addict hanging around, the odd time you'd wake up in the morning and go down to the lobby of the apartment building, my dad he'd be rousting somebody out who'd been, you know, stoned the night before and that. It was a real big issue at the time, it became real big, literally as they say in America, a federal case. America went to war on drugs: deputised tens of thousands of people, a huge chunk of the criminal justice system tied up in it, perhaps as many as 1% of the entire American population in prison, from minority communities. Desperate statistics, as many as 20% of people at any one time in active engagement in the criminal justice system in the big cities like New York - how much of this is just to do with drugs? Has it worked? This is the question you have to ask yourself in a calm and not hysterical way.

I have three kids. To the best of my knowledge, none of them are users of illegal drugs, and I'm not going to personalise this against any TDs that have been, on a libertarian impulse, espousing the cause for free access to drugs, where I'm coming from on this is I'm anti-drugs. I hope none of my kids use drugs.

I don't think drugs make the world better. No, I'd like to wage the war on drugs but make it a smart one. I don't think we're doing it the right way. We should stop

calling it a war, we should acknowledge it's a bunch of different problems and they need to be treated in different ways. Heroin I believe is a very medical problem and I think we need to open our minds to the possibility that the way to treat it is medically, perhaps not for all, but for some, using a different model to the one we are using now.

Thank you very much for your time.

Conference Delegates

"Harm Reduction is good but is it good enough?"

Professor Catherine Comiskey, Trinity College Dublin

Thank you to the Association for Criminal Justice Research and Development, for inviting me to speak and I regret that I was not able to attend in person, but I am delighted to have the opportunity to share this work with you. I'd like to talk to you today about outcomes for opiate users in addiction services and what I believe are very good outcomes but I also believe that they could be better. While I'm a firm believer in the philosophy of harm reduction, I do believe that the research evidence has shown that there is room for improvement.

Today I will be talking to you about national opiate treatment outcomes studies. I'm particularly going to talk to you about our Irish study the *Research Outcome Study in Ireland Evaluating Drug Treatment Effectiveness*, known as the ROSIE Study (see www.nuim.ie/rosie and the treatment publication within www.nacda.ie). I'm going to give some overview of results on health and wellbeing from that study, which demonstrates our main point. I'll also show you the positive outcomes from treatment and then we'll address the gaps in outcomes. We will build upon that gap in the literature and in the ROSIE findings and I will talk to you about a new study that is endeavouring to address these gaps. Firstly, I'll provide little bit about the background to the ROSIE Study and I'll talk to you about the design of the study.

The ROSIE study was a longitudinal study, an outcomes study examining different modalities of treatment. There were a range of modalities of treatment, within which pre-treatment and post-treatment comparisons were made without a control group. There was no control group, as one cannot deny opiate users treatment. The clients entering treatment were interviewed at intake to treatment, at 1-year and at 3-years' post-treatment follow-up. All the clients recruited were adults and they were defined as new treatment episodes, so we were getting people at the start of a treatment episode. We defined new treatment episodes as those who had never presented for treatment before, those who had presented for treatment before but were not in receipt of the current treatment and those who had presented for other types of treatment.

Similar designs have been used inter-nationally so we were confident in our study design choice. Within the study we had four modalities of treatment in two different setting types. Our modalities were what we call substitution treatment, where heroin use was treated with a substitute treatment. We also had chemical detoxification, this was not a rapid detoxification but rather a detoxification programme supported by chemical interventions. We also had abstinence-based programmes and finally we had needle exchange programmes. The two setting types were in-patient settings, these were hospitals, residential programmes and prison settings. The second setting type was within out-patient settings consisting of health board clinics, local community services and general practitioners. Similar studies have been carried out internationally, in Australia over a period of ten years; in the UK, Scotland and America over a period of

30 years, and similar study designs were used.

Participants were recruited into the study from a pool of sixty different treatment services, including forty three different agencies and organisations and thirty GP surgeries, making this a very large scale study. At baseline we recruited 404 opiate-users all new to treatment; 302 males and 102 females, with a male to female ratio of three to one and that ratio reflected the standard ratio found in treatment services at that time. A fifth of all participants recruited were under the age of 24 and two thirds, 66%, were under 30 years of age, which demonstrated quite a young population. At 1-year follow-up, 92.3% or 373 participants were located and 75.4% or 305 participants were interviewed. At the 3-year follow-up 97% of participants were located, that was 392 of the original 404 participants and 88.3% or 357 individuals were interviewed. This was an extremely high follow-up rate, much higher than those found in the international literature, and provided us with great confidence in the study results. As a result, the findings cannot be said to reflect only those participants that were retained in treatment or had good outcomes. In addition, whereas some international studies follow up a random selection of baseline participants, the ROSIE Study sought to follow up everyone that was recruited achieving a 97% location rate and 88.3% interviewed at 3-years. These excellent follow-up rates were a credit to the ROSIE research team and the agencies, organisations and individuals they worked with.

In terms of the personal and social background to the participants, one research aspect of interest, both to me personally and internationally in the literature, was if respondents were parents to children. In the ROSIE Study we found that 56% or 216 of the respondents had children and that the majority had one or more children. In total, the ROSIE cohort of 404 individuals had 391 children; demonstrating that there was almost one child to every adult in the cohort.

In terms of the health of the respondents, when asked about their health and health risk behaviours, it was found that 77% of clients had said yes, they had injected in their lifetime. Of those that had injected, over half reported that they had done so in the past three months and this identified risk to individuals. Participants were also asked about their sexual relations within the last three months; 205 respondents said they had sex with a regular sexual partner and 68 said they had used condoms with their regular partner. In terms of sexual contact with a non-regular partner, 78 respondents said yes they did have sex within the last 3 months with someone other than a regular partner. In addition, 23 of these said they didn't use condoms. Another finding was that 12 respondents said they had sold sex in the last 12 months and two said they had paid for sex in the last 12 months.

In terms of general health, when asked directly how their health was, 51% said their health was good or excellent, which was encouraging. Approximately half of participants reported their health was good or excellent, however, the remaining respondents, 49%, said that their health was either fair or poor. When asked about specific health problems, the three main issues clients experienced problems with were with their teeth and gums,

53%; breathing problems, 29%; and, interestingly, problems with their sight. With regard to the primary or key variable on risk of death to the individual due to suicide or accidental overdose, it was found that over half of the cohort, 52% or 199 individuals, had seriously considered committing suicide. A quarter of all participants had considered suicide within the last six months and 45% also reported an accidental overdose in the past. Therefore, in terms of harm reduction and health risk, risk of death was considered our key outcome variable.

In terms of mortality rates, two deaths occurred in the first year, giving a mortality rate of just half a percent, or 0.5%. At the three year follow-up period six deaths were recorded, all male participants, giving a mortality rate of 1.5%. However, these rates were in fact lower than those reported internationally. As a point of interest, two participants died from a drug overdose; two died as a result of a brain haemorrhage; one died in a road traffic crash; and one participant was murdered. With regard to the two participants who died from a brain haemorrhage, while this was the recorded cause of death, it occurred following a drug overdose. With regard to treatment modality, three of the deceased were recruited from the methadone modality, two from the detoxification modality and one was recruited in the needle exchange modality.

Turning to health outcomes, both statistically significant and non-significant improvements were found. Table 1 below details the number and proportions of respondents experiencing physical health symptoms.

A significant reduction in poor appetite was reported between baseline and 1-year and between baseline and 3-years, however there was no change between 1-year 3-years. What this is telling us is that the change occurred early and it was sustained, but that there were no further changes.

Table 1: Number and Percentage Experiencing Physical Health Symptoms

	Intake		**1-year**		**3-years**	
	n	%	n	%	n	%
Physical health symptoms experienced over last three months						
Poor appetite	269	71.7ab	175	59.5a	194	55.6b
Tiredness/fatigue	268	71.5a	185	63.4ac	239	68.5c
Nausea	148	39.8b	97	32.9	114	32.6b
Stomach pains	148	39.8	101	34.2	127	36.5
Difficulty breathing	105	28.2	74	25.1	105	30.2
Chest pains	85	22.7	57	19.3	74	21.3
Joint/bone pains	135	36.0ab	78	26.4a	95	27.3b
Muscle pains	122	32.7ab	71	24.1a	77	22.0b
Numbness/tingling	84	22.6	53	18.0c	95	27.4c
Tremors/shakes	105	28.7ab	48	16.3ac	80	22.9bc

Note: Matching subscript letters denote statistical significance.

There were also significant reductions in terms of tiredness and fatigue, joint pains, muscle pains, numbness and tingling and accordingly, there was a mixed picture on physical health outcomes; some significant physical improvements and proportions experiencing physical health symptoms, and some non-significant.

Table 2 shows the mean number of days these symptoms were experienced and you can see that again, there was a similar pattern – some statistically significant reductions in the mean days for physical tremors and shakes. But, none in terms of nausea and feeling sick, stomach pains, difficulty breathing or chest pains. health symptoms were experienced, and some non-significant.

Treatment for a medical condition was also reported and Table 3 shows that for those who attended hospital and stayed overnight, the proportion at 1-year increased slightly although it was not significant, visiting a GP increased significantly at 1-year.

Table 2: Mean Days Physical Health Symptoms Experienced: Population

	Intake Mean(s.d.)	**1-year** Mean (s.d.)	**3-years** Mean (s.d.)
Physical health symptoms experienced over last three months			
Poor appetite	47.3 (38.6)ab	37.2 (39.0)ac	31.9 (37.7)bc
Tiredness/fatigue	43.0 (38.5)a	38.3 (39.1)a	39.6 (38.1)
Nausea	14.2 (27.2)	15.2 (29.5)	12.6 (27.3)
Stomach pains	14.5 (26.6)	15.1 (29.1)	15.9 (29.5)
Difficulty breathing	13.4 (28.6)	13.8 (29.6)c	17.5 (32.6)c
Chest pains	8.2 (21.4)	8.2 (22.9)	6.8 (19.8)
Joint/bone pains	13.4 (27.7)	11.4 (26.0)	14.3 (29.9)
Muscle pains	9.8 (22.1)	10.4 (25.5)	10.1 (25.0)
Numbness/tingling	8.5 (22.6)	7.7 (21.8)c	11.5 (26.3)c
Tremors/shakes	10.2 (23.5)	7.3 (21.2)c	11.2 (26.8)c

Table 3: Treatment for a Medical Condition

	Intake		**1-year**		**3-years**	
	n	%	n	%	n	%
Treatment received in last three months						
Attended hospital and stayed overnight	34	8.7b	34	11.1	56	15.7b
Attended Accident and Emergency unit	67	17.4	53	17.4	82	23.0
Visited a GP (not methadone GP)	124	33.6a	140	45.9a	140	39.2
Visited an outpatient department/ received community treatment	49	12.7b	59	19.4	73	20.4b

Note: Matching subscript letters denote statistical significance.

In terms of mental health, Table 4 details the outcomes for mental health and the proportions experiencing a range of psychological health symptoms. Ten outcomes were assessed at baseline, including feeling tense/suddenly scared for no reason, feeling fearful and so forth; and again some significant reductions were reported at 1-year.

However, not all of the outcomes improved. While thoughts of ending your life, the key outcome variable, showed a sustained and significant reduction in the proportions experiencing it to 3-years, no further reductions between 1-year and 3-years were reported. Again, with regard to the mean number of days these symptoms of psychological health were experienced by participants, a mixed picture emerged (Table 5).

Table 4: Number and Percentage Experiencing Mental Health Symptoms

	Intake		**1-year**		**3-years**	
	n	%	n	%	n	%
Psychological health symptoms experienced over last three months						
Feeling tense	234	65.2a	144	51.4ac	231	67.3c
Suddenly scared for no reason	129	35.6a	70	24.7ac	122	35.3c
Feeling fearful	149	42.3a	98	35.1ca	163	47.4c
Nervousness or shakiness inside	153	42.6a	91	32.6ac	143	41.6c
Spells of terror/panic	90	24.5	69	24.6	80	23.3
Feeling hopeless about the future	196	55.8b	138	49.1	169	49.0b
Feeling of worthlessness	188	52.8a	120	42.6a	165	48.0
Feeling no interest in things	206	57.4	152	54.1	192	55.8
Feeling lonely	202	57.4ab	137	49.3a	165	48.1b
Thoughts of ending your life	88	25.4ab	52	18.1a	65	18.8b

Table 5: Mean Days Mental Health Symptoms Experienced: Population

	Intake	**1-year**	**3-years**
	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)
Psychological health symptoms experienced over last three months			
Feeling tense	36.8	21.9	31.5
Suddenly scared for no reason	15.5 (29.7)a	9.2 (22.8)ac	13.1
Feeling fearful	19.6 (31.7)a	13.7	18.6
Nervousness or shakiness inside	19.8	11.4	16.3
Spells of terror/panic	9.0 (23.0)b	7.9 (20.6)	6.3 (19.3)b
Feeling hopeless about the future	29.6	20.8 (32.2)a	22.2
Feeling of worthlessness	28.6	18.6 (31.4)a	21.4
Feeling no interest in things	31.1	26.1 (35.1)a	25.7
Feeling lonely	32.7	23.4 (33.6)a	23.4
Thoughts of ending your life	8.1 (22.3)a	3.2 (13.9)a	5.7 (18.4)

Note: Matching subscript letters denote statistical significance.

The findings were also examined in relation to treatment modality and Table 6 shows that few significant reductions in the proportions experiencing these physical health symptoms were reported in the methadone modality at intake and 1-year.

This analysis was also repeated for methadone modality and mental health symptoms at intake and at 1-year (Table 7). Again, no significant reductions in the proportions experiencing these symptoms were found. While being in methadone treatment significantly decreased crime rates, significantly decreased drug-use and increased social functioning; it was not found to statistically affect physical and mental health outcomes (see Rosie Findings 4 at http://www.nacd.ie/index.php/publications/106-rosie-findings-4-summary-of-1-year-outcomes-methadone-modality.html for the full details on all statistically significant improvements in drug use, crime and social functioning).

Table 6: Physical health symptoms in the 90 days prior to treatment intake & 1-year interview

	Intake %	n	**1-year** %	n
Psychological health symptoms experienced over last three months				
Poor appetite	74	110	68	101
Tiredness/fatigue	66	97	67	99
Nausea	37	55	38	56
Stomach pains	28	41	39	58*
Difficulty breathing	27	40	28	41
Chest pains	18	26	18	27
Joint/bone pains	25	37	29	44
Muscle pains	22	33	25	37
Numbness/tingling	18	26	23	34
Tremors/shakes	22	31	22	32

* *McNemar test revealed statistically significant changes*

Table 7: Mental health symptoms in the 90 days prior to treatment intake & 1-year interview

	Intake %	n	**1-year** %	n
Psychological health symptoms experienced over last three months				
Feeling tense	55	76	53	73
Suddenly scared for no reason	25	35	25	36
Feeling fearful	29	40	34	46
Nervousness or shakiness inside	30	42	33	46
Spells of terror/panic	18	26	24	34
Feeling hopeless about the future	53	72	53	73
Feeling of worthlessness	46	63	40	55
Feeling no interest in things	52	74	58	82
Feeling lonely	50	69	47	64
Thoughts of ending your life	22	30	20	27

As fewer improvements in the physical and mental health outcomes were observed within the ROSIE study than expected, it was decided to conduct a new study on the health and wellbeing of opiate-users. This new study looked specifically at the health and wellbeing of opiate-users in greater depth. As the ROSIE Study had highlighted information on the number of opiate users' children, child health outcomes were also a key focus. This new study on health and wellbeing of opiate-users and their children is also a longitudinal, prospective cohort study which tracks forward and follows participants over time. The study also has a comparison group of opiate-users who are not in treatment at baseline. It is important to note that those individuals were not denied treatment, rather they were participants not in treatment at recruitment, but they may have entered treatment during the follow-up period. Participants were recruited between February and December 2010 and they are being followed up for their 2-year follow-up between April 2012 and 2013. While the new study is a smaller study, it looks specifically at health and wellbeing, and the risk to the physical and mental health of opiate-users and their children. There were 171 clients recruited to this study; 119 males and 52 females, which reflected the gender ratio of three to one males to females. Participants were allocated to two groups; those in treatment and this time it was substitution and maintenance treatment, and not in treatment which was mainly needle exchange services. There are 115 parents in the study and they were asked to provide information on their youngest child's health. As parents can have more than one child it was decided it would be easier to ask them just about their youngest child. There were 106 eligible children and data were collected on 58 or 55%.

The Maudsley Addiction Profile instrument (or survey) was used to capture adult substance use and drug treatment history data were also collected, however, a more in-depth investigation of physical and psychological health was carried out using instruments known as the SF-12, the Beck Depression Inventory and the Beck Anxiety Inventory. Family history of substance misuse and family relationships were also captured. Where applicable, health data for the children were gathered using the Kidscreen-27 instrument and the Strengths and Difficulties Questionnaire.

In terms of parental physical and psychological health; results from the new study found that 25% had moderate physical disability and 16% described themselves as having severe disability. With regard to psychological disability, 31% described themselves as experiencing moderate symptoms and 35% as severe. Adult participants were also asked about symptoms of depression and anxiety; 52% reported severe depression symptoms and 31% for severe anxiety. The physical and psychological health components for opiate-users were significantly worse than the general population, and that bears out the results of the ROSIE Study, where physical and psychological health outcomes were poor. In addition, there was a significant difference in depression scores for those in treatment and those not in treatment at baseline.

In terms of the children, the Strengths and Difficulties survey was completed by parents on behalf of their children and the results showed that mean Strengths and

Difficulties scores were significantly higher than UK norms for conduct problems and emotional symptoms, and a higher proportion of children were classed as abnormal compared to the general population, with regard to peer problems. Thus, parents were rating their children as having significantly higher conduct and emotional problems. Similarly, a correlation between increased emotional symptoms and parents' concurrent use of opiates while in treatment was found. Looking at the results from the Kidscreen survey instrument which was also completed by the parents on behalf of their children, it was found that parents described the overall physical and psychological health of their children in good terms and in fact, their children's wellbeing was significantly higher than EU norms.

So what can we conclude from all of this? From the ROSIE Study, it was clear that drug treatment and harm reduction works, there is no debate about that. It was clear that there were significant improvements in drugs, in crime and in social functioning; however there is a greater need to address general health; the physical and psychological health and wellbeing outcomes for opiate users within and outside of treatment. This is being addressed in the smaller study, but there is a definite need for ongoing studies in terms of treatment outcomes. We are now in our third generation of opiate-users in Ireland and while we have evidence from the ROSIE Study; an excellent study with a high international standing, it was a three year cohort study. The treatment outcome study in the US is over thirty years and has an ongoing study where the outcome changes reflected through society can be seen. In Australia the outcomes study is over ten years, so there certainly is room for improvement on the ROSIE Study in Ireland. Additionally, in terms of physical health and psychological health specifically, I do believe that while harm reduction is good, in fact I would say it is excellent, more can be, and must be done to improve the lives of both those using opiates and those families affected by that use.

Thank you.

"Developing a restorative community – the experience to date in Tallaght West"

Claire Casey, Childhood Development Initiative

About the Childhood Development Initiative (CDI)

CDI was established in 2003 and began by undertaking a comprehensive research and consultation process with local service users and the community of Tallaght West, in order to identify the priority needs of children and families in the area. Implementation of programmes began in 2007 with funding from the then Office, and now Department, of Children and Youth Affairs (DCYA) and The Atlantic Philanthropies when CDI was included in the Prevention and Early Intervention Programme (PEIP).

The PEIP had the job of designing, delivering and evaluating services to improve outcomes for children and families in Tallaght West and of informing policy and practice. Since 2007, seven independent evaluations have been conducted and published by CDI and in 2013 we were included in the new Area Based Response to Child Poverty Initiative (again funded by DCYA and The Atlantic Philanthropies), in order to work on integrating the models of service provision that have been proven to work into mainstream services.

What is Restorative Practices?

Restorative Practice (RP) is both a philosophy and a set of skills that have the core aim of building strong relationships and resolving conflict in a simple and emotionally healthy manner. RP is about doing things **with** people, rather than **to** them or **for** them; it offers high levels of support, whilst at the same time enabling people to challenge inappropriate behaviour and encouraging acceptance of responsibility. The word "restorative" comes from the word "restore". Being restorative means being able to easily and effectively restore broken relationships and, more importantly, it means being able to consciously prevent relationships breaking down in the first place.

CDI's Restorative Practices Programme

In 2010, CDI began developing a RP Programme as part of our Community Safety Initiative (CSI), which has been in operation since 2008. The CSI had been attempting to develop local neighbourhood[1] community safety agreements or contracts and while some headway was made in community development terms, CDI had not succeeded in its efforts to mediate such agreements. In February 2010, members of CDI attended an Irish Youth Justice Service Conference at which they heard a presentation about the work of the Hull Centre for Restorative Practices to make Hull a restorative city. They immediately understood that RP had the potential to support the Community Safety Initiative by providing people with the skills to build and maintain good relationships, to prevent conflict and to effectively and easily resolve conflict when it does arise.

CDI began delivery of its RP Programme in May 2010 by bringing together key stakeholders with responsibility for the welfare of children and young people.

[1] Pilot sites for the CSI consisted of approximately 100 households.

The partnership that has been working together for three years now to promote the use of RP has included parents, schools, Foróige Tallaght, the Gardaí, South Dublin County Council, Tallaght Restorative Justice Services, Tallaght Probation Project and others.

With the overall aim of supporting Tallaght West to become a Restorative Community, the RP Programme had a number of immediate objectives, including:

- The delivery of training in RP to key stakeholders with responsibility for children and young people;
- Accreditation of local RP trainers to build capacity and enable sustainability of the approach; and
- Support to organisations and people seeking to work restoratively.

Since 2010, the RP Programme has involved the provision of training to over 1,000 people including parents, residents and young people, and to the management and staff of statutory, community and voluntary organisations with responsibility for the well-being of children. The RP Programme has also involved the accreditation of 16 Ireland-based RP trainers, the development of "communities of practice" that share learning and undertake a range of activities to support the use of RP, and the establishment and support of an All-Ireland Strategic Forum for the promotion and development of RP nationally.

By September 2013, more than 750 people in Tallaght had completed the RP training. Across Tallaght, parents; young people; schools; youth services; community centres; Gardaí; childcare workers; and other service providers have started taking an RP approach to their work. 14 RP trainers that live or work in Tallaght have been accredited. St. Marks Community School in Fettercairn became the first organisation to declare itself a restorative community in October 2012 (they raised a flag!) and the South Dublin County Council Social Worker Team followed them in September 2013 by being awarded a plaque in recognition of their use of a restorative approach to their work. Four more organisations in Tallaght are due to be launched as restorative by the end of 2013.

Claire Casey

Evaluation of CDI's RP Programme

The Child and Family Research Centre at the National University of Ireland, Galway, conducted an independent evaluation of the RP Programme between 2010 and 2012. The authors[2] of the evaluation report conclude that: '*The findings demonstrate the effectiveness of the RP*

[2] Fives, A., Keenaghan, C., Canavan, J., Moran, L. and Coen, L. (2013) Evaluation of the Restorative Practice Programme of the Childhood Development Initiative. Dublin: Childhood Development Initiative (CDI), available at http://www.twcdi.ie/images/uploads/general/CDI-RP_Report_25.09.13.pdf.

Programme for the management of conflict in Tallaght West. There were improvements in people's ability to deal with conflict in work, school, in the home, in the community and in interagency settings.'

Key findings include:

- A restorative approach is being used frequently across a range of sectors in Tallaght West. 75% of those surveyed reported that they had experienced RP being used at work, home or in the community.
- For those who had undertaken RP training, there were significant improvements in their ability to manage conflict – 87% reported being better able to manage conflict and 82% found that they were better able to manage other difficulties by using a restorative approach.
- In terms of prevention, 43% of those surveyed reported experiencing a reduction in disputes, with the greatest gain made in the reduction of disputes at work (reported by 23% of those surveyed).
- Prevention of conflict was supported by the reported improvements in a variety of relationships. 61% of those surveyed reported that taking a restorative approach had improved relationships between service providers and service users. 47% reported improved relationships with their work colleagues as a result of using RP and an equal proportion of those surveyed (47%) said that relationships with their family members had improved through using RP. The lowest (yet still significant) gain in this respect was the reported improvement in relationships with neighbours (14%).
- Significantly, from a community safety point of view, 36% of those surveyed said that they were more willing to report crime and/or anti-social behaviour as a result of restorative approaches being employed across the community.

Lessons for Policy Makers

The main policy recommendations arising from the experience of implementing and evaluating the RP Programme in Tallaght are:

- That all children and young people be dealt with restoratively by the adults in their lives;
- That RP training modules be included in all teacher training courses;
- That relevant professional associations and support organisations recognise RP as a core skill for the continuing professional development of people with responsibility for the well-being of children and young people;
- That RP comprise an integral element of training for all those working with children, young people and communities;
- That consideration be given to the opportunities for RP to support the public reform agenda, particularly in relation to the reduction of work-based conflict;
- The establishment of a national framework of support for the development and promotion of restorative practices;
- This framework to include a national office for coordinating the development of capacity, systems and infrastructures which support the growth, evolution and quality of RP and build their sustainability; and
- The further development of accredited training for restorative practices and the establishment of a national system

for the accreditation and professional development of RP trainers.

How has it Actually Worked?

It is easy to adopt and use an RP approach. Individuals or organisations can do basic training which is accessible and appropriate to anyone aged 12 years or over. Anyone can become competent to begin using RP after training for one day and can gain the skills to become an expert RP practitioner after a further three days training. This is possible because RP builds on skills that everyone has and provides a simple framework for using those skills more consistently and consequently, more effectively. Using the skills acquired to improve outcomes in your life or work is supported by participating on-going "communities of practice", where people come together to share experiences and learning, and by taking part in short "booster training" from time to time if a new need arises.

Examples of Restorative Practice in Action in Tallaght West

1. Foróige Tallaght

In keeping with a wide range of research literature on restorative practices, the greatest gains in terms of using RP have been found to occur in agencies that have taken on RP as a way of working and have sought to embed this approach throughout the organisation. Once such agency is Foróige Tallaght, a local youth service which provides a wide range of supports for all young people aged 10-25 years living in Tallaght, through their general services and also to vulnerable young people who require additional support.

Foróige Tallaght became a member of CDI's RP Management Committee when it was established and supported its frontline Youth Workers to undertake RP training as part of their continuing professional development. Youth Workers found the RP skills that they developed to be very useful in managing the clubs, groups and targeted interventions that they were working with and many have made the use of restorative circles, conferences and communications "business as usual" for their on-going work. Foróige Tallaght also supported three of their Youth Workers in becoming accredited as RP Trainers through CDI's RP Programme. These Trainers are proving a valuable resource as they have particular skills in providing the training to young people and fellow Youth Workers, thus supporting a sustainable approach within the organisation.

A very concrete example of where RP supported the work of both Foróige Tallaght and CDI occurred in June 2012 at a community resource centre in Tallaght West, where Foróige Tallaght operate a number of youth clubs and targeted programmes/interventions. In June 2011 CDI began work with an Estate Management Group based in the community centre to develop a Community Safety Initiative (CSI) within the centre's catchment area. The Estate Management Group identified a small neighbourhood of relatively new housing as the priority for a CSI as this was a neighbourhood that was experiencing high levels of anti-social behaviour. Work began with a local survey which identified the priority safety issues for residents and also identified the small group of young people who were principally responsible for incidents of anti-social behaviour that were causing residents to feel very unsafe in their own homes and neighbourhood.

The CSI group undertook a series of actions to respond to the issues identified by residents including a variety of interventions with the young people and some small security–related investments (e.g. one CCTV camera, locks for refuse bins). Over the space of 12 months, the young people were challenged to examine their own behaviour (their families received visits from the Gardaí and the Council's Anti-Social Behaviour officers) and were supported to get involved with alternative pro-social activities and groups. Foróige Tallaght had engaged six young people aged 10-12 years of age, who were referred by the Garda Junior Liaison Officers and Community Gardaí in 2011. A number of the young people were amongst the group identified through the CSI as being involved in anti-social behaviour in the community. When these young people were accessing their local community centre, problems arose with what centre staff found to be disruptive behaviour and following a number of incidents the young people were on the verge of being excluded from the premises.

At the suggestion of Foróige Tallaght Youth Workers, the young people and centre staff agreed to participate in a restorative conference about the incidents involving the young people and this was organised and facilitated by two local RP trainers (who were independent of all of the groups within the community centre). The conference was attended by all of the young people involved and some of their supporters (family or friends), by all of the staff of the community centre and some of the voluntary Board of Management. The restorative process gave everyone a chance to say what had happened from their point of view and, as importantly, to hear how what had happened impacted everyone else. In this instance, the young people got to hear how their behaviour had impacted centre staff and the centre staff got to hear what had prompted the young people to behave in the way that they had.

The group as a whole came to a set of agreements about both how the young people would behave while in the community centre and about how they would be treated by centre staff. These agreements made it possible for the young people to begin using their community centre and the agreements have been held to by everybody ever since. Residents of the CSI neighbourhood have reported a positive sea-change in their experience of safety in their homes and community and the community centre has reported an increase in the use of its services by young people in the area.

2. Restorative Practice Used in the Home

"My teenage daughter arrived home with her school report, which wasn't great. My instincts were to defend, argue. Her body language was defensive, and she was monosyllabic. But eventually we got to the point in the conversation where we really began to talk, listen, understand. There were plenty of tears. RP helped me to really listen to and understand her. It gave me an empathy that was missing previously. I needed to leave my own emotions out of it. It allowed both of us to offload something. The restorative training helped me to ask the right questions and to step out of thinking of her as my daughter and instead to really listen to what she was saying. You have to put in the time to make it work. We would never have got there in a five minute chat." Local Parent 1.

"A family dispute has been going on for a year now. I used RP in an attempt to resolve the issue. Asking the core questions helped. Stepping back, removing myself was key. I stopped being part of the problem by removing my own feelings from the discussion. People felt having the opportunity to be heard was what made the difference. Although it is not completely resolved it is now well on the way to recovery." Local Parent 2.

3. Restorative Practice in a Work Setting

"I manage a centre in Tallaght and am responsible for a number of staff members. On occasion I have been aware certain staff members were not getting on but I did not get involved and hoped it would work itself out. Following the restorative practice training I decided to try the process out with the staff. It was obvious something was erupting as the tension in the air was quite apparent. I was nervous but I prepared myself by rehearsing the questions provided in the training. The staff were gathered in a circle and each member was given the opportunity to say how they felt about the situation. Everyone felt truly respected and listened to. The process allowed me not to become involved and on occasion the focus wandered and I had to remind them of the purpose of the gathering. Overall it was a great experience and all staff members were happy at the end. Using the script really works and is very useful." Community Centre Manager.

4. Restorative Practice in School

"A parent came to the school recently to tell us that her son was afraid to come to school. At home, both she and her son were experiencing intimidation, verbal abuse and verbal threats from a local group of young people. The group were involved in a feud with her son and his friends. The group "leader" is also a student at our school. She was looking for school support in resolving the issue. We told her about restorative practices. We offered to bring her son and the other young person together to help resolve the issues causing the conflict. Preparation was the key to a successful outcome. Both agreed to a restorative circle, once I explained what would happen. It was easy for them to agree to the circle because they knew what would happen, and what questions would be asked. A restorative circle took place between the two students, I and a colleague. The leader of the group involved in the intimidation showed great empathy for the thoughts of the other student. As part of "what needs to happen next", the student leading the group agreed to speak with his friends and ask them to end the feud and the intimidation. It has been three weeks now since the restorative circle. All is well." Secondary School Teacher.

5. Restorative Practice in the Community

"I heard about RP from my neighbour when I asked her how she had sorted out a problem she had been having. There was a group of teens hanging around on her front garden wall consistently causing a disturbance and her husband had been going out all guns blazing trying to get them to move away but they kept returning. Then one day my neighbour went out and, even though she was incredibly nervous, she approached the youths and calmly explained that there was a baby in the house and she was trying to get him to sleep in the front room but with all the messing going on outside she couldn't manage it. The teens immediately changed their attitudes and once they could see the pressure and,

more importantly understand the pressure, the woman was under they apologised and moved off. They haven't returned since and I want to do the RP training now." Local Resident.

Conclusion

CDI has many, many more reports from people and organisations in Tallaght of where RP has improved a situation that was difficult or prevented difficulties arising in the first place. Overall, these reports convince us that people are using RP as a way of working because it makes their work easier, more enjoyable and more effective. Parents report better relationships with their children, residents report better relationships with their neighbours and young people report increased confidence and better relationships with their teachers, their families, their friends and their peers.

CDI is now working towards launching Tallaght West as a Restorative Community in 2014. In the meantime, we work to share what we have learned in Tallaght with a view to supporting the adoption of RP across the country in order to make everybody's job easier!

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Delegate asking a question

"The Victims' Rights Directive: A Force for Change?"

Maria McDonald, BL

Introduction

Victims often feel that *'the law is on the side of the criminal and not the victim'*[1]. This view is understandable given the importance placed in the criminal justice system on the rights of the accused to a fair trial. In comparison, a victim can perceive a criminal justice system where they have little or no legal rights[2].

The rights of the accused and the victim are not mutually exclusive. Victims' rights are focused on providing information, support and protection to victims of crime to ensure that they are not re-victimised by the criminal justice system or by the perpetrator. They should not impinge on the rights of an accused to a fair trial.

References to victims in Irish legislation is sparse[3] and is limited to situations including victims' impact statements[4], the provision of evidence via television link[5], safety[6], protection[7], (interim[8]) barring orders[9] and compensation.[10] There have been two failed attempts to implement legislation on victims' rights in Ireland, namely, the Victims' Rights Bill 2002[11] and the Victims' Rights Bill 2008.[12]

A Victims' Charter outlines the rights and entitlements which should be provided to victims of crime by state agencies in Ireland[13]; however, this document is

[1] Survey by AdVIC, the DRCC and SAH of victims of crime; comment made by victim in response to the survey. For further information on the survey. please contact marianidhomhnaill@gmail.com

[2] Ibid, Survey by AdVIC, the DRCC and SAH of victims of crime; reoccurring comment made by victims of crime in response to the survey.

[3] Section 5 (1) Criminal Justice Act 1993; Criminal Justice (Location of Victims' Remains) Act, 1999 (No. 9 of 1999).

[4] Section 5 of the Criminal Justice Act 1993 as substituted by s.4 of the Criminal Procedure Act 2010; See also s.13 of the Criminal Justice (Female Genital Mutilation) Act 2012.

[5] Section 13 Criminal Evidence Act 1992 as amended, Section 14 Criminal Evidence Act 1992 as amended, Section 16 Criminal Evidence Act 1992, Section 39 Criminal Justice Act 1999 as amended.

[6] Section 2 Domestic Violence Act 1996, as amended.

[7] Section 5 Domestic Violence Act 1996, as amended.

[8] Section 4 Domestic Violence Act 1996, as amended.

[9] Section 3 Domestic Violence Act 1996, as amended.

[10] Council Directive 2004/80/EC of 29 April 2004 relating to compensation to crime victims available at http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32004L0080:EN:NOT See also the Criminal Injuries Compensation Scheme and the Criminal Injuries Compensation Tribunal Victims Charter Available at <http://www.victimsofcrimeoffice.ie/en/vco/Chapter%209.pdf/Files/Chapter%209.pdf> Last accessed 17th October 2013.

[11] Victims' Rights Bill, (No.5 of 2002), sponsored by Fine Gael & Deputy Alan Shatter, as he was then. Available at <http://www.oireachtas.ie/documents/bills28/bills/2002/0502/b502d.pdf>Last accessed 1st October 2013.

[12] Victims' Rights Bill 2008 (No. 1 of 2008) sponsored by Deputy Alan Shatter and Deputy Charles Flanagan of Fine Gael. Available at <http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/bills/2008/0108/document1.htm> Last accessed 1st October 2013.

[13] *Victims Charter and Guide to the Criminal Justice System;* Department of Justice and Criminal Law Reform 2010. [Hereafter the Victims Charter (2010)] Available at http://www.victimsofcrimeoffice.ie/en/vco/Entire

aspirational in nature and has no legal force[14]. The Victims' Charter acknowledges that it *'is only a guide. It is not a legal document and does not give you legal rights'.*[15] NGO's working with victims of crime state that information provided to victims, as required by the Charter, is not consistent and varies from victim to victim.[16] There are no checks and balances to ensure that the Victims' Charter is adhered to and therefore victims have no recourse if their rights, as provided for by the Charter, are breached. In 2007 The Commission for the Support of Victims of Crimes called on the Charter to have legal force as *'although the Charter introduces victims to the criminal justice system, it does not provide a comprehensive account of their legal position within that system. Unlike most charters, it does not define their rights under law (limited as they are), nor the methods by which any such rights may be enforced.'*[17]

Efforts at International[18] and EU[19] level have thus far failed to result in the implementation of victims' rights legislation in Ireland.[20] However, the *Directive of the European Parliament and of the Council establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA*[21] [hereafter the Victims' Rights Directive], offers an impetus for change in victims' rights in Ireland; rights which will not impinge on the rights of an accused to a fair trial.

%20Charter.pdf/Files/Entire%20Charter.pdf [Last Accessed 13th October 2013] Earlier Version: *Victims Charter and Guide to the Criminal Justice System (1995),* Department of Equality, Justice and Law Reform;

[14] These failures are also illustrated by the Report from the Commission pursuant to Article 18 of the Council Framework Decision of 15 March 2001 on the standing of victims in criminal proceedings.

[15] *The Victims' Charter (2010)*, 9, Supra note 13

[16] Information obtained from working with victims' rights NGO's.

[17] Bacik, Heffernan, Brazil, Woods; *Report on Services and Legislation providing support for victims of crime*, Report prepared for The Commission for the Support for Victims of Crime (December 2007), 39, available at <www.csvc.ie/en/CSVC/...doc/Files/Research%20Document.doc> Last accessed 22nd October 2013.

[18] UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power (29 November, 1985 - A/RES/40/34) available at <http://www.un.org/documents/ga/res/40/a40r034.htm> Last accessed 1st October 2013; UN Office on Drugs and Crime (UNODC), Handbook on Justice for Victims, 1999, available at <http://www.uncjin.org/Standards/9857854.pdf> Last accessed 1st October 2013.

[19] Council Framework Decision of 15 March 2001 on standing of victims in criminal proceedings (2001/220/JHA) [Hereafter the Framework Decision] Available at http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32001F0220:EN :NOT Last visited 1st October 2013. The Framework decision provided for the provision of information to victims including information on the type of support they can obtain.

[20] A number of Bills have been prepared in Ireland on Victims' Rights none of which became law. The Victims' Support Bill [No. 42 of 1995] Available in hardcopy only; The Victims' Rights Bill 2002 [No 5 of 2002] Available at http://www.oireachtas.ie/documents/bills28/bills/2002/0502/b502d.pdf; Victims' Rights Bill 2008 (No 1 of 2008) http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/bills/2008/0108/document1.htm

[21] Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA < http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:315:FULL:EN:PDF> [Accessed 23rd October 2013] Article 1 (1) [Hereafter Victims' Rights Directive]

The Victims' Rights Directive

The Victims' Rights Directive came into force on the 15th of November 2012[22] and it must be transposed by the 16th of November 2015.

The Directive defines a victim as a person who has suffered '*physical, mental or emotional harm or economic loss,'* as a direct result of a criminal offence[23]. Family members who have lost a loved one due to homicide are also deemed to be victims under the Directive.[24]

The Directive provides for minimum rights, supports and protection for all victims of crime regardless of where the crime was committed in the European Union, the residential status of the victim, or the victims' citizenship or nationality.

The Victims' Rights Directive will help improve victims' experience of the criminal justice system by ensuring that victims have a right to:

A. Information
B. Support Services
C. Protection

The Right to Information

Victims' Rights organisations have found inconsistencies in the manner by which information is being provided to victims of crime.

An on-going survey being conducted by Advocates for Victims of Homicide [AdVIC], the Dublin Rape Crisis Centre [DRCC] and Support after Homicide [SAH] illustrates that there appears to be breakdowns in the provision of information to victims. Of 81 victims surveyed, 63 were homicide victims, while 18 were victims of rape and/or sexual assault. Victims were asked whether they were provided with information on victims' support services. Surprisingly only 46% of victims stated that they were informed by the Gardaí about victims support services. These figures were lower due to the inclusion of rape/sexual assault victims, 89% of which stated that they did not receive information from the Gardaí about victim support services. The extremely high number can be explained by the fact that only half, 50% of rape victims actually make a formal complaint to the Gardaí[25].

This survey is on-going and involves cases of historical child abuse; crimes which occurred in advance of the most recent Victims' Charter. That being said, it is clear that victims who do not make a formal complaint to the Gardaí are not being informed about victims' support services. Also, there appears to be inconsistencies in the provision of information by the Gardaí to victims.

It is hoped that the Victims' Rights Directive will ensure that certain information is provided to all victims of crime.

The Directive requires that on first contact with the '*competent authority',* namely the Gardaí, victims should be offered certain information without *'unnecessary delay'*.[26] This information includes:-

- Information on the type of support services they can obtain, including medical, specialist support services,

[22] *Ibid, The Victims' Rights Directive.*
[23] *The Victims' Rights Directive, Article 2 (1)(a) (i).*
[24] *The Victims' Rights Directive, Article 2 (1)(a) (ii).*
[25] A report on the survey is due to be published in the new year. For further information on the survey please contact marianidhomhnaill@gmail.com
[26] *The Victims' Rights Directive, Article 4 (1).*

psychological support and alternative accommodation, such as shelters[27];
- The process for making a complaint about a criminal offence and the victim's role in any procedures[28];
- How and under what circumstances a victim can get protection and protection measures[29];
- In what circumstances a victim can access legal aid and advice[30];
- How and when a victim can obtain compensation[31];
- When a victim can obtain translation and interpretation[32];
- If a victim is not resident in the member state where the crime was committed then they should be informed by the member state where contact is first made of any '*special measures, procedures or arrangements which are available to protect their interests in the member state*'[33];
- What procedures are available for making a complaint if the victim's rights were not respected by the competent authority, Gardaí, during the course of criminal proceedings[34];
- The contact details where a victim can communicate about their case[35];
- Any restorative justice services which are available[36];
- The Directive provides that victims should also be informed on how expenses, such as travel and loss of wages that were incurred as a result of their role in criminal proceedings, can be reimbursed[37].

Upon request, victims have a right to receive certain information about their case, such as the place and time of the trial and the type of crimes the offender was charged with.[38] Subject to a victim's role in criminal proceedings, and upon request, they can be informed of any final judgement of the trial[39]. Information should also be given, on request, to a victim on the state of the criminal proceedings, save where the provision of this information could damage the case[40].

The Directive provides that if a decision is taken to end proceedings or not to prosecute, then, a brief summary of the reasons should be given to the victim, upon request, with certain exceptions[41]. A victim can appeal a decision not to prosecute[42].

This information, if provided consistently, will remove the difficulties which some victims have in obtaining information about their case.

Right to Support Services

As we have seen there appear to be inconsistencies in the provision of information to victims of crime about victims support services. It is hoped that the Victims' Rights Directive can alleviate these issues.

[27] *The Victims' Rights Directive, Article 4 (1) (a).*
[28] *The Victims' Rights Directive, Article 4 (1)(b).*
[29] *The Victims' Rights Directive, Article 4 (1) (c).*
[30] *The Victims' Rights Directive, Article 4 (1) (d).*
[31] *The Victims' Rights Directive, Article 4 (1) (e).*
[32] *The Victims' Rights Directive, Article 4 (1) (f).*
[33] *The Victims' Rights Directive, Article 4 (1) (g).*
[34] *The Victims' Rights Directive, Article 4 (1) (h).*
[35] *The Victims' Rights Directive, Article 4 (1) (i).*
[36] *The Victims' Rights Directive, Article 4 (1) (j).*
[37] *The Victims' Rights Directive, Article 4 (1) (k) and Article 14.*
[38] *The Victims' Rights Directive, Article 6 (1) (b).*
[39] *The Victims' Rights Directive, Article 6 (2)(a).*
[40] *The Victims' Rights Directive, Article 6 (2)(b).*
[41] *The Victims' Rights Directive, Article 6 (1) (a) & Article 6 (3).*
[42] *The Victims' Rights Directive, Article 11.*

Referral to Victim Support Services

The Directive will require that the competent authority which received the complaint, namely the Gardaí, must *'facilitate the referral'* of victims to victim support services[43].

Presently in Ireland, data protection legislation has an '*opt in'* approach that requires Gardaí to seek permission from victims prior to their referral to a victim support service[44]. The UK on the other hand has an '*opt out'* approach which automatically refers victims to support services unless the victim does not wish to be referred[45]. The latter approach ensures that all victims are referred to victims' support services and it ensures consistency of service. An *'opt out'* referral scheme in Ireland would require a change in data protection legislation and a debate on any issues which may arise as a result of obligations under the Irish constitution and/or the European Convention on Human Rights.

Access to support services for victims who do not make a formal complaint

The Directive provides '*that access to any victim support services is not dependent on a victim making a formal complaint with regard to a criminal offence to a competent authority'*[46]. This will ensure that victims who are unwilling or are too afraid to make a statement to the Gardaí get the support and help that they need. The underreporting of crime is prevalent in victims of domestic violence, rape and sexual assault. In order to ensure access to victims who do not report crimes, it is important that these victims obtain information about victim support services which are available to them. It is a conundrum as to how this can be achieved. Further research and work with relevant interest groups will need to be facilitated in order to find or create a solution to this issue.

The provision of support services free of charge

The Directive requires that victims will have access to support services, free of charge, before, during and for a period after, criminal proceedings[47].

At a minimum support services shall provide information, support and advice in relation to the victim's role, if any, in criminal proceedings.[48] Information on specialist support services,[49] psycho-logical, emotional support[50], and financial

[43] The Victims' Rights Directive, Article 8 (2)

[44] Data Protection Acts 1988 as amended by the Data Protection (Amendment) Act 2003; See the Code of Practice for An Garda Síochána; Data Protection; 4.1 "*There will be circumstances when the purpose of information or data to be used is obvious. On other occasions it may be necessary to provide an explanation to the individual. An example of this would be where a Garda will seek the consent of victim(s) of crime to pass their details on to an organisation such as Victim Support or other similar support or research group*" Available at < http://www.garda.ie/Controller.aspx?Page=136&Lang=1> Last visited 23rd October 2013

[45] Victim Support Europe EU Handbook on Implementation of Legislation and Best Practice for Victims of Crime, 19 & 35, Available at <https://www.google.ie/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&ved=0CEAQFjAB&url=http%3A%2F%2Fvictimsupporteurope.eu%2Factiveapp%2Fwp-content%2Ffiles_mf%2F1370518579EUHandbookforimplementationandbestpracticeforvictimsofcrime.pdf&ei=w_rXUd7AEeqI7AbD8ID4Cw&usg=AFQjCNEQpFYR6R4NraeKfsdgq_xH3Oi__A&sig2=ViVKpO4oCEJOzAJ_H30vhA> Last visited 23rd October 2013.

[46] *The Victims' Rights Directive, Article 8(5).*

[47] *The Victims' Rights Directive, Article 8 (1).*

[48] *The Victims' Rights Directive, Article 9 (1) (a).*

[49] *The Victims' Rights Directive, Article 9 (1) (b).*

[50] *The Victims' Rights Directive, Article 9 (1) (c).*

issues should also be provided[51]. Shelters and accommodation for victims who are at imminent risk of repeat victimisation must be developed and delivered,[52] as should counselling and trauma support services for victims of sexual and domestic violence[53]. Conditions should be established to avoid contact between the victim and the accused[54].

Some victims' support organisations are under resourced and rely on donations and the goodwill of the public to provide their service. It therefore appears that without additional resources, both human and monetary, it is going to be very difficult, if not impossible, for some victims' rights organisations to assist all victims of crime, as required under the Directive. One such example relates to support services for victims at court. Presently, these services are available in the criminal courts complex [CCJ] in Dublin and in larger cities around the country. Where a victim resides therefore decides whether they will receive support services at court. Circuit courts nationwide often deal with very serious and disturbing cases; including serious sexual assault cases. Some of these victims are not obtaining support services at court. Where a victim resides should not dictate whether they receive such a service. Victim support services will need to be rolled out nationwide, which will require additional support and resources. This is only one example of where additional resources are going to be needed to achieve the aims of the Directive; there are many more.

Right to Protection

There are major concerns in relation to the prevalence of repeat victimisation in the criminal justice system. This is illustrated by the results of a survey currently being completed by AdVIC, the DRCC and SAH. Victims were asked did they *'feel intimidated or re-victimised by the accused and/or the criminal justice system and/or other.'* In response, 52% of people surveyed said that they felt intimidated or re-victimised and 6% stated that they did not. The remainder, 42%, did not answer this question and this may be due to the fact that the case had not gone to trial. More interesting are the results which consider what victims felt re-victimised by;

- 49% of victims stated that they felt intimidated/re-victimised by the accused;
- 72% stated that they felt re-victimised by the criminal justice system;
- Others stated that they also felt re-victimised by the accused's family and/or the media.

The proportion of victims who felt re-victimised by the criminal justice system is shocking but when one reads their comments their feelings are understandable. For example, one person stated that they '*found dealing with Gardaí very traumatic and worse than the original experience of rape. Felt re-traumatised*.' Another stated that they felt re-victimised by the fact that *'the guards coming to my home informed me that they still had my son's leg after he was buried the day previous*'. While another victim sums it up as follows:

'The accused and his family [were] sneering, making faces, brushing past me. The criminal justice system were all about

[51] *The Victims' Rights Directive, Article 9 (1) (d).*
[52] *The Victims' Rights Directive, Article 9 (3) (a).*
[53] *The Victims' Rights Directive, Article 9 (3) (b).*
[54] *The Victims' Rights Directive, Article 19.*

the offender and we were not considered in the court and we had nowhere to complain about the defence counsel'

There are many more shocking examples given by victims in the survey. The criminal justice system sometimes is so focused on protecting the rights of the accused that it can forget that victims are real people with real feelings. Victims are serving their public duty to society by reporting the crime and being a witness and yet they feel re-victimised by the criminal justice system. The process needs to change in order to ensure that victims are not re-traumatised by the process. A change need not impede on the rights of an accused to a fair trial; both can work in tandem.

The Directive implements a number of measures in order to protect people from repeat victimisation and intimidation[55]. Both medical examinations and interviews should only be done where strictly necessary[56]. Victims, during the course of criminal investigations can, in certain circumstances, be accompanied by a person of their choice and a legal representative[57].

The Directive also provides for the individual assessment of all victims of crime in order to identify those victims that may have specific protection requirements[58]. In considering whether a victim needs extra protection measures regard will be given to the characteristics of the victim, the nature of the crime and circumstances of the crime[59]. It is assumed that child victims need extra protection.[60]

A Force for Change?

The transposition deadline for the Directive is the 16th of November 2015. If a member state fails to transpose the Directive by this date then the EU Commission can bring an infringement action against the member state before the Court of Justice of the European Union.

Will the Directive really be a force for change for all victims of crime? The answer will depend on the manner in which the Directive is implemented and the legal force with which it is allocated.

The Directive requires that persons working with victims of crime should receive training[61]. However, training in and of itself will not ensure that the Victims' Rights Directive is implemented for the benefit of all victims of crime.

In the author's view, the success or failure of the implementation of the Directive will depend on the implementation of a transparent, clear and easy complaints procedure which would enable victims to make a complaint about a breach of their rights under the Directive.

Victims who were surveyed by AdVIC, the DRCC and SAH stated that they did not make a complaint as:-

- *'I was afraid'*
- *'Didn't want to bother them'*
- *'I didn't make a complaint as I was afraid and confused'*
- *'Didn't think there was any point'*

[55] *The Victims' Rights Directive, Article 18 & Article 20.*
[56] *The Victims' Rights Directive, Article 20 (a) & (b).*
[57] *The Victims' Rights Directive, Article 20 (c).*
[58] *The Victims' Rights Directive, Article 22.*
[59] *The Victims' Rights Directive, Article 22 (2) .*
[60] *The Victims' Rights Directive, Article 22 (4) & Article 24.*
[61] *The Victims' Rights Directive, Article 25.*

- *'We were afraid that it would damage our case'.*

The survey illustrates the need for an independent complaints procedure. The Directive does not require member states to establish enforcement mechanisms but it does require that victims be informed of complaint procedures. Article 4 (1) (h) of the Victims' Rights Directive provides that victims should be informed by the Gardaí of '*the available procedures for making complaints where their rights are not respected by the competent authority operating within the context of criminal proceedings'.*

A complaints mechanism should be established in order to ensure that victims' rights are protected under the Directive and any complaints made by victims could be dealt with and resolved in a timely manner.

A Victim of Crimes Ombudsman may be the appropriate mechanism to deal with victims' complaints. This is not a new concept. The Canadians have a Federal Ombudsman for Victims of Crime, which has a very broad mandate.[62] In the US there is an Office of the Victims' Rights Ombudsman in the Department of Justice, which deals with complaints made by victims of a federal crime in relation to the manner by which their rights were breached by a Department of Justice employee. In the state of South Carolina there is a Crime Victims' Ombudsman which deals with complaints made by victims relating to the criminal justice system and victims' assistance programmes. In the UK Minister Damian Green MP is looking into establishing an independent Victims of Crime Ombudsman.[63]

Also, the development of a complaints procedure for victims of crime was considered in Ireland in 2007 in a *Report on Services and Legislation providing support for victims of crime,* which was prepared for the Commission for the Support for Victims of Crime[64]. The report recommended that an independent body should be set up to deal with the complaints of victims of crime, namely a '*national agency or Ombudsman for Victims, who should have the statutory power to investigate a complaint, issue a report following investigation and make recommendations based on those findings'*[65]

The foreword to the Directive recommends that "*Member states should consider developing 'sole points of access' or 'one-stop shops', that address victims' multiple needs when involved in criminal*

[62] Office of the Federal Ombudsman for Victims of Crime, Available at <http://www.victimsfirst.gc.ca/index.html> and <http://www.victimsfirst.gc.ca/abt-apd/wwa-qsn.html> Last accessed 23th October 2013.

[63] Press release: Damian Green: '*Digital Courtrooms' to be rolled out nationally*' (Gov.uk, 28th June 2013) Available at <https://www.gov.uk/government/news/damian-green-digital-courtrooms-to-be-rolled-out-nationally> Last accessed 23rd October 2013; See also '*MPs call for a rebalance of victims' rights'* (Victims Support, 11th July 2013) available at <http://www.victimsupport.org.uk/about-us/news/2013/07/mps-rebalance-of-victims-rights#.Umfk0vmsim4> .

[64] Bacik, Heffernan, Brazil, Woods; *Report on Services and Legislation providing support for victims of crime*, Report prepared for The Commission for the Support for Victims of Crime (December 2007) .

[65] Bacik, Heffernan, Brazil, Woods; *Report on Services and Legislation providing support for victims of crime*, Report prepared for The Commission for the Support for Victims of Crime (December 2007) at para 5.

proceedings, including the need to receive information, assistance, support, protection and compensation".[66] A Victim of Crimes Ombudsman offers such a solution. If established a Victim of Crimes Ombudsman could have a very broad or narrow mandate depending on the manner in which it is established under legislation. It could be established as an independent body or form part of the mandate of a pre-existing Ombudsman's office.

Conclusion

The Victims' Rights Directive offers a force for change for victims in Ireland and abroad. The big concern is how it will be achieved and whether the Directive will be successfully implemented within the timeframe for the benefit of all victims of crime.

The foreword to the Victims' Rights Directive states that "*Member states should encourage and work closely with civil society organisations, including recognised and active non-governmental organisations working with victims of crime, in particular in policy making initiatives, information and awareness-raising campaigns, research and education programmes and in training, as well as in monitoring and evaluating the impact of measures to support and protect victims of crime.*[67]"

Therefore victims' rights NGO's are encouraged to engage with Government on policy issues relating to the Directive. A Victims' Rights Alliance has been established to provide a platform for NGO's to engage with relevant interest groups on the implementation of the Directive. As envisaged by the Directive, it is hoped that the Victims' Rights Alliance will start a conversation with, and engage with Government to ensure that the Directive is implemented within the time frame. At the Victims' Rights Alliance launch in November 2013, Alan Shatter TD, Minister for Justice, Equality and Defence indicated that he intended to implement legislation which went over and above what was required by the Victims' Rights Directive. The Minister also welcomed the establishment of the Victims' Rights Alliance and he looked forward to submissions on the implementation of the Directive by the group[68]. The Victims' Rights Alliance is currently working on submissions on the implementation of the Directive in Ireland.[69]

[66] Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA, para 62 available at < http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:315:FULL:EN:PDF> Last accessed 23rd October 2013.

[67] Ibid; Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA, para 62 available at < http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:315:FULL:EN:PDF> Last accessed 23rd October 2013.

[68] Speech by Alan Shatter T D, Minister for Justice, Equality and Defence at the launch of the Victims' Rights Alliance at the Mansion House Dublin on Friday 15 November 2013 Available at http://www.justice.ie/en/JELR/Pages/SP13000390

[69] For further information on the Victims' Rights Alliance [VRA] please contact marianidhomhnaill@gmail.com or see www.victimsrightsalliance.com

This is only the beginning of a process to give legal force to victims' rights in Ireland. A substantial amount of work needs to be done in the coming two years to ensure that the Victims' Rights Directive will offer a force for change for victims of crime.

Presentation by Maria McDonald

1. "Responding to victims in a civil society: the policing challenges"

Presenter: Sergeant Aidan Curtin, Garda Victim Liaison Office, Garda Community Relations Bureau
Chair: Doncha O'Sullivan
Rapporteur: Kelly Lynch

Sergeant Aidan Curtin identified a recurring theme perceived by Gardaí working with victims of crime – victims don't always want somebody to be put in prison, they just want justice. He framed the role of the police in meeting this need with two quotes from the *Organisation for Security and Co-Operation in Europe* (OSCE*):*
"*The Police are the most visible manifestation of government authority responsible for public security*"
"*Recognising that effective policing requires partnership with the communities being served for democratic policing*"

The Role of An Garda Síochána
While, the Garda Síochána Act 2005 makes no specific references to victims other than the investigation of crime, Section 7(2) of the Act was quoted as saying:
"...For the purpose of achieving the objective referred to in subsection (1), the Garda Síochána shall co-operate, as appropriate, with other Departments of State, agencies and bodies having, by law, responsibility for any matter relating to any aspect of that objective." This includes work for victims of crime.

However, the Policing Plan 2013 *does* make a reference to victims:
"...supports the needs of victims of crime, treats them with dignity and keeps them informed about the progress of cases relevant to them."

The new EU Directive[70] sets out the needs of victims. The introduction of this Directive represents a major development and challenge for the Gardaí in relation to the rights of victims and how issues are dealt with.

The Gardaí already recognise the special needs of certain categories of victims such as foreign visitors to the country, the elderly and disabled. In the Victims' Charter, the Gardaí were the only organisation out of seven to mention victims with special needs and they are committed to "*take special needs or requirements into account*".

Civil society in Ireland and the criminal justice system
An Garda Síochána has always had a strong community focus. An Garda Síochána works with a wide range of civil society organisations including NGOs and community based organisations, such as residents associations and this is very important in how they take on board the concerns of victims, and the public generally, about crime. A new example of this is the operation of the *Community Text Alert Schemes* which allow residents of a community to circulate information in a structured format. It is a clear example of the Garda response to the request to provide smarter policing. The Irish Farmers' Association (IFA) are also on board in relation to this scheme.

[70] Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA

Responding to the needs of victims - the policing challenges

Eight categories of policing challenges were identified, with information cited as the most important issue. An issue raised by some domestic violence agencies was that the standard of service provided by An Garda Síochána can vary from station to station and evaluations are conducted to deal with this.

1. Policing and criminal justice system

The victim as the '*injured party'* has now been given a legal definition under the Directive which will act as an impetus towards the system becoming more accessible to victims of crime.

2. Victim support organisations

There are 49 different victim support organisations and victims should be provided with a letter containing details of a number of these. The Gardaí are not permitted to recommend one organisation over another. In the United Kingdom there is a more streamlined approach and in Northern Ireland there is a victim support desk within the police control room. To create a similar service here would require agreement from all organisations as to who would provide the service.

3. & 4. Prosecution difficulties & civic responsibility

A refusal from victims to report crime can be a difficulty for An Garda Síochána in the tackling of crime. The Gardaí are committed to acting when a crime *is* reported but need the support of communities in this regard.

5. Finance and austerity

An Garda Síochána is to begin recruitment again in 2014. The Commissioner has stated that policing services can be provided with 13,000 members. The training programme for recruitment has been shortened to just a year and a half, with a stronger focus on "on-the-job" learning.

6. Criminal justice agencies

The success in the bringing together of the Revenue Commissioners and An Garda Síochána in the formation of the Criminal Assets Bureau (CAB) was highlighted as a good model of partnership. Comparison is made to systems used by Australian Police and the Police Service of Northern Ireland (PSNI), in which there is just one computer system for all relevant criminal justice information. Once a court updates a conviction on the system, the police and the DPP will have access to up-to-date information. However, to create such a system would take a lot of time and resources.

7. A diverse society

One very practical challenge is the translation needs in a diverse society. Translation services are provided to a victim who comes into a station to report a crime and to persons who are witnesses. However, the family of a deceased victim attending court, who are not witnesses, have no entitlement to translation services but the Gardaí often step in to assist in these cases.

8. Victims and suspects

The chairperson of the Irish Council for Civil Liberties (ICCL), speaking in relation to the EU Directive, recognised that the rights of the accused and the rights of the victim are not competing rights and it is not a case of taking from one right to provide more to the other but rather balancing the two.

What does the future hold?

The implementation of the new EU Directive will require the training of Gardaí and all criminal justice staff. Information is to be provided in relation to other agencies such as the Legal Aid Board and the Prison Service etc.

An Garda Síochána are working with finite resources. The Gardaí are required to provide a better service, smarter policing and a more competent system, without losing the personal touch.

Suggestions of smarter policing, a clearly defined policing role, shared resources and increased partnership are made in relation to developing into the future. By reviewing approaches in other jurisdictions, the Gardaí will be able to make better choices for the future of policing in Ireland. For example, guidelines have been set out for victims to assist them regarding victim impact statements. This has cost very little money and has been produced in simple language to make it accessible to everyone.

Discussion

Points that were raised during open discussion:

- Concerns were raised about victims of drug-related intimidation, particularly within disadvantaged communities, and people's fear of coming forward. It was noted that there is a huge amount of non-formal reporting and that there are a number of confidential options through which people can report crime anonymously. The Garda National Drug Unit (GNDU) also works with families affected by drugs, including responding to the question of intimidation and drug debts.
- In relation to the criminal justice agencies, it was suggested that communication between agencies is not always as efficient as it should be. There was agreement that the agencies need to work together and to see their dealings with a particular victim as forming a continuum from their original contact with the Gardaí and then, where a person is prosecuted and sentenced, with the Courts and possibly the Probation Service and/or the Prison Service.
- Data protection issues prevent the Gardaí from passing on a victim's details directly to support organisations. It was suggested that there should be a means of addressing this, as seems to have been done in the UK.
- Regarding the question of prosecutions without witness identification evidence, it was said that the DPP will usually look for witness evidence, not simply CCTV. Issues arise with accused persons being identified from CCTV by a Garda on the basis of previous convictions. This affects their rights as it draws a jury's attention to previous bad behaviour. However, working closely within the community allows members of An Garda Síochána to identify individuals from the general policing interaction.
- Frustration of victims because of lack of information could be reduced by maintaining regular contact. However the difference between a commitment and a right was raised and it was noted that the Directive is going to include new rights to information. A trial service in some stations, such as Store Street and Waterford, is

providing a 9-5 central office information service so that victims can get information even if the Garda dealing with their case is not on duty. However, this is not necessarily as straightforward as it might sound, as great care has to be taken with access to information and dissemination about on-going investigations, and the risk of disclosure to third parties.

- In relation to the tendency to refer to 'balancing' of the rights of victims and suspects, this description was criticised and it was argued that the rights of both groups should not be seen as being truly in conflict or a trade-off. In many situations, particularly in disadvantaged communities, persons can be both victim and accused, depending on the circumstances. The emphasis needs to be placed on providing the victim with information, whilst at the same time also upholding the rights of the accused.
- Emphasis needs to be on information, the way in which it is communicated and at what point. Points of contact are available on the Garda website, however, overall lack of resources frustrates this issue. With juvenile cases, there is usually a single person to contact – this appears to work well. Aspects of the Garda website and contact with Garda stations in certain particular instances were criticised. In the cases cited, the person in question did not feel the Gardaí had dealt with queries professionally or courteously. The speaker offered the person the opportunity to address the issue after the presentation. This offer was declined. The importance of ensuring across the board compliance with the standards set centrally was highlighted.
- It was suggested that if a case goes to the DPP, the victims *should* be informed of this development.

2. "Victims of crime and their service to society – should the burden be on their shoulders?"

Presenter: Shirley Cummins, Dublin Rape Crisis Centre
Chairperson: Finbarr O'Leary
Rapporteur: Tara O'Donoghue

The Dublin Rape Crisis Centre (DRCC) provides counselling and advocacy services to help people recover from the trauma of sexual violence. Shirley Cummins, a telephone counsellor, who also works in the area of policy for the Dublin Rape Crisis Centre is today arguing whether the rights and treatment afforded to victims eases the burden thrust upon them by virtue of being a victim of crime.

Introduction

A victim enters the criminal justice system by chance rather than by choice. It is necessary to ensure that that the rights afforded to victims ease the burden thrust upon them as a result of this crime, instead of adding to the severity of the violence committed against them. Furthermore, the question must be posed as to whether these rights go far enough to support and protect the victim. The rhetorical nature of this question must be addressed by offering a definition of who is a victim of crime. The definition offered by the United Nations is:

"*persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment*

of their fundamental rights through acts or omissions...in violation of criminal laws."[1]

Historical Overview

Up to the early part of the 19th century, the responsibility for prosecuting an offender lay with the victim. The victim gathered the evidence and paid the lawyer. An inherent problem with that system was the imbalance of power it created, whereby those who were well off won cases regardless of guilt or innocence. Over the years, that imbalance in the criminal justice process began to be redressed. Investigatory powers were given to the Gardaí and under the *Prosecution of Offences Act 1974*, which set up the independent office of the DPP, which was charged with prosecuting all serious cases in the name of the State. The prosecution's role is to work in the public interest. For this reason, victims see themselves as playing a peripheral role in the criminal justice system. It was against the backdrop of that historical context that the victims' movement really began and as the years have progressed some positive substantive changes have occurred.

Criminal Justice Act 1993

Notwithstanding some of the victim centred policies and measures implemented, it can often take a high profile case, such as *Lavinia Kerwick's 1992* case, to highlight deficiencies in the criminal justice system. In the wake of the intense lobbying which followed, a bill proposing increased rights and protection for victims of crime was introduced. This resulted in the enactment of the *Criminal Justice Act 1993*, which was hailed as watershed legislation for victims. It provided for a provision to appeal unduly lenient sentences and the legal provision of victim impact statements which would give victims the opportunity to describe the effects of the offence upon them and their lives.

Criminal Procedure Act 2010

One of the provisions of The *Criminal Procedure Act 2010* amended the *1993 Act* to allow families of murder victims to give victim impact statements at the discretion of the court. This was heavily lobbied for by organisations such as *AdVic*, to ensure that the victim and their families maintain a meaningful role within the criminal justice system. It is left to the judiciary to decide upon the weight if any that is placed on the victim impact statement. It is important that a victim does not rely too heavily on the impact of their victim impact statement because it could lead to disappointment if the result is not as they expect.

Victims' Charter

1999 saw the introduction of the Victims' Charter. At the time, it was seen as another positive step in considering the rights of victims. In 2005 the *Commission for the Support for Victims of Crime* was established to create a framework for victims of crime into the future and to distribute funding to NGO's that support victims of crime. Research carried out for the Commission in 2010, '*The Needs and Concerns of Victims of Crime in Ireland*' identified information needs as being a key concern for victims. Victims who are unfamiliar with the workings of the criminal justice system do not know what to expect, so access to information is crucial. While the latest edition of the Victims' Charter outlines the work of state agencies in support of victims throughout

[1] Article 1 of the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power

all stages of the criminal justice system, it does not contain statutory rights and obligations for victims of crime.

The Trial Process

Victims of crime can find the court experience daunting, confusing and frustrating. Adjournments, delays, and a lack of sentencing consistency all impact on victims and add to their burden.

(1)Disclosure

The Rape Crisis Centre have had specific concerns relating to requests for access to their clients' counselling notes. On the one hand, a victim becomes concerned that without those notes their case may not proceed; on the other hand the prospect of their personal internal world being exposed to the court is hugely distressing. As an interim measure a memorandum of understanding has been drawn up between the DRCC and the DPP. Ultimately what is needed though is legislation that is robust enough to ensure that counselling notes are not readily disclosed which acknowledges the victim's right to privacy and respects the counselling process; at the same time the legislation permits the disclosure of counselling notes where relevance has been established, thus affirming the accused's right to a fair trial.

(2)Cross-Examination

Cross examination is very unpleasant for victims', its purpose is to probe and determine whether there is reason for the jury to reject the evidence. Temkin (2000)[71] noted that the approach of the defence counsel in a rape case in particular is robust to the point of ruthlessness. Discrediting the victim involved deliberately maligning her behaviour, clothing and sexual character. Being questioned in such a manner can leave the victim feeling under attack. In 2009, Senator Ivana Bacik undertook research on behalf of the DRCC[72], which was based on an analysis of 40 rape cases tried in the Central Criminal Court between 2003 and 2009. The study showed that judges granted defence application to introduce evidence about the sexual history of rape victims very frequently, despite the highly prejudicial nature of the reasons being offered by the defence. One commonly used defence argument was that the victim was promiscuous. This sort of argument unfortunately strengthens the myths about rape and has the potential to undermine the victim's evidence in court. If during a rape or sexual assault case, the accused applies to the court to raise issues about the complainant's prior sexual experience, the Legal Aid Board will provide legal representation for the complainant. But such unnecessarily aggressive cross-examination and the inappropriate introduction of evidence of victims' past sexual history results in an unduly traumatic court experience for victims.

(3) Sentencing

Sometimes sentences are difficult to understand without context. A sentence that the victim/public may consider excessively lenient or severe based on a brief media report may be understandable in light of the detailed information available to the court. However, there is little public awareness of how judges decide on a sentence. There have been a number of cases in recent years where the victim and the public alike have expressed

[71] Temkin, J. (2000), '*Prosecuting and Defending Rape: Perspectives from the Bar*', Journal of Law and Society, 27(2): 219-48.

[72] Bacik et al (2010) *Separate Legal Representation in Rape Trials* DRCC Conference

their dissatisfaction with the sentence handed down by the courts. One of the provisions of the Criminal Justice Act is that if the DPP considers that a sentence imposed was unduly lenient s/he can apply to the Court of Criminal Appeal to review the sentence. That power has been utilised with varying results. The work of Mr. Justice Peter Charleton in cataloguing a large number of sentencing decisions in rape cases and classifying them according to whether they fell into low, middle or most serious scale of offences will ultimately be of great assistance in addressing sentencing issues in rape cases.

Conclusion

To conclude, not only is it necessary for the criminal justice system to combat and prevent crime but we need to properly support and protect individuals who do fall victim to crime and go on to engage in the criminal justice system. Giving victims the chance to have their voice heard should not mean a dilution of the legal process, rather a demonstration of respect for them and the service they do for civil society.

Question and Answers

- **Planned EU Directive**

An EU directive set to transpose into Irish law by 2015 will strengthen victims' rights. Among the articles of the Victims' Directive, victims will have a right to receive information about their case (Article 6) and to be informed as to why decisions not to prosecute have been taken (Article 11). These are crucial in further strengthening victims' rights and the key aim of the legislation will be to support a genuine improvement in the service and information to victims. If the Victims Directive does not give rise to consistent action on the ground, then it will be of limited value in protecting victims of crime.

- **Civil versus Criminal evidence**

A discussion arose regarding the failure of the state to investigate sexual offences unless there has been a statement given by the victim, in contrast to the law as it applies in other countries. This is due to varying degrees of proof which must be given in both a civil and criminal court case. When a person is in court on suspicion of a sexual assault, the prosecution must prove beyond a reasonable doubt that a crime has been committed. However, in theory, if the victim does not report such a crime to the Garda, then a civil case for compensation could be taken and the standard of proof is that which is on the balance of probabilities.

- **Role of restorative justice**

Restorative justice has previously been used in circumstances where victims have requested face to face meetings with their attacker. The therapy team at the Dublin Rape Crisis Centre had a presentation from some members of Facing Forward who work in the area of exploring the development of restorative justice processes in the area of serious crime in Ireland. Their input provided some debate among the staff. A discussion arose that the success of restorative justice would only be seen if the victim's expectations were matched with the capacity of the offender.

- **Role**

The Dublin Rape Crisis Centre is a national organisation offering a wide range of services to women and men who are affected by rape, sexual assault, sexual harassment or childhood sexual abuse.

The services include a National 24-Hour Helpline, one to one counselling, court accompaniment, outreach services, training, awareness raising and lobbying. In addition, the Dublin Rape Crisis Centre has a team of more than 70 trained volunteers who provide telephone counselling outside of office hours. Our volunteers will also accompany and offer support to women and men who attend the Sexual Assault Treatment Unit in the Rotunda hospital.

3. "From harm reduction to total abstinence: a continuum of care in drug treatment"

Presenter: Tony Geoghegan, CEO Merchants Quay Ireland
Chair: Patricia Flynn
Rapporteur: Sean Byrne

Focus on harm reduction – how has Irish drug treatment evolved

It's hard to find anything in Irish social policy or law that specifically mentions drug use predating the 1960's. The earliest mention was in the Mental Health Treatment Act of 1945 whereby people could be involuntarily sectioned for drug or alcohol addiction. The 1960's in Ireland, as in the rest of the world, saw an explosion of youth culture, of which a new drug culture was a part.

Report of Working Party On Drug Abuse 1971.

'Persons who have become dependent on drugs should be regarded as sick people in need of medical care to be treated with sympathy and understanding'.

There was little drug use until the latter half of the 1960's, problems that had been arising previous to this had been among professionals, such as doctors or nurses who had access to medical drugs. This pattern changed with the advent of the youth culture and wider access to travel whereby people who had been abroad and encountered drug use, on their return brought drugs into the country from the UK, Europe and America. In 1966 a Report of the Commission of Inquiry on Mental Illness stated:

'The Commission considers that drug addiction could reach serious proportions in this country unless a constant effort is maintained to prevent the abuse of habit forming drugs'.

Later as drug use began to emerge more publicly, the Government established a Working Party on Drug Abuse which published a report in 1971 stating:

'Persons who have become dependent on drugs should be regarded as sick people in need of medical care to be treated with sympathy and understanding'.

How did treatment begin?

The first Statutory drug treatment unit was established in a caravan on the grounds of the Jervis St hospital, which perhaps highlights the level of importance afforded the issue and also the lack of demand for the service. The unit was later updated and was housed in a prefab on the grounds of the hospital. The locations of early drug treatment units such as this one and others located in hospital basements etc., highlights the 'out of sight out of mind' approach being adopted at the time. The first doctor involved in the drug treatment unit in Jervis St was not an addiction specialist but was one of few to show an interest.

The first residential unit for drug detoxification was set up at the same period in the grounds of the Central

Mental Hospital in Dundrum. It had been mooted to merge it with a residential alcohol treatment centre on the North Circular Road, however, it was feared that alcohol users and drug users would not mix well. The detox unit was later moved back to the St Michaels ward of Jervis St Hospital, where it remained until the hospital closed in 1987. The unit was then moved to a new purpose built facility, Trinity Court, on Pearse Street in Dublin. The first voluntary drug treatment service to be set up was the Coolmine Therapeutic Community in 1972.

The Interdepartmental Committee on Drug Abuse released the following results from studies conducted between 1972 – 1982. In 1979, 55 persons were treated in the Jervis St unit; this rose to 417 persons being treated in 1981. The number of people charged with possession of heroin rose from just 5 people in 1979 to 177 people in 1981.

What are the treatment processes?

Most treatment processes were based on methods developed to treat alcohol dependency. The Moral Model was developed during the Victorian era in England due to the 'gin epidemics'. The epidemic was seen to undermine the economic growth of society. The view of the moral model was that dependency was a human flaw, a vice or sin, and that users abuse of alcohol was due to a weak moral character. There was a very particular approach to dealing with people, such as religious persecution or criminal incarceration with the train of thought being that punishment will eliminate bad behaviour.

Concept houses, which were established in California in 1959, focused on honesty and were community driven. The Coolmine treatment facility adopted this approach; the main form of therapy was the 'encounter group' where residents were to be honest with one another. Similar Christian based communities also existed with their focus being on divine intervention which would bring about change.

There is also the Disease Model or Medical Model, which was developed by E.M. Jellinek, and views dependency as an illness that cannot be cured, with abstention being the only option. The disease model was important for policy makers, the alcohol industry also favoured it as it suggests that only a small proportion of society are affected by the disease.

The most popular and comprehensive model is the Minnesota Model, which incorporated the Disease Model / Theological Models / Psychological Model. The Minnesota Model is used by organisations such as St John of God, and sees treatment go beyond the person abusing a substance, but also looks at the effects on the family, and other aspects of the life of the person.

Opiate Epidemics / HIV & AIDS

1979 to the mid 1980's saw an opiate epidemic spread across Ireland and Europe. For the first time there was a free movement of heroin from Iran and Afghanistan. The Bradshaw report of 1982 showed that 1 in 10 people in the 15 – 24 year old age bracket of Dublin's North Inner City were involved in heroin use. There was still little change of attitude in Ireland towards drug use and drug culture.

This changed with the advent of HIV and AIDS in Ireland. The spread of fear and

panic saw HIV become the basis of public health interest in drug use. The first harm reduction service began in Baggot St Hospital in 1989 with the use of an outreach programme and a limited needle exchange. The next big shift came in 1992 with the launch of the National AIDS Strategy Committee, which recommended wider availability of drug treatment including methadone maintenance programmes for heroin users. On foot of its recommendations a number of satellite clinics for drug treatment at local level opened around the city of Dublin.

Harm Reduction – What is it?

Harm reduction seeks to reduce the harmful effects of drug use on the individual user and on others around the user, such a family, friends and children. The principles are simple and acknowledge that the idea of a drug free society is not realistic or achievable as drugs are always going to be here. Harm reduction aims to ensure that drug users have a voice in the creation of drug treatment programmes aimed to treat them. It calls for non-judgmental and non-coercive provision of services and resources. Harm reduction looks at the complex nature of drugs, drug use and society and why people take drugs and why some people can cease drug use easier than others. It does not attempt to minimise or ignore the harm and danger associated with drug use.

Key Concepts of Harm Reduction

- Practical and human rights approach to drug treatment.
- Drug users to be treated with respect.
- Reduce the spread of AIDS, HIV and other diseases.
- Introduction of needle exchanges.

Harm Reduction – The case against

The case against argues that Harm Reduction ideology may increase drug use, by spreading the message that it is acceptable and can be done safely. There is also the worry that harm reduction allows governments 'off the hook' as harm reduction treatments can be cheaper than drug free treatments. Harm reduction may not look at the issue of dependency, and the idea that the best way to a drug free society is promoting a drug free lifestyle and a crackdown on drugs.

Harm Reduction – The case for

The use of harm reduction strategies has helped to reduce the spread of HIV, AIDS, reduced the level of drug overdose deaths and other forms of drug related harm. Harm reduction benefits not just the drug user, but their families and the wider community by creating a safer environment. Harm reduction is completely supportive of a drug free lifestyle, allowing drug users to enter into a safe network first and ultimately making the decision themselves to become drug free.

Turning Points for Harm Reduction

At a community level in Dublin, public marches were held against the open dealing of drugs and against drug users in the 70's / 80's. These same communities then began to demand better treatment facilities in the 90's, as they recognised that it was their children that were affected and that the provision of treatment was what was needed. The Rabbite Reports of 1996 and 1997 recognised the need for resources in particular parts of Dublin city and saw the introduction of the National Drug Strategy Team and Local Drugs Task Forces in the areas of the city that were most affected

by drugs. There has also been a reduction in tension between agencies with both harm reduction / drug free treatments offering similar services.

Where are we now?

The Interim National Drug Strategy 2009-2016 aims to create a national substance misuse policy and to also to incorporate alcohol abuse. This policy is/will face obvious resistance to the restricting of alcohol advertising, the strategy also has the goal to engage in needle exchange and outreach programmes. The strategy proposes a four tier approach to addressing drug and alcohol issues.

- Tier One – Offering general information, but not expertise. Making basic advice available to everyone.
- Tier Two – Looking at engaging people in the early stages of drug use and working with youth and young adults who face drug addiction.
- Tier Three – Working at a community level to offer professional services aimed at people becoming drug free.
- Tier Four – Offering residential in-house treatment for drug addiction, with professional care and service for those addicted to drugs.

Currently there are estimated to be approximately 18-24,000 heroin users in Ireland with 72% of these located in the greater Dublin area. There are approximately 10,000 people involved in methadone maintenance treatment programmes. Ireland would seem to have come in a full circle, where before it was impossible to obtain methadone maintenance treatment and only detox programmes, it is now more difficult to get a place on a detox programme than methadone maintenance treatment. In the current economic climate the Government are not willing/able to fund the full range of treatment services that would allow people to become drug free if they so wish.

4. "Evidence based harm reduction practices – addressing issues of chronic addiction in the community"

Presenter: Kerry Anthony, MBE, DePaul Ireland
Chairperson: Eugene Corcoran
Rapporteur: Louise Rooney

Kerry's presentation focused on harm reduction and Kerry gave this using the evidence from Depaul Ireland services where a low threshold approach using harm reduction principles is the organisational ethos.

Depaul Ireland is a charitable organisation that provides support and accommodation for homeless individuals or those at risk of becoming homeless. Depaul Ireland is part of an international group of charities, Depaul International, supporting homeless people across the world. Depaul Ireland was first established in the Republic of Ireland in 2002 and in Northern Ireland in 2005. The organisation works toward preventing homelessness through a range of support services, such as; accommodation based services, community and outreach services, services for vulnerable families and criminal justice services. Depaul Ireland are dedicated to supporting vulnerable people who are the most in need. Their range of services have been specifically developed to cater for people with acute complex needs; families, women and children who are homeless;

homeless individuals living with addiction; individuals who struggle with acute mental illness; and individuals exiting prison who are homeless.

In 2003 Depaul Ireland opened the Republic of Irelands first 'wet' service in Dublin's inner city. This revolutionary service provides a warm sheltered environment for 'street drinkers' to avail of overnight accommodation whilst also allowing them to consume alcohol. Depaul Ireland strives to make their low threshold services accessible, especially to those who have been homeless for extended periods of time and/ or those who have been excluded from other services due to the complexity of their needs. The aim of the 'wet' service is to bring 'street drinkers' out of the cold and into an environment where they are safe, can receive key working support, medical care, and access a specialised support network. Since then Depaul Ireland have established a number of different services all using a harm reduction approach to support the service users dependant on their presenting needs.

Depaul Ireland is a 'values led' organisation that provides care and support for its service users through a low threshold approach. The aim of the low threshold approach is to '*consciously maintain the admittance requirements of a service at such a level that as few people as possible are denied access to the service. Every attempt will be made to build a mutually respectful relationship with the service user'*. Professionally trained staff and volunteers encourage service users to find their own individual path to positive change regardless of how many attempts may have proven unsuccessful in the past. Depaul Ireland promotes a non-exclusionary philosophy which insures that care provision and support is delivered in a non-judgmental fashion to individuals who require their help the most.

The staff work directly with individuals who are living with acute alcohol and/ or drug addiction on a daily basis. Depaul Ireland recognises that total abstinence, while desirable, is not always a viable option for individuals battling addiction; as a result they provide a Harm Reduction Model of service to homeless individuals with active drug and alcohol addictions. The Harm Reduction Model aims to '*reduce drug and alcohol related harm in instances where individuals are either unwilling or unable to stop using. This includes the reduction of health issues, social difficulties, and any other problems associated with drug and alcohol misuse*'.

The management team at Depaul Ireland work hard to maintain the core ethos for service provision throughout the organisation. Training relating to the delivery of the harm reduction model using a low threshold approach is given to staff and volunteers throughout the organisation. As part of this training staff are taught to acknowledge the minor positive changes and soft outcomes that are associated with the service user group. They are encouraged to be creative and facilitate any avenue of support that reduces harm, using a non-judgmental supportive approach. Furthermore, staff are also trained to recognise their own personal prejudices, to uphold personal awareness, and actively monitor their own wellbeing.

Great efforts have been made by management and staff to provide good infrastructural facilities where service users are not only safe but can grow

toward making positive changes in their lives. Support units across both Northern Ireland and the Republic of Ireland are comprised of 'dry' areas (no alcohol), 'wet' areas (alcohol), communal areas, life skill areas, and areas for medical assistance.

Interventions implemented using the Harm Reduction Model include but are not limited to; basic medical and health support, provision of a supportive and healthy living environment, the delivery of accurate information regarding treatment options in a non-judgmental manner, and life skills training. Service users who struggle with addiction may also avail of needle exchange services, additionally they are also encouraged to manage and change their alcohol and drug use, using individualised tools such as 'alcohol management plans'.

The introduction of personalised harm reduction support plans into the services has resulted in a number of positive outcomes. Staff and volunteers working directly with service users have reported a reduction in alcohol consumption leading to alcohol management on the behalf of service users, a decrease in the number of ambulances called to individual units throughout the service, improved mental health, improved nutrition, better engagement with health services, higher involvement in needle exchange programmes and a significant decrease in alcohol and drug related antisocial behaviour and criminality. As a result Depaul Ireland has developed a localised procedure which aims to implement harm reduction support plans with all of its service users.

Discussion

The following paragraphs will outline the pertinent themes that arose during the workshop discussion.

- **Accommodation**

Depaul Ireland offers 343 beds throughout Ireland. A total of 153 of these beds are made available through support services located in Dublin. Statistics show that on a quarterly basis overnight accommodation throughout the country functions at almost full occupancy (Between 96-98%).

- **Staff Training**

General training is provided by Depaul Ireland to all staff and volunteers who work within the organisation through an initial induction process. During this process staff are taught the philosophy and deliverance of the Harm Reduction Model, the Low Threshold approach, and risk management. New staff and volunteers are also educated as to the ethos of the organisation- '*helping those who are most in need*'. Staff and volunteers also receive further onsite training that is specifically relevant to individual services and support units.

- **Person- Centred Harm Reduction Management Plans**

Although service users are encouraged to participate in harm reduction management plans to help manage their addiction, compliance is by no means compulsory. Service users are never excluded from the support services because of non-participation in any harm reduction intervention and participation is continually discussed and encouraged. Usually, once an individual has developed a good level of rapport and trust with staff and has witnessed the positive outcomes associated with harm reduction

management plan participation, service users who have previously declined involvement often agree to take part.

- **Service User Mortality**

An unfortunate part of working with individuals with acute needs, long term homelessness and chronic addictions is that sometimes they become extremely ill and pass away as result of their alcohol and/ or drug use. More often than not, a large proportion of individuals who avail of the support facilities provided by Depaul Ireland are already quite unwell when they first make contact with the service. In 2012 a total of 19 service users died as a result of their acute addiction, three deaths were drug related and 16 deaths were alcohol related.

5. "Roots of Empathy programme – developing empathy in the classroom and beyond"

Presenters: Susana Nunez, Project Leader & Catherine Sheridan, Project Worker and Mentor, Roots of Empathy Programme, Barnardos
Chairperson: Gerry McNally
Rapporteur: Louise Rooney

The Roots of Empathy programme is a universally applied evidence-based classroom programme developed in Canada in 1996 by Mary Gordon. The primary aims of this programme are: to promote the development of empathy and emotional literacy; reduce bullying, aggression, and violence; develop and encourage pro-social behaviour; and increase knowledge of human development, learning and infant safety. Barnardos has been running the Roots of Empathy programme for three years, at present 56 programmes are being implemented in primary schools across the Republic of Ireland. Over the next two years Barnardos aim to train a further 80 instructors in order to expand programme delivery.

Why Teach Empathy?

Empathy may be defined as:
'*The capacity to know emotionally what another is experiencing within the frame of reference of that other person, the capacity to sample the feelings of another or to put oneself in another's shoes*'[1]

The Roots of Empathy programme advocates that empathy is an important component of social and emotional competency which is key to developing successful relationships and conflict resolution. Following participation in the Roots of Empathy programme, studies have shown that school childrens' emotional competence and level of empathy have increased whilst levels of aggression have significantly reduced. The Roots of Empathy programme is preventative in nature; advocates for the programme assert that the development of empathy in this generation of children will have a positive effect on society in the future.

Programme Implementation

A trained Roots of Empathy instructor, a neighbourhood parent(s), and their infant visit a primary school classroom over the course of the academic year. In total the infant and parent(s) will visit the classroom once a month (9 times). The Roots of Empathy Programme is comprised of nine separate themes:

[1] Berger, D.M. (1987), Clinical Empathy, Northvale: Jason Aronson Inc.

1. Meeting Baby
2. Crying
3. Caring and Planning
4. Emotions
5. Sleep
6. Safety
7. Communicating
8. Who am I?
9. Baby Celebration

As each of the nine themes are addressed the children are encouraged to observe and label the infant's emotions, identify and reflect on their own emotions, learn to understand the emotions of others, and learn to become comfortable with discussing their emotionality.

Each Roots of Empathy theme consists of a pre-family visit, a family visit, and a post-family visit.

Pre-Family Visit: A Roots of Empathy instructor visits the classroom alone to prepare the children for the family visit. The instructor talks the children through the activities they will be participating in and addresses the children's expectations for the upcoming family visit.

Family Visit: The parent(s), their infant, and the instructor visit the classroom together. During this time the children gain experiential learning through observation and interaction with the visiting family. They are encouraged to recognise the infant's inherent vulnerabilities and the importance of pro-social behaviours such as sharing and caring.

Post-Family Visit: This visit is conducted by the Roots of Empathy instructor. Children are encouraged to reflect on the family visit, practice problem solving skills, and identify emotions.

Currently, four different Roots of Empathy manuals have been developed. Each of these manuals has been specifically designed for four different age groups according to developmental ability. Namely, Kindergarten (Jr Infants), Primary (1st – 2nd class), Junior (3rd – 5th class), and Senior (6th class).

Why a Baby?

The Roots of Empathy programme advocates that the presence of a baby naturally brings out the kindest instincts in people. The baby not only acts as an emotional mirror, but encourages the development of empathetic thinking and behaviour which children are then taught to generalise and apply in their day to day lives.

Research Evidence

International research carried out in Australia, Canada, the Isle of Man, and New Zealand demonstrates that when compared to control groups, children who have completed the Roots of Empathy programme show increased levels of social and emotional knowledge, increased pro-social behaviour with peers, and decreased levels of aggression during peer interactions. Findings from a longitudinal follow-up study also reveal that increased pro-social behaviours and decreased levels of aggression were maintained in child participants of the Roots of Empathy programme after a three year time period.

Barnardos

Barnardos is dedicated to increasing the emotional well-being of children and improving their learning and development. Barnardos advocate that the classroom is a window on the future, a primary learning environment where

children learn to care for one another, their world, and their future. Building good citizens in the classroom today with the help of useful tools such as the Roots of Empathy programme will lead to a civil society tomorrow.

Discussion
The following themes arose during the workshop discussion:

- **Programme Delivery**

The Roots of Empathy Programme is currently delivered in every province in Canada. It has also been mainstreamed nationwide across primary schools in Scotland. Barnardos emphasise that this programme is not just for children from disadvantaged areas but a beneficial learning experience for all children. As a result Barnardos are working hard to follow Scotland's lead and aim to have the Roots of Empathy programme mainstreamed in the Republic of Ireland.

- **Infant Safety**

The baby's safety is paramount. Risk assessments are carried out by the Roots of Empathy instructor prior to any visit that includes the baby. Additionally, health and safety issues are continually assessed throughout the implementation of the programme to insure that the baby is safe at all times. All participating children are given a distinct set of rules with regards to family visits. Depending on the wishes of the infant's parent(s) these rules can range from whether or not the children are allowed to touch the baby's hands and/or feet, to having no physical contact at all.

- **Programme Delivery to Adolescents & Special Needs Groups**

At present a Roots of Empathy programme equivalent has not been developed for adolescent groups or children with intellectual disabilities. However, as more and more children with minor intellectual disabilities are attending mainstream schools due to the availability of specialised classroom supports, the Roots of Empathy instructors encounter this minority group on a daily basis. The general feeling amongst instructors is that children with minor intellectual disabilities benefit immensely from the programme, specifically in relation to peer interaction and integration.

6. "Valuing young people in our community"

Presenter: Sean Kinahan, CEO, Le Chéile Mentoring and Youth Justice Support Services
Chair: Jim Mitchell
Rapporteur: Tara O'Donoghue

Sean Kinahan is the CEO of Le Chéile Mentoring and Youth Justice Support Services. He joined the organisation in 2007 and is now a key member with roots in many areas of this service. He is actively involved in developing the Strengthening Families Programme and the Restorative Justice project in Limerick and is today focusing his discussion on the importance of recruitment and selection of volunteers as mentors for young persons within the criminal justice system.

Overview of the organisation
Le Chéile was established in 2005 in order to provide a mentoring service to young persons who have come to the attention of the Probation Service, in order to affect positive change in their lives and their families. Their role is to complement, rather than replace, the role of the Young

Person's Probation in reducing offending behaviour. Le Chéile is the Irish translation for 'together' because the organisation believes that people achieve more when they work together. This is carried out by utilisation of volunteers from the community to work with young offenders and their families, through a strict regime of recruitment, selection and training of the mentor. The planning, supervision and support towards these mentors enables them to provide top quality services to young persons in an effort to recognise their full potential.

Role of a mentor

Mentoring is designed to influence social behaviours, such as positive lifestyle choices, personal development, education and communication in order to eliminate offending behaviour. The role of a mentor towards a young person is to actively listen and explore life with them and to take a shared interest in their lives which will result in the creation of a valued climate of trust. Young persons are matched with a mentor for 12-18 months, who then meet weekly for two to three hours a week. They are expected to be a role model for pro-social behaviour and the initial goal is relationship building with the young person.

Benefits of training volunteers as mentors

The Taskforce on Active Citizenship defines volunteering as 'the commitment of time and energy, for the benefit of society, local communities, and individuals outside the immediate family, the environment or other causes'.[1] Volunteers have the ability to relate to and value the young person through their journey within the criminal justice system by spending prolonged time with them on a one to one continuous basis. The fact that they are volunteers and not 'part of the system' is very important to the young person in relationship building. Often, they are matched with young persons who have similar life circumstances, so as to offer further support and connect on a deeper level. A key finding of the '*My World Study'* is the presence of 'One Good Adult' which Le Chéile firmly believes directly impacts a young person's confidence, coping skills and social behaviour.[2] Often, young persons do not have a stable presence in their lives and it is this lack of support in their lives that Le Chéile is designed to provide.

Recruitment and Selection

Recruitment is an intensive process, typically taking up to three months, commencing with individual interviews and training courses. Garda vetting and careful analysis of how a potential volunteer interacts with others allows assessment of the suitability of the person to the organisation, and crucially, the potential for matching this person to a young person in need of mentoring. In relation to time periods, the organisation requests that a minimum of 18 months commitment is given for mentoring as if a mentor breaks contact with a young person, this often has a massive impact which is difficult to restore. Throughout a volunteer's mentoring experience, they are continually rewarded for their contribution through newsletters, thank you cards and volunteer recognition events as well as consultation, participation and communication with the organisation. With regard to previous convictions of a volunteer, this would not impact on suitability for mentoring unless

[1] Source: Volunteer Ireland

[2] Source: www.headstrong.ie

the conviction was that of one which involves harm to a child.

Impact of Le Chéile

The specific impact of the organisation is difficult to monitor, as was previously stated, it is the probation officer that has the case file and so progress is difficult to analyse. However, they utilise a Youth Mentoring Outcome tool which measures a young person's personal and social development. This is based on the Wheel of Change as well as a Rickter scale. Independent evaluation and quality standard marks are assessed as well as general feedback on an ongoing basis. In turn, volunteers themselves are assessed and measured in their work with a young person in order to ensure consistency and progress within the organisation. Benefits of the programme, although not reported and analysed, are seen on a personal level and through direct involvement with the volunteer. The young person becomes more focused, shows improved time keeping skills and seeks support from the volunteer instead of confrontation.

Case study

Le Chéile took on the role of obtaining a mentor for a 16 year old girl, who was experiencing a difficult time in her life and who was abusive towards her mother. The daughter was matched with a mentor who has similar life experiences and when it looked like she was going to reoffend, her mentor was there to reinforce a stable presence in her life. Her mother was also matched with a mentor whose son had an addiction to narcotics. She now describes her daughter as being 'a different person' and is able to positively reinforce and approve of her daughter's new social behaviours through coping strategies which her own mentor had provided her with.

Case study 2

A second case study is of a young man who committed a serious offence whilst intoxicated. This young person could not cope with the enormity of the crime which he had committed and became suicidal and unable to engage with his peers. His mother did not have the necessary coping strategies to assist her son as she had recently lost her own mother. She engaged in the Parenting Programme offered by Le Chéile and her son went into the care of the Probation Service, where football and swimming activities were enrolled in as a method of restoring normality and highlighting the need for social norms.

Conclusion

Le Chéile is continually growing and developing in order to fully embrace the positive impact which mentoring has on a young person and their family, during their journey throughout probation. Community referrals and preventative measures arise from time to time as well but there are insufficient numbers from each culture to recognise a deep need for initiating such a programme. However, within the Roma and Eastern European communities, there are often referrals and so mentoring would be tailored to specific cases. Based on feedback and the growth of the organisation, Le Chéile is confident that they are contributing successfully to the growth of the young persons, and therefore society as a whole.

7. "Creativity, inclusiveness and boundaries – the three pillars of family support"

Presenter: Larry de Cléir, Bedford Row Family Project
Chairperson: Dr Yvonne Daly
Rapporteur: Sean Byrne

Bedford Row Family Project was set up in 1999 to respond to the specific needs of families of prisoners. It is based in Limerick and now supports families of prisoners, prisoners and ex-prisoners in many different ways. A significant focus of the Project's work is on mothers and grandmothers of prisoners as they are often the ones who bear the greatest burden of dealing with the worries and anxieties brought about by imprisonment.

In 2009 Bedford Row began more formal work with children of prisoners, as 2008 Research (*Voices of Families Affected by Imprisonment,* see www.bedfordrow.ie) showed that the needs of many such children were not being met by any other agency.

Bedford Row has found that because some members of the Board, some staff and indeed volunteers are ex-prisoners and/or families of prisoners, the Project is well equipped to deal with the problems prisoners and their families face. Bedford Row believes that some programmes /organisations are not necessarily interchangeable or applicable to every situation as they work best when they are set up for a specific area or group. Some ideologies and practices that may work for Bedford Row may not work for others.

Prior to the Workshop proper, Larry spoke about a very sad news item that he had seen the previous night about a woman in Birmingham who had tragically killed her child. On the programme a city council official had suggested that children's needs were not being met because the city was 'down on social work staff'. The point was put to the workshop as to whether having 'more social workers' would necessarily have prevented this tragedy. While society cannot prevent every tragedy, major protective factors in communities are the eyes and ears of extended family members who can alert trusted others to 'at risk' situations before they become crises. The need for fostering trusting relationships with healthy boundaries, so that this can occur, was stressed. Boundaries are very important in the work of Bedford Row, from the very important 'eyes and ears' work in communities that enable concerned people to protect other vulnerable people including children, to encouraging people to say no to prisoners who make unreasonable demands (e.g. money, expensive clothes) that they cannot afford, and, on the other hand, to help prisoners to be mindful of families' situations.

Aim of the Workshop
The aim of this workshop was to look at how family support applies at a personal level and to offer a general introduction to the Three Pillars of Family Support; inclusiveness, boundedness and creativity, that is taught on the two-year Bedford Row Family Support and Crisis Intervention Course.

While ***inclusiveness*** is generally a good thing, it involves a risk of falling into the trap of not wanting to disappoint anyone and to include everyone. ***Boundaries*** are important for the families of prisoners and they often need guidance on creating boundaries of time or on resources where

they are needed. ***Creativity*** is the third pillar of family support and it involves dealing with different problems and situations with an open mind and recognising ways to avoid such problems/situations in the future.

Archetypal Background

Two archetypal references were mentioned which are widely recognised by society and influenced the process of thinking about, and the evolution of, the 'Three Pillars'.

The first reference is to the three basic elements Earth, Fire and Water. Earth can be considered as the ground, which is the ultimate boundary. Water, in which many things may dissolve, can be seen as being inclusive and fire has the ability to make, shape and change things and therefore incorporates the factor of creativity.

For those brought up in the Christian tradition, another reference might be the Blessed Trinity. From this viewpoint, God the Father is the boundary, as he is generally seen as a God of authority or even punishment. God as the son, Jesus Christ incorporates the factor of inclusiveness, as he was so inclusive, he died so that we all could be saved. The Holy Spirit is seen as a creative force, a mysterious factor that can give people the inspiration to do good in their lives.

Application of the Three Factors

Bedford Row aims to maintain a balance between inclusiveness, boundedness and creativity. An example of this was given in dealing with a drug addict who visited the Project. Instead of completely excluding him, (as staff were suspicious that he had used bathroom facilities at the Project's premises to 'shoot up'), the person was asked to meet with a staff member outside instead, to avoid repetition of the situation. This was the *boundary* and also reflected the pillar of *creativity* in dealing with the issue, and *inclusiveness*, in not excluding him.

When working with a group of 'at risk' young mothers, there was an initial burst of enthusiasm within the group. However after a short space of time the group began to disband. Instead of giving up, Bedford Row had to become *creative*, and decided to hold meetings in the homes of the young women. It still offered the healthy *boundary* of the group for them, but allowed a more comfortable and easily accessible environment so that they felt *included*.

The Three Pillars in the Self

There is great importance placed on teamwork in Bedford Row. A team is made up of individuals and everyone needs to work together towards a common goal for a team to be successful. Larry noted that Bedford Row aims to nurture creativity in relationships within their team so that conflict can be resolved in a satisfactory manner that is inclusive of all parties' points of view, while still maintaining the boundary of respect for each other.

If there are good relations in a team, and a good understanding of the common goal of the group, this will reflect the same back to the public and to the families that the Project works with.

Developmental Perspective

From birth we learn very quickly how to recognise boundaries and behavioural attributes of adults that are responsible for our care. Healthy attachment in infancy is a prelude to satisfactory inclusion, schools initially need to have a

lot of creative pursuits so that children have a feeling of inclusion and a sense of belonging. As school progresses to Leaving Certificate more and more boundaries can be introduced (e.g. formal timetable, curricula, exams etc.) because the important work of inclusion has been completed in early years. Creativity, inclusion and boundaries are all qualities that are present in a reasonably healthy adult's relationships, and he/she will be able to strike a balance between each of the three elements.

The Bedford Row Course aims to teach students how to be creative in including families that might be very accustomed to being excluded from all services, while still maintaining healthy boundaries. This in turn models this process to families and prisoners in doing the same with their children.

This, for example, might apply to adults leaving prison and passing the skills on to their own children, i.e. giving ex-prisoners the ability to help a child and their development, while knowing that each child may be different. Or there may be the development of self, allowing family members to deal with situations in family units; dealing with grandchildren or dealing with the family member in prison.

The Workshops concluded with a short exercise in boundaries which the group did in pairs.

Conclusion
This workshop generated a lot of discussion and reflection on the individual's own view of the world. The participants were also very impressed by the work of Bedford Row and eager to know if similar projects exist in other parts of the country (Bedford Row being based in Limerick and working with the families of prisoners in Limerick Prison).

Larry de Cléir noted that the local nature of the project is to a large extent responsible for its success and it might not be particularly effective to just 'lift' the Bedford Row model and place it down in another part of the country, with another cohort of prisoners and their families.

Nonetheless, there seemed support among the workshop participants for this kind of project to exist throughout the country. One participant remarked that the absence of the word 'prisoner' from the name of the Project is a strength and Larry noted that this is something that he had not thought about before!

8. "What's love got to do with it?"

Presenter: Graham Jones, Managing Partner, Solas Project
Chairperson: Finbarr O'Leary
Rapporteur: Kelly Lynch

Solas Project (Education & Sport), a registered charity since 2007, is a community development organisation in South Inner-City Dublin. It began as an after-school initiative and has now grown to include the Prison and Probation Programme. The organisation has been under on-going development over the past couple of years.

As a typical example to illustrate the work of the organisation, a story centring on a young man who was abandoned as a child, who never knew his father and who dropped out of school was shared. Aged 18 he was released from prison and was homeless. This is by no means uncommon – 1 in 4 prisoners end up in similar

situations. The young man was invited to dinner with Graham Jones and his family and became upset, when asked the reason for this, he replied that up until that point in his life he didn't feel as though anybody loved him. The Project recognises that this is a common occurrence for prisoners and this lack of confidence in, or hope for, the future results in a serious lack of stability. Central Statics Office figures show that 70% of prisoners between 17 and 25 re-offend within three years of release.

The Prison and Probation Programme

The Solas Project Prison and Probation programme has two distinct parts. The first begins in prison and the second is within the community upon the prisoner's release. The reason that the programme begins whilst the prisoner is still incarcerated is in order to develop relationships based on trust that can be leveraged within the community. A major reason for re-offending is the need for pre-release support in conjunction with post-release support. The programme is based on trust and is delivered through intense mentoring. The mentoring is the main support offered by Solas Project for participants in the community.

Phases One and Two

The programme consists of five specific phases, the first two of these take place within the prison. Phase one consists of building up a relationship of trust with the prisoner. This can be difficult as young adults in particular appear to struggle in building meaningful relationships with professionals. The second phase occurs when the prisoner is preparing for release. During the course of these two phases, the prisoner is given the title of "potential student".

Phases Three, Four and Five

The second half of the programme – phases three, four and five, are conducted upon the prisoner's release from prison. At this point they become a 'student' of the program. Phase three centres around 'hand-holding' on release, phase four progresses to continuous interaction with the student as they settle back into the community, and phase five is the student's graduation from the program.

Strategic Objectives for 2013-2016

In relation to the programme itself, Solas Project wants to share their story and experiences so that people can get an understanding of who they are and what they do. By measuring and communicating with communities, they are hoping to build trust and support in their work. Regarding partnerships, Solas Project wishes to communicate with other organisations involved in the process and work towards an increased support structure and awareness of issues. They also endeavour to build a good working relationship with the public sector and the wider community. Finally, looking at the issue of people, Solas Project is working to ensure that the best people for the job are in the organisation, where there is optimal resource and organisational capacity. By 2016, the Solas Project Prison and Probation Programme hopes to achieve the following objectives:

- have 40 students graduate from the programme and identify 230 target students
- have 50 students at the pre-release planning stage and have 50 students within the community
- have a fully operational social enterprise system and have 'peace builders' fully integrated into the programme

- have four mentors working with the programme while recruiting 60 volunteers
- develop a high degree of awareness and acquire a diverse mix of funding

The more talks that are given on the topic, the more Solas Project has come to engage with it and understand the needs of the prisoners for support, care, advice on how to deal with challenges, how to discipline themselves and how to resolve conflict effectively. Solas Project believes that the young individuals involved in the programme need to be shown love in order for them to grow and progress within the community.

Discussion points

- Solas Project was recently revised internally with a vision to rejuvenate communities by promoting education, supporting sport and by helping individuals make better choices. The management of the student's transition back into the community focuses on resettlement and relies on the relationship of trust that was created whilst the person was still in prison.
- It is suggested that the most drop-outs occur around Week 5 when either the student *believes* they are up and running and doing okay and they actually are not, or because the student is so disillusioned with being out of prison that they can no longer cope. Solas Project has mentors dedicated to post-release support to try and tackle this issue.
- Since the start, four students have actively engaged in the programme, one has returned to prison on a longer sentence and one student has left the project. The expectation is that students will be in the programme for 12 months. With regards to the target group, the programme is focused only on Dublin for the next three years.
- Students react badly when they feel that people are "only there because they are being paid". When they realise that the Solas Project volunteers are there because they want to be, this makes building a relationship with them easier. Solas Project recognises the Probation Service and are trying to compliment the services that are already in place. The Prison and Probation Programme also takes formal and informal referrals from the Probation Service.
- Time spent with students depends on how long they have been out of prison for and can range from eight hours (immediately after the student is released) to four hours by phone or in person. Solas Project engages in particular with wives and girlfriends of the students as they recognise the influence certain members of the family will have on them.
- Activities in prison can include tag rugby and music production. In phase two, Solas Project will look at creating a care plan with the student which will be actioned following their release. Representatives will spend time with the student, their partners and their families, engaging in different activities from having a coffee to attending a football match or watching a movie.

CONFERENCE ATTENDEES

NAME	ORGANISATION
Sergeant Aidan Curtin	Garda Victim Liaison Office
Professor Alva O'Herlihy	Office of the DPP
Councillor Andrew Montague	Dublin City Council
Andy Brennan	Irish Prison Service
Anne Timoney	Oireachtas Eireann
Professor Anthea Hucklesby	University of Leeds
Bernadette Kavanagh	Carlow I T
Brendan O'Connell	Midlands Prison
Brian Murphy	Irish Prison Service
Brian Hanley	Irish Council for Prisoners Overseas
Brian Hogan	Don Bosco Services
Catherine Adejuyigbe	DePaul Ireland
Catherine Sheridan	Barnardos
Christine Littlefield	Depaul Ireland
Clare Cresswell	UCD
Claire Casey	Tallaght West Childhood Development Initiative
Sergeant David McInerney	An Garda Siochana Racial and Intercultural Office
Doncha O'Sullivan	Department of Justice & Equality
Governor Edward Whelan	Irish Prison Service
Eithne Ní Mhurchadha	
Emily Sheary	Nenagh Community Reparation Project
Eoin Carroll	Jesuit Centre for Faith and Justice
Eugene Corcoran	An Garda Siochana
The Honourable Mr. Justice Eugene O'Kelly	
Finbarr O'Leary	Revenue Commissioners
Frances Nangle-Connor	Irish Prison Service
Frank Durojaye	Depaul Ireland
George B. Trimble	Department of Justice & Equality
Gerry McNally	The Probation Service
Graham Jones	Solas Project
Isolde Doyle	Office of the DPP
JJ Grace	Carlow Regional Youth Services
Jacinta DePaor	Next Phases
Jim Mitchell	Irish Prison Service
Joanne Gleeson	Office of the DPP
John Corr	PACE
Professor and Senator John Crown	
John Dolan	Galway Simon Community
June Tinsley	Barnardos
Katayoun Bahramian	Pavee Point Traveller and Roma Centre
Kelly Lynch	DCU
Ken Sauvage	Treo Portlairge Ltd
Kerry Anthony	DePaul Ireland

Kieran O'Dwyer	
Lakshmy Gunawardhana	
Larry DeCléir	Bedford Row Family Project
Liam Herrick	Irish Penal Reform Trust
Lisa Buckley	Citywide Drug Crisis Campaign
Louise Rooney	UCD
Maria McDonald BL	
Maria Portundo	NUI Galway
Marie Kennedy	Le Chéile Mentoring Project
Maura Butler	Law Society of Ireland
Nadette Foley	Facing Forward
Niamh Joyce	
Nora Owen	TV3
Patricia Flynn	ACJRD Council
Patrick Field	NUI Maynooth
Fr Paul Murphy	Capuchin Friary
Pyers Walsh	
Samantha Kennedy	PACE
Sandra Cox	Galway Simon Community
Seamus Sisk	Irish Prison Service
Sean Kinahan	Le Chéile Mentoring Project
Sean Byrne	DCU
ShirleyCummins	Dublin Rape Crisis Centre
Siobhan Kavanagh	The Probation Service
Susana Nunez	Barnardos
Tara O'Donoghue	UCC
Teresa McCormack	Midlands Prison
Tony Geoghegan	Merchants Quay Ireland
Vincent Lavery	DID Eire
Vivian Geiran	The Probation Service
Dr Yvonne Daly	DCU


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