Ireland: national report for 2015 - Prevention

Health Research Board. Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction

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Health Research Board

European Monitoring Centre for Drugs and Drug Addiction

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0. Summary

Drug prevention is one of five pillars in the current National Drugs Strategy (NDS). The stated objectives of the Prevention pillar are to:

- develop a greater understanding of the dangers of problem drug/alcohol use among the general population,
- promote healthier lifestyle choices among society generally, and
- prioritise prevention interventions on those in communities who are at particular risk of problem drug/alcohol use.

There are 13 specific actions under the prevention pillar in the NDS through which interventions are delivered in schools and non-school settings. Interventions in primary and post-primary schools are delivered through the Social, Personal and Health Education (SPHE) programme and the aim is to help students understand the social influences that impact on decision-making, and help them to develop life skills to improve their self-esteem, develop resilience and build meaningful and trusting relationships. Interventions in non-school settings that target young people include information and awareness and diversionary initiatives including youth work, youth cafés and supports for those at risk of early school leaving. Families are targeted through a range of initiatives including the Strengthening Families Programme. The drugs.ie website contains information on the risks and consequences of misusing alcohol and drugs and information on services and support mechanisms; such information targets the general population. Environmental prevention strategies include alcohol and tobacco control policies and legislation.

Policy and practice in drug prevention have changed little over the last ten years; the key objectives of policy are to develop awareness of and resistance to the dangers and consequences of misusing substances. Interventions have remained focused on delivering information, developing knowledge and awareness and providing life skills to booster resilience. Diversionary programmes have sought to promote healthy choices and behaviour through sport and recreation and support those at risk of early school leaving. There have been sporadic attempts to deliver psycho-social interventions to young people but these are poorly documented.

There have been little in the way of new developments around policy and practice in drug prevention. The most notable recent development has been the approval to use harm reduction approaches in post-primary schools as part of the SPHE programme.

1. National profile

1.1 Policy and organization

1.1.1 Main prevention-related objectives of national drug strategy

Drug prevention is one of five pillars in the National Drugs Strategy (Department of Community 2009). The stated objectives of the prevention pillar are to:

- develop a greater understanding of the dangers of problem drug/alcohol use among the general population,
- promote healthier lifestyle choices among society generally, and
- prioritise prevention interventions on those in communities who are at particular risk of problem drug/alcohol use.

The strategy identifies three levels on which prevention measures can be delivered: universal, selective and targeted. However, the vast majority of measures are delivered at the universal and selective levels, targeting young people and their families.

For further information see Sections 1.1.1 and 1.2.2 in *national report for 2015 -* policy.

1.1.2 Organisational structure responsible for the development and implementation of prevention interventions

The lead agencies for developing and delivering prevention-related actions under the NDS are the Department of Health, with support from the Health Service Executive (HSE), Department of Education and Skills (DES), Department of Children and Youth Affairs (DCYA), An Garda Síochána, drugs task forces and service providers. The last category includes non-governmental organisations (NGOs).

1.1.3 Funding system underlying prevention interventions

The bulk of funding is provided by the statutory sector with some small assistance from philanthropists.

1.2 Prevention interventions

1.2.1 Environmental prevention interventions and policies

Alcohol policy development

In October 2013 the government approved a number of measures to be included in a Public Health (Alcohol) Bill including health labelling of alcohol products, regulation of marketing and advertising of alcohol products, minimum unit pricing for the retailing of alcohol products and enforcement powers for Environmental Health Officers. This is the first time that alcohol misuse will have been addressed as a public health issue by an Irish government. The bill was published early in 2015.

Alcohol price and taxation

Tax on alcohol, which includes excise duty and value-added tax (VAT), remains high. Tax on a bottle of wine costing €10 is estimated at €5.58, on 20 cigarettes costing €10 at €8.12, and on a standard pint of beer costing € 5 at €1.79. (Data retrieved on 5 August 2015 at http://www.publicpolicy.ie/budget2015.)

Blood alcohol concentration allowed for drivers

The blood alcohol concentration (BAC) limit is 50 mg for all drivers, and 20 mg for specified drivers, defined as learner or newly qualified drivers (for a period of two years after passing their driving test) or professional drivers (of buses, goods vehicles and public service vehicles).

Age limits for purchasing (or consuming) alcohol

Anyone aged under 18 cannot legally buy alcohol. It is an offence to pretend to be over 18 in order to buy or consume alcohol. If found guilty of these offences, the individual is liable to a class E fine on summary conviction in a District Court. Children (anyone under the age of 18) are only allowed in licensed premises between the hours of 10.30 am and 9.00 pm and if they are with a parent or guardian. Children aged between 15 and 17 years may remain on the premises after 9.00 pm when attending a private function. All licensed premises must display a sign to this effect and failure to do so can result in a fine. If the licence holder is found guilty of allowing unsupervised children in his or her premises, a fine can be imposed on summary conviction in a District Court.

Distribution of alcohol

Under the Intoxicating Liquor Act 2008, it is an offence to sell alcohol to anyone under the age of 18. Anyone found guilty of doing so is liable on summary conviction in a District Court to a class B fine of €3,000 for a first offence and a class A fine of €5,000 for a second and any subsequent offence.

It is an offence to buy alcohol for anyone under the age of 18. It is also an offence to give alcohol to anyone under the age of 18 unless in a domestic home and they have parental consent. If found guilty of any of these offences, a person is liable on summary conviction in a District Court to a class B fine of €3,000 for a first offence and a class A fine of €5,000 for a second or any subsequent offence.

Public policy with regard to alcohol-related nuisance

While there is no national legislation prohibiting drinking in public, each local authority is entitled to pass bye-laws prohibiting the consumption of alcohol in a public place within its area. Under the Intoxicating Liquor Act 2008, the Gardaí have the power to seize alcohol in the possession of anyone under 18 years of age where they have reasonable cause to believe that the alcohol will be consumed by someone aged under 18 years in a public place.

Tobacco control measures

National policy on tobacco control is guided by the 2013 report *Tobacco-free Ireland* (Tobacco Policy Review Group 2013). The policy sets a target of a tobacco-free Ireland by 2025, in other words a prevalence rate of smokers of less than 5%.There are two key themes in the report: protecting children and the de-normalisation of smoking. The current prevalence estimate suggests that in 2014, 19.5% of the population reported to smoke one or more cigarettes each week. This report shows a steady decline from 28.2% of the population who reported smoking one or more cigarettes each week in 2003 (Hickey P and Evans DS 2014)

Smoke-free work and other public places

Enclosed workplaces became smoke-free by law in Ireland on 29 March 2004 under provisions in the Public Health (Tobacco) Acts 2002 and 2004. Two sections in the legislation provide for the banning of smoking in the workplace. Section 46 of the Public Health (Tobacco) Act 2002, as amended by Section 16 of the Public Health (Tobacco) (Amendment) Act 2004, requires No Smoking signs to be displayed in the workplace. Section 47 of the Public Health (Tobacco) Act 2002, as amended by Section 16 of the Public Health (Tobacco) (Amendment) Act 2004, prohibits smoking in the workplace. In effect, this means that it is illegal for persons to smoke cigarettes in offices, shops, factories, bars, restaurants and other enclosed work places. The primary aim of this legislation is to protect workers and members of the public from exposure to second-hand environmental tobacco smoke (ETS). As part of the National Tobacco Control Framework, the Health Service Executive (HSE) has committed to making all its workplaces and campuses smoke-free by 2015.

In December 2014, the Protection of Children's Health (Tobacco Smoke in Mechanically Propelled Vehicles) Act was enacted. The legislation amends 47(1) of the Public Health (Tobacco) Act 2002 by extending the ban on smoking in workplaces to motor vehicles in which a person under the age of 18 is present, making the driver of the vehicle responsible. The aim of the legislation is to protect children and denormalise smoking.

Age limits for purchasing (or consuming) tobacco products

Since August 2001, it has been illegal to sell tobacco products to anyone aged under 18 years. In May 2007 it became illegal to sell cigarettes in packs of less than 20, or confectioneries resembling tobacco products. By increasing the minimum number of units which may be bought, the price barrier was raised for children at the experimental stage.

Advertising and promotion of tobacco

On 1 July 2009 new legislation came into effect prohibiting all point of sale advertising in retail outlets and requiring the storage of tobacco products out of sight of the customer. Section 33A of the Public Health (Tobacco) Acts 2002 and 2004 prohibits all advertising of tobacco products in retail premises where tobacco products are sold.

In June 2014 the Government approved the publication of the Public Health (Standardised Packaging of Tobacco) Bill to outlaw all forms of branding from tobacco products except for the brand and a variant name to be presented in a uniform typeface for all tobacco products. All products will have to use a plain neutral colour, except for the mandatory health warnings which are to be included on all products packaging. The aim is to make tobacco packaging less attractive and make health warning more prominent.

Delinquency and crime prevention strategies

See Section 2.2 in *national report for 2015* - legal framework.

1.2.2 Universal prevention interventions

Social, Personal and Health Education (SPHE)
The SPHE programme is the main vehicle through which substance use prevention is delivered in both primary and post-primary schools. The SPHE programme is a mandatory part of the primary school and post-primary (junior cycle) curriculum and supports the personal and social development, health and well-being of students through ten modules including a module on substance use. The themes and content of modules are built around helping students to understand the nature of social influences that impact on their development and decision-making, and helping them to develop adequate life-skills to improve their self-esteem, develop resilience and build meaningful and trusting relationships.

Implementing SPHE in post-primary schools
Recent information about the implementation of SPHE is post-primary schools suggests that the vast majority of schools are complying with the curriculum requirement to timetable SPHE for at least one period per week (Department of Education and Skills 2013a). The deployment of staff to deliver SPHE was considered 'good' or 'very good' in over 80% of schools visited during a recent official inspection. Schools are encouraged to promote a whole-school approach to the provision of SPHE, i.e. personal and social development of students is supported through an integrated and structured set of initiatives such as anti-bullying and positive mental health interventions. The inspectors reported that in 90% of the schools visited the quality of the whole-school approach was 'good' or 'very good'. (Department of Education and Skills 2013a)

Implementing SPHE in primary schools
The overall quality of teaching, and learning through, SPHE in primary schools was found to be 'good' or 'very good' according to a recent official inspection report (Department of Education and Skills 2013b). The majority of parents surveyed (96%) agreed that the school helped their child's social and personal development, although a sizeable proportion (24%) did not know how the school dealt with bullying. (Department of Education and Skills 2013b)

Additional components to SPHE in post-primary schools
The working group set up to examine how education on substance use is provided in post-primary schools in the context of SPHE recommended that educational measures to promote harm reduction could be included in the SPHE programme in post-primary schools (Working Group on educational materials for use in SPHE in post-primary schools and centres for education 2014).

Substance use policies in schools
Over 80% of primary schools and over 90% of post-primary schools report having a substance use policy in place (Department of Education and Skills 2014).

Universal prevention interventions in families
An eclectic mix of measures are provided to support families under the NDS, including individual counselling, family therapy and, in some regions, the Strengthening Families programme (SFP) and the Community Reinforcement Approach (CRA). There are an estimated 80 accredited CRA practitioners in Ireland (Keane 2012).

The SFP has been implemented in Ballymun in Dublin for the last seven years, and between 2008 and 2014, 116 families graduated, with some of these families repeating the programme. A recently-published evaluation of this work documented a seven-year follow-up study with graduates of the programme (Roe 2015). In total, respondents from 53 different families who graduated from the SFP participated in the evaluation, representing 45.6% of all families who graduated from the programme. Data were collected via in-depth interviews, focus groups and an on-line survey. The overwhelming majority of survey respondents (96%) reported the programme had made a difference in their lives; improved communication was the primary difference cited, followed by improved relationships; 97% of parents reported improvement in their parenting skills and 100% of teenagers agreed with this view; 88.6% reported reduced conflict in their family and all respondents reported a positive impact on the community.

Data from focus groups with facilitators corroborated the survey findings concerning improved relationships within families, improved parenting skills and improved communication skills, and benefits to the community including better communication and respect between young people and neighbours and increased engagement with education, training and other community projects among graduates from the SFP.

Data from focus groups with young people also corroborated these findings; the primary benefits accruing to young people included improved communication skills, the ability to deal with stress, conflict, criticism and anger better, more positive relationships with parents and guardians, doing better in school, learning more about alcohol and drug misuse and getting involved in activities in the community.

Universal prevention interventions in communities

A number of interventions in communities, particularly for children and young people, are delivered under a national policy framework for children (Department of Children and Youth Affairs 2014a). The framework sets out an ambitious plan to achieve five outcomes for children and young people up to the age of 24 by the year 2020:

1. To be active and healthy and have physical and mental wellbeing
2. To achieve full potential in all areas of learning and development
3. To feel safe and protected from harm
4. To have economic security and opportunity
5. To feel connected, respected and contributing to their world

Indicators measuring the prevalence of substance use among young people and closely related correlates of substance use will be used to assess progress towards achieving outcome 1, which relates to the health and wellbeing of children and young people.

Youth work interventions

The first comprehensive and rigorous economic assessment of youth work in Ireland includes useful information on the nature and extent of youth work activities in Ireland (Indecon International Economic Consultants 2012). The vast majority (80%) of youth work organisations provide recreational, arts and sports-related activities; over half provide activities focused on the welfare and well-being of young people, including measures that address substance misuse and early school-leaving; some provide activities to divert young people from crime and anti-social behaviours. An estimated 312,615 young people aged between 10 and 24 participated in youth work activities during 2011; this figure represented 43.3% of this age cohort nationally; 54% of participants were female and 53.3% were believed to be socially or economically disadvantaged.

Youth café interventions

Youth cafés have become an established community resource for young people in a number of geographical locations. Although the precise number of youth cafés in operation remains undocumented, it is estimated there are between 20 and 30 providing services to the youth population in general. The establishment and development of youth cafés have been underpinned by a best-practice guide (Forkan C*, et al.* 2010b) and an accompanying toolkit (Forkan C*, et al.* 2010a).

The key objectives of the youth café model are to provide formal and informal social support to young people in the community; to encourage and promote social attachment by providing young people with a secure base from which to explore talents, interact with peers and develop social skills; to assist young people to develop and maintain resilience; and to encourage and promote civic engagement between young people and the wider community (Forkan C 2010).

Interventions targeting youth mental health

Jigsaw is an early-intervention mental health service developed by Headstrong, the national centre for youth mental health. The service currently operates in 10 communities across Ireland and is staffed by multi-disciplinary teams of allied health professionals. The service targets young people aged 12–25 with mild and emerging mental health problems; young people presenting with more

serious mental health problems are referred to other services. It is estimated that more than 8,000 young people have received a service from Jigsaw.

Data have recently been published on the profile of young people presenting to Jigsaw, the services they receive and a before-and-after comparison on the severity of their mental health problems (O'Keeffe*, et al.* 2015). Data were collected from young people (n=2,420) who received support from Jigsaw between 1 January and 31 December 2013. Fifty-one per cent (n=1,237) received brief interventions comprising one to six sessions of goal-focused therapeutic support; 34.3% (n=829) received indirect support through services engaging with their parents and other professionals about their mental health needs; and 14% (n=354) had brief contact with the Jigsaw service but their mental health needs exceeded the scope of the services provided by Jigsaw. The majority (56.5%, n=1,367) presenting to Jigsaw in 2013 were female and the most frequent users were aged 15–17 years. Almost a third of the 1,608 young people (31.3%, n=504) who engaged directly with the service self-referred; this cohort included those receiving brief interventions and those who were brief contacts.

Young people presenting to the Jigsaw service reported a large number of mental health problems (see Table 1.2.2.1). Anxiety was the most common mental health problem.

Table 1.2.2.1: Most common presenting issues for males (n = 1,053) and females (n = 1,367), 2013

Presenting problem	Males n (%)	Females n (%)
Anxiety[a]	329 (31.2)	489 (35.8)
Anger[a]	277 (26.3)	232 (17.0)
Family problems	217 (20.6)	289 (21.1)
Isolation from others	204 (19.4)	285 (20.8)
Feelings of depression	191 (18.1)	282 (20.6)
Stress	176 (16.7)	246 (18.0)
Parent/youth conflict	170 (16.1)	226 (16.5)
Sleep changes	165 (15.7)	253 (18.5)
Feelings of sadness/loss[a]	129 (12.3)	233 (17.0)
Drug use[a]	128 (12.2)	40 (2.9)
Thoughts of hurting self[a]	118 (11.2)	228 (16.7)
Low self-esteem[a]	103 (9.8)	248 (18.1)

Source: (O'Keeffe*, et al.* 2015)
[a] Denotes a significant difference between males and females

Levels of psychological distress were assessed in young people via a brief intervention using the Clinical Outcome Routine Evaluation (CORE) questionnaires, either the CORE 10 or the YP-CORE. The CORE questionnaires are validated instruments and were used to assess symptoms of anxiety and depression, and associated aspects of social functioning. Questionnaires were completed by 709 young people at their first session and by 315 young people at their final session. The authors report that 89% presented to Jigsaw with clinical levels of psychological distress prior to intervention, and 52% reported moderate/severe or severe levels of distress. After engaging with Jigsaw, 47.2% had healthy, and 28.8% had low, levels of psychological distress.

The authors acknowledge the limitations of the study: '…self-reported levels of distress should be interpreted with caution as a multitude of other influences on young people's lives make it difficult to attribute any change directly to the use of a specific service…' (p. 76).

1.2.3 Selective prevention interventions

An evaluation of Ireland's first and only non-statutory youth restorative justice programme claims that its work is cost-effective and can save substantial sums of money by helping to reduce crime and keep young people from entering prison (Quigley*, et al.* 2015). Le Chéile's Restorative Justice Project is based in Limerick and provides a range of restorative justice services to young people who have been involved in crime and are engaged with the Probation Service. The project, established in 2010, works with young people on probation, using face-to-face meetings with the victims of their crimes, forums using proxy victims, victim empathy programmes, and measures to achieve reparation between victim and offender.

Young people consulted in the evaluation reported positive experiences of engagement with the programme, indicating the intervention was well received. Their reported experience was one of receiving respect and support from the staff as well as being challenged to confront their offending behaviour and its impact on their victims. Young people reported increased levels of empathy towards victims of crime and family members, improved relationships with their own families, reduced substance use, increased pro-social peer relationships and a reduction in their involvement in criminal behaviour.

The reported experience of the victims of crime and their representatives was that the programme was more inclusive, respectful and meaningful than the traditional criminal justice process. Parents of offenders reported a greater understanding of their children and also improvements in their parenting skills. They also reported lower levels of stress and anxiety and improved learning about the nature of substance addiction.

This was an observational study using a retrospective design; therefore, the outcomes reported can only be correlated with engagement with the programme as any attempt to imply causation would require using a more robust study design.

Prevention interventions targeting at-risk youth

The Department of Children and Youth Affairs (DCYA) published a review of three youth programmes targeting youth at risk: the Special Projects for Youth (SPY), the Young People's Facilities and Services Fund (YPFSF) and the Local Drugs Task Force (LDTF) projects (Department of Children and Youth Affairs 2014b). The three programmes under review target at-risk young people who are disadvantaged in different ways, with some experiencing multiple disadvantages. The programmes generally target 10–21-year-olds in areas characterised by problem drug use, educational disadvantage, criminal activity, unemployment and homelessness. The review notes that there are indications in the available national data that, overall, drug use, youth crime and youth homelessness have declined while unemployment and poverty rates among young people of working age have increased. The review points out that students attending DEIS schools, which are located in disadvantaged areas, continue to experience higher levels of non-attendance, suspensions and expulsions compared to students in non-DEIS schools and the gap is widening. Furthermore, the review notes that young people with lower levels of education are more likely to be unemployed. Based on these factors and the expected increase in the overall youth population, the review suggests that '…there remains a valid rationale for the provision of youth programmes for young people who are disadvantaged…' (p. 67).

Prevention interventions targeting educational disadvantage

The Delivering Equality of Opportunity in Schools (DEIS) programme aims to improve attendance, participation and retention in designated schools located in disadvantaged areas. The School Completion Programme (SCP) targets those most at risk of early school-leaving as well as those who are already outside of the formal system. This includes in-school, after-school and holiday-time supports. Recent data from the Department of Health (Department of Health 2015) (Department of Health 2015) suggests that in the 2014/2015 school year, there were 849 schools (circa 168,000 pupils) participating in the DEIS Programme (852 schools in 2013/14) (Department of Health 2015). Under DEIS, there are a range of supports provided to help address early school leaving (ESL) and the retention of students in schools. These include:

- a lower pupil teacher ratio (PTR) in DEIS Band 1 schools,
- allocation of administrative principal on lower enrolment,

• additional funding based on level of disadvantage,
• access to Home School Community Liaison Scheme and the SCP,
• access to the School Meals Programme, and
• access to literacy and numeracy supports.

1.2.4 Indicated prevention interventions

Child and Adolescent Mental Health Service (CAMHS) teams are the first line of specialist mental health services for children and young people. The service is provided by multi-disciplinary teams including psychiatrists, psychologists, nurses, social workers, speech and language therapists and occupational therapists. The most recent CAMHS annual report states that 66 such teams are currently in place (Health Service Executive 2014). The report shows that from October 2012 to September 2013 they recorded a 21% increase in referrals on the previous 12 months and an increase of 11% in new cases seen by the service. Drawing on data collected from 8,577 cases seen in the course of a month (November 2012), the report states that the ADHD/hyperkinetic category was the most frequently recorded primary presentation (31.6%), followed by the anxiety category (18.3%). Street drugs were involved in 12% of male and just 1% of female intentional drug overdose acts and substance abuse, referred to as drug and alcohol misuse, accounted for 0.5% (n=40) of primary presentations.

1.3 Quality assurance of prevention interventions

1.3.1 Overview of the main prevention quality assurance standards, guidelines and targets

Standards for volunteer-led youth work

According to a report published in 2012 (Indecon International Economic Consultants 2012), it is estimated that 40,145 individuals work in a voluntary capacity in the youth work sector in Ireland, and 1,397 full-time equivalents are employed in management, service delivery and training and support for volunteers.

In a move designed to support the large voluntary capacity within the youth sector, the Department of Children and Youth Affairs (DCYA) published a set of quality standards to support volunteer-led youth groups in creating and providing quality, developmental and educational programmes and activities for young people in safe and supportive environments (Department of Children and Youth Affairs 2013). The standards are designed to improve the quality of the programmes and activities provided, improve the way programmes and activities are planned and delivered, and provide young people with the opportunity to have a say in the development and review of the group and its activities. The standards are based on three core principles: young person-centred, safety and well-being of the young person, and focus on developmental and educational services for the young person.

Generic youth work standards

Standards in the overall youth work sector are underpinned by the National Quality Standards Framework (NQSF) for Youth Work (Office of the Minister for Children and Youth Affairs 2010). The framework provides for youth organisations and groups involved in working with young people in Ireland to be subject to external assessment. The NQSF applies to all staff-led youth work organisations, services, projects and programmes which are funded under DCYA schemes.

2. Trends

2.1 Main changes in prevention interventions in the last 10 years

Drug policy focusing on prevention has changed little over the past 10 years. The two objectives of the 2001–2008 National Drugs Strategy (Department of Tourism 2001) for the Prevention pillar were to:

- create greater societal awareness about the dangers and prevalence of drug misuse, and
- equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.

In the 2009–2016 National Drugs Strategy (Department of Community 2009), the Prevention objectives are to:

- develop a greater understanding of the dangers of problem drug/alcohol use among the general population,
- promote healthier lifestyle choices among society generally, and
- prioritise prevention interventions on those in communities who are at particular risk of problem drug/alcohol use.

The common threads running through these objectives are to make people aware of and improve understanding of the dangers and problems related to using drugs, as well as to promote positive health choices. There is also continuing recognition that certain groups and communities may be at a higher risk than the general population.

The types of interventions delivered as part of drug prevention have remained much the same over the last 10 years. Interventions delivered in schools have provided information and awareness to students about drugs (substance misuse policies) and have also focused on developing the personal and social skills of young people. Interventions delivered in non-school settings have comprised a mix of information and awareness measures and diversionary initiatives (youth work, youth cafés, outdoor recreation and measures targeting early school leaving). There have been sporadic attempts at psycho-social interventions in out of school settings, but these have not been consistently employed and the evidence is poorly documented.

3. Additional information

3.1 Specific studies or data on prevention

Young people in drug treatment
Darker and colleagues report on research undertaken with 20 young people aged 15–19 years who were recruited from two addiction treatment programmes in Ireland – a residential programme in the south-east and an out-patient programme in Dublin (Darker*, et al.* 2014). Data were collected using in-depth interviews and analysed using thematic analysis.

Initial substance use
Factors reported by respondents as having contributed to their initial use of substances were grouped by the authors as either 'personal' factors or 'environmental' factors.

- Under personal factors, using substances as a coping strategy or a means of escaping emotional difficulties were the most common themes reported. Participants recalled using substances to cope with family dysfunction, including domestic violence, and with inter-personal difficulties at school. Other personal stressors leading to initial substance use included family bereavement, relationship break-up, being bullied, being placed in care and episodes of depression or anorexia. Some participants reported using substances to increase confidence and improve self-esteem.
- Environmental factors contributing to initial substance use were friends' substance use and a family history of substance use. Young people described substance use as a normative experience, citing use by peers and influential elders as rendering use acceptable. The neighbourhood was also a factor, with access to substances having been easy and alternative recreational resources limited.

Problematic substance use
All participants were engaged in problematic substance use to a level requiring specialist treatment. Their responses to how they progressed to this stage were grouped by the authors of the research under 'substance-related' factors, 'substance use as a coping strategy' and other factors.

- Participants reported experiencing cravings, withdrawal symptoms, hangovers, come-downs and other consequences of use, all indicating a cycle of addiction; increased tolerance and a

growing desire to be high were other substance-related factors contributing to progression to problematic use.
- Participants reported continued and increased use of substances as a means of coping with family dysfunction and a myriad of personal life stressors, including family illness or death. Other factors cited by some participants included criminal justice problems and problems at school.

Coping with problems and stress
A common theme to emerge from respondents was their reliance on alcohol and drugs before they entered treatment to cope with problems and stress. Some also reported trying to avoid coping, or using emotion-focused coping such as getting angry and aggressive when under stress.

Parental roles
Responses about the roles played by parents in the initiation and development of problematic substance use among participants were grouped under the following themes: relationship difficulties, enabling behaviour, parents' permissive attitude and parents' own substance misuse. Relationship difficulties appeared to arise through resistance to mothers' efforts to control respondents' problem behaviour and through lack of emotional support from some fathers; these experiences contributed to disengagement, anger and frustration among respondents. Parents' lack of boundary-setting and giving money to respondents were perceived as enabling substance use, and parents' tolerance of and participation in respondents' alcohol consumption gave the impression of a permissive attitude. Parents' own substance use was a factor that overlapped with many other factors reported by respondents.

Conclusion
As noted by the authors, this is a small study of 20 young people attending treatment for substance use. It was designed to provide an insight into the factors that influence young people to use substances and the factors that contribute to use becoming problematic to the point where the young user needs specialist treatment. The findings should not be generalised to the wider population of young people in treatment. However, they may be used to inform the design and focus of further research that might test the relevance of these factors among a larger sample.

What is notable in the findings is the pivotal role played by the family in the young person's initiation into and development of problematic substance use. The dysfunctional nature of the respondents' families and their experience of parental conflict, violence and substance use, and the ensuing emotional trauma reported by them, appear to have been key 'triggers' in their decision to use substances. The authors point out that these young people used substances as the 'default' coping mechanism, but they did this in a context where the use of substances among significant others was perceived as the norm. These insights provide a useful basis for discussion about the design of effective prevention programmes.

4. Notes and queries

4.1 Recent relevant changes in tobacco and alcohol policies
Tobacco control policy has been strengthened by introducing legislation to ban smoking cigarettes in motor vehicles while carrying a person under age 18. This legislation puts an onus on parents/guardians to prioritise the health of their children over their own need to smoke and could further the cause of the denormalisation of tobacco smoking in Ireland.

4.2 Recent research on aetiology and/or effectiveness of prevention interventions
Darker and colleagues (Darker*, et al.* 2015) have reported on research undertaken with 20 young people aged 15–19 years who were recruited from two addiction treatment programmes in Ireland. See response to T4.1 above for a full account of this research and its implications for the design of effective prevention programmes.

5. Sources, methodology and references

5.1 Sources

National Drugs Strategy

Social, Personal and Health Education

http://www.drugs.ie/

Health Service Executive

Department of Education and Skills

Department of Children and Youth Affairs

An Garda Síochána

Drugs Task Forces

http://www.irishstatutebook.ie/eli/home.html

5.2 Methodology

Darker C et al. (2014) Young people in drug treatment in Ireland: their views on substance use aetiology, trajectory, parents' role in substance use and coping skills.
Darker and colleagues report on research undertaken with 20 young people aged 15–19 years who were recruited from two addiction treatment programmes in Ireland – a residential programme in the south-east and an out-patient programme in Dublin.

Hickey P and Evans DS (2014) *Smoking in Ireland 2013: synopsis of key patterns and trends*. Health Service Executive, Dublin.
Prior to May 2008, the survey was conducted with respondents via landline telephone numbers only. From May 2008 the data collection methodology was updated to include mobile telephone users. The sample population is now drawn from a combination of both landline and mobile phone numbers. While the questionnaire and quota controls are unchanged, some population subgroups that may previously have been difficult to contact are now better represented in the sample.

O'Keeffe L et al. (2015) Description and outcome evaluation of Jigsaw: an emergent Irish mental health early intervention programme for young people.
Participants were 2,420 young people who received support, directly or indirectly, from Jigsaw. Demographic details, including age, gender, presenting issues and referral pathways, captured on the Jigsaw Data System were described and psychological distress was assessed using the Clinical Outcomes in Routine Evaluation (CORE) questionnaires.

Quigley M (2015) Building bridges – an evaluation and social return on investment study of the Le Cheile Restorative Justice Project in Limerick.
To match the aims of this research, a mixed methods approach was designed, to gather data from multiple sources. The following six-phase methodology was designed by the evaluation team and agreed by the evaluation steering group:
Step 1: Stakeholder Mapping
Step 2. Review of Literature:
Step 3: Focus Groups
Step 4. Interviews
Step 5. File and Document Review
Step 6. Social Return On Investment Analysis

5.3 References

Darker, C. D., Palmer, D., O'Reilly, G., Whiston, L. and Smyth, B. P. (2014). Young people in drug treatment in Ireland: their views on substance use aetiology, trajectory, parents' role in substance use and coping skills. Irish Journal of Psychological Medicine, **32**, (3), 247-258. Available at http://www.drugsandalcohol.ie/23180/

Darker, C. D., Ho, J., Kelly, G., Whiston, L. and Barry, J. (2015). Demographic and clinical factors predicting retention in methadone maintenance: results from an Irish cohort. Irish Journal of Medical Science, **Early online**. Available at http://www.drugsandalcohol.ie/24022/

Department of Children and Youth Affairs (2013). Volunteer group leaders' guide to national quality standards for volunteer-led youth groups. Department of Children and Youth Affairs, Dublin. Available at http://www.drugsandalcohol.ie/20356/

Department of Children and Youth Affairs (2014a). Better outcomes brighter futures. The national policy framework for children & young people 2014 - 2020. Stationery Office, Dublin. Available at http://www.drugsandalcohol.ie/21773/

Department of Children and Youth Affairs (2014b). Value for money and policy review of the youth programmes that target disadvantaged young people. Government Publications, Dublin. Available at http://www.drugsandalcohol.ie/23242/

Department of Community, Rural and Gaeltacht Affairs, (2009). National Drugs Strategy (interim) 2009–2016. Department of Community, Rural and Gaeltacht Affairs, Dublin. Available at http://www.drugsandalcohol.ie/12388/

Department of Education and Skills (2013a). Looking at Social, Personal and Health Education. Teaching and Learning in Post-Primary Schools. Department of Education and Skills, Dublin. Available at http://www.education.ie/en/Publications/Inspection-Reports-Publications/Evaluation-Reports-Guidelines/Looking-at-Social-Personal-and-Health-Education-Teaching-and-Learning-in-Post-Primary-Schools.pdf

Department of Education and Skills (2013b). Chief Inspector's Report 2010 - 2012. Inspectorate of the Department of Education and Skills, Dublin. Available at http://www.drugsandalcohol.ie/24895/

Department of Education and Skills (2014). Results of the Department of Education and Skills 'lifeskills' survey, 2012. Department of Education and Skills, Dublin. Available at http://www.drugsandalcohol.ie/21391/

Department of Health (2015). National Drugs Strategy 2009-2016: progress report to end 2014. Department of Health, Dublin. Available at http://www.drugsandalcohol.ie/23935/

Department of Tourism, Sport and Recreation (2001). Building on experience: National Drugs Strategy 2001–2008. Stationery Office, Dublin. Available at http://www.drugsandalcohol.ie/5187/

Forkan C (2010). Brief guide to recent youth café publications. Child and Family Research Centre, Galway. Available at http://www.drugsandalcohol.ie/18226/

Forkan C, Canavan J, Devaney C, Dolan P, Child Family Research Centre, National University of Ireland Galway *, et al.* (2010a). Youth café toolkit: how to set up and run a youth café in Ireland. Stationery Office, Dublin. Available at http://www.drugsandalcohol.ie/13317/

Forkan C, Canavan J, Dolan P, Bradley C, Brady B, Carty C *, et al.* (2010b). Youth cafés in Ireland: a best practice guide. Stationery Office, Dublin. Available at http://www.drugsandalcohol.ie/13315/

Health Service Executive (2014). Fifth annual child & adolescent mental health service report 2012 - 2013. Health Service Executive, Dublin. Available at http://www.drugsandalcohol.ie/21387/

Hickey P and Evans DS (2014). Smoking in Ireland 2013: synopsis of key patterns and trends. Health Service Executive, Dublin. Available at http://www.drugsandalcohol.ie/23200/

Indecon International Economic Consultants (2012). Assessment of the economic value of youth work. Report prepared for the National Youth Council. National Youth Council of Ireland, Dublin. Available at www.drugsandalcohol.ie/19045

Keane, M. (2012). Service providers accredited in Community Reinforcement Approach. Drugnet Ireland, **Issue 40, Winter 2011**, 16. Available at http://www.drugsandalcohol.ie/16877/

O'Keeffe, L., O'Reilly, A., O'Brien, G., Buckley, R. and Illback, R. (2015). Description and outcome evaluation of Jigsaw: an emergent Irish mental health early intervention programme for young people. Irish Journal of Psychological Medicine, **Special issue 01: youth mental health**, (71-77). Available at http://www.drugsandalcohol.ie/23291/

Office of the Minister for Children and Youth Affairs (2010). National quality standards framework (NQSF) for youth work. Office of the Minister for Children and Youth Affairs, Dublin. Available at http://www.drugsandalcohol.ie/13490/

Quigley, M., Martynowicz, A. and Gardner, C. (2015). Building bridges – an evaluation and social return on investment study of the Le Cheile Restorative Justice Project in Limerick. Excecutive summary. Le Chéile, Ireland. Available at http://www.drugsandalcohol.ie/23342/

Roe, S. (2015). A 7 year Follow-Up Study (2008-2014) with Graduates of the Ballymun Strengthening Families Programme (SFP 12-16 years). Ballymun Local Drugs & Alcohol Task Force, Dublin, Ireland. Available at http://www.drugsandalcohol.ie/24195/

Tobacco Policy Review Group (2013). Tobacco free Ireland. Department of Health, Dublin. Available at www.drugsandalcohol.ie/20655

Working Group on educational materials for use in SPHE in post-primary schools and centres for education (2014). Report of the Working Group on educational materials for use in SPHE in post-primary schools and centres for education with particular reference to substance use education in the context of SPHE. Department of Education and Skills, Dublin. Available at http://www.drugsandalcohol.ie/22264/

European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised EU agency based in Lisbon. The EMCDDA provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the European Union and Member States.

There are 30 National Focal Points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data-collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the Centre for analysis, from which it produces the annual *European drug report* and other outputs.

The Irish Focal Point to the EMCDDA is based in the Health Research Board. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators and supply indicators in the form of standard tables and structured questionnaires on response-related issues such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances.

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