The newsletter of
Ireland's focal point
to the EMCDDA

drugnet IRELAND

Issue 80 ▌ Winter 2022

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National drugs strategy: progress report for 2020

A progress report on the national drugs strategy was published in June 2021, entitled *Reducing Harm, Supporting Recovery: progress report 2020*.[1] This forms part of the evidence base used for the midterm review of the national drug strategy.[2]

The report, like its predecessors for 2018 and 2019, is structured around the strategic action plan for 2017–2020 that was included in the main strategy document.[3,4,5] The strategy set out measures by which progress on delivery of its goals would be monitored and assessed. Among these measures, it was stated that 'the key bodies responsible for delivering the strategic actions will be required to report on progress on an annual basis to the Minister with responsibility for the National Drugs Strategy' (p. 73).[5] The Drugs Policy and Social Inclusion Unit at the Department of Health is responsible for collating this feedback and these progress reports are the output from this work.[1,3,4]

Reducing Harm, Supporting Recovery
Progress Report 2020

HRB Health Research Board

Research. Evidence. Action.

Contents

The policy, research, and other documents covered
in this issue of *Drugnet Ireland* have all been
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In brief

The next two to three years will see important changes in the coordination of the drug monitoring systems of the European Union (EU) and in the role played by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in supporting research and science-based responses at the national level. The European Commission has presented a legislative proposal to revise the mandate of the EMCDDA to ensure that the agency is prepared to meet future challenges of the drugs phenomenon.[1] Specifically, the revision of the mandate seeks to strengthen the agency's capacity to monitor polysubstance use, build its threat assessment capabilities, establish a laboratory to provide forensic and toxicological information to the agency, reinforce the position of national focal points, and give the agency a leading role in the development of EU-level prevention and awareness-raising campaigns.

The proposed revision restates the logic behind an EU-approach to the drugs phenomenon and the need to have a coordinated response to a problem which has a strong transnational dimension. This position is reinforced by the growing diversity of drugs of increasing purity and potency, the widespread availability of drugs across all member states, and the increasing complexity of patterns of use and distribution. Innovation and technological developments in the synthesis, sale, and supply of drugs result in a continually changing drugs environment. This will require an adaptable and coherent response that develops through learning and efficient knowledge exchange. A monitoring system able to avail quickly of scientific breakthroughs and capable of supporting national drug observatories is essential to the success of this response.

The European Commission considered a number of policy options, or rationalisations, to underpin the proposed administrative and technical changes proposed in the revision. The preferred policy option is *delivering more value in drugs policy*. This envisages national focal points being better equipped to avail of support from the agency and will give the agency the breadth to devise services specifically for member states. It will also support the expansion of methodologies developed to monitor illegal drug supply and drug markets. The changes envisaged in the legislative proposal will provide the basis for the agency to provide a comprehensive understanding of the current drugs situation. The proposal will have a significant impact on the work of the agency and will require a substantial increase in its budget and staffing.

The EMCDDA will be renamed the European Union Drugs Agency (EUDA). The new legislation will pay particular attention to monitoring and risk assessment procedures for new psychoactive substances, in particular producing assessments of threats to public health, safety, and security. Another important expansion of the agency's role is in the area of competence development. The EUDA will develop prevention programmes for the entire EU and will work directly with member states in preparing national campaigns. The agency will also act as an accreditation and certification body for national prevention, treatment, harm reduction, and other programmes. The European Commission's proposal is a strong endorsement of the agency's work over the past 25 years. The EUDA will be a driver of innovation in drugs monitoring, scientific practice, and evaluation in all member states. The new mandate will present real opportunities for researchers, policy analysts, and practitioners, particularly in the area of threat assessment and competence building.

1   European Commission (2022) *Proposal for a regulation of the European Parliament and of the Council on the European Union Drugs Agency*. COM/2022/18 final. Brussels: European Commission. Available online at:
    https://eur-lex.europa.eu/resource.html?uri=cellar:11305b3a-738c-11ec-9136-01aa75ed71a1.0001.02/DOC_1&format=PDF

National drugs strategy: progress report for 2020   continued

Table 1: Summary of the action status for 2020 for each strategic goal

No.	Strategic goal	Fully completed	Broadly on track	Progressing but with a minor delivery issue	Delayed with a significant delivery issue
1	Promote and protect health and wellbeing	4	2	3	2
2	Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery	3	6	5	3
3	Address the harms of drug markets and reduce access to drugs for harmful use	2	3	1	1
4	Support participation of individuals, families, and communities	2	2	0	1
5	Develop sound and comprehensive evidence–informed policies and actions	0	1	3	0
6	Strengthen the performance of the strategy	0	0	0	1
	Total	**11**	**14**	**12**	**8**

Source: Adapted from *Reducing Harm, Supporting Recovery: progress report 2020* (p. 2)[1]

As with the previous reports, data for 2020 were descriptive and presented in tabular form. They listed activities undertaken in the implementation of the actions to the end of 2020. The only analyses included in this progress report were categorisations of the status of the actions. No details were given about the basis of these categorisations. Table 1 shows a summary of this progress. In addition, the report only provided information for 45 of the 50 strategic actions.

Lucy Dillon

1 Drugs Policy and Social Inclusion Unit (2021) *Reducing Harm, Supporting Recovery: progress report 2020*. Dublin: Department of Health. https://www.drugsandalcohol.ie/34857/

2 Drugs Policy and Social Inclusion Unit (2021) *Mid-term review of the national drugs strategy, Reducing Harm, Supporting Recovery and strategic priorities 2021–2025*. Dublin: Department of Health. https://www.drugsandalcohol.ie/35183/

3 Drugs Policy and Social Inclusion Unit (2020) *Reducing Harm, Supporting Recovery: progress report 2019*. Dublin: Department of Health. https://www.drugsandalcohol.ie/34530/

4 Drugs Policy Unit (2019) *Reducing Harm, Supporting Recovery: progress 2018 and planned activity 2019*. Dublin: Department of Health. https://www.drugsandalcohol.ie/30660/

5 Department of Health (2017) *Reducing Harm, Supporting Recovery: a health–led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. https://www.drugsandalcohol.ie/27603/

POLICY AND LEGISLATION

National Drugs Forum 2021 – Foresight: preparing for uncertainty in drug use, markets, and responses

The 2021 National Drugs Forum focused on future needs and how we can anticipate changing patterns in drug use and supply to ensure our responses are robust and ready to meet new challenges. The forum was held online on 23 November 2021. The Department of Health in November 2021 published the midterm review of the national drugs strategy and has begun work on the six strategy priorities for 2021–2025.[1] The forum provided an opportunity to reflect on the themes of preparation and foresight central to both national and European drug policies.

Strategic foresight

The forum introduced participants to the concept of strategic foresight and explained its relevance for anticipating trends in the drugs area. Strategic foresight is an approach to planning and policymaking that attempts to manage uncertainty by identifying a number of possibilities. Governments, institutions, non–governmental organisations, and other national and international collective entities can develop anticipatory capacity by making better use of what is known already.

The discipline of strategic foresight puts particular emphasis on harnessing existing knowledge. The session was led by Future Impacts, a consultancy that specialises in foresight capacity building, coaching, training, and research. Future Impacts has worked extensively on European Commission foresight projects

National Drugs Forum 2021   continued

and has advised the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) on a number of projects on drug-related futures.

Megatrends workshop

The workshop at the National Drugs Forum involved identifying and analysing megatrends to explore global changes and their implications for local policy. The overall objective of the workshop was to provide participants with an understanding of what foresight is and why it is important, as well as understanding wider changes in the environment that may have implications for drugs and drug monitoring in the future.

In the workshop, participants engaged with a number of groups and were asked to complete some simple exercises that provided them with hands-on experience of working with foresight and megatrends. Each group was tasked with prioritising megatrends according to their potential impact on the future of drugs, related policies, and development of services in response to the changing situation. They were then asked to identify the potential implications of the trends that could have an impact on drugs until 2030. The responses were imaginative and thoughtful, and each group gave consideration to possible developments for which we have, as yet, few early indicators.

Climate change and migration

The benefit of working with several megatrends together was clear from the groups' recorded observations, as separate megatrends overlapped and reinforced the impact of one another. For instance, several groups considered climate change and environmental degradation, which has clear links to another megatrend, the increasing significance of migration. The needs of new communities will challenge the response capability of existing services. Climate change and migration will drive increasing urbanisation, with newer housing isolated from the centre and many people traumatised by dislocation and the loss of social networks. Climate change may facilitate drug production activities locally that are not feasible or economic at the moment and strain law enforcement resources.

On the positive side, the need to mitigate the harmful effects of climate change and Covid-19 may stimulate more cooperation between institutions and international cooperation.

Technological developments

One group highlighted increasing levels of self-medication as a result of both mental health challenges and changing consumer patterns facilitated by technological changes and consumer-oriented cultures in wealthier, but more unequal, societies. Participants were well aware of the preventative, early intervention, treatment, and harm reduction possibilities that technological innovations can bring. Remote access to services can increase availability and lessen the stigma associated with traditional treatment approaches.

While technological changes will provide new opportunities in service provision, differing digital literacy levels may compound existing inequalities and impede access for some. Services already facing challenges in staffing may struggle to provide new interventions and adapt to a rapidly changing drug environment.

The Covid-19 pandemic has demonstrated the powerful impact of easily available misinformation and poor research. The traditional gatekeepers for public discourse are becoming less relevant. This multiplies the effect of a growing global marketplace for drugs, as consumers use non-scientific sources of information about potentially dangerous new products.

Technological change and hyperconnectivity also encourages more openness and curiosity among younger people, especially in social drugs that are increasingly seen as a normal part of the festival or event experience. This particular market is highly lucrative and likely to be exploited in increasingly sophisticated ways in the future. Easier transition to virtual spaces through accelerating technological change and hyperconnectivity may result in behavioural shifts similar to substance dependency and present a very different arena for treatment professionals to work in.

Global political and economic changes

Several groups considered the economic consequences of resource scarcity and the expanding influence of the East and the South. The increasing industrialisation of these regions will inevitably present opportunities for greater production of synthetic drugs, more easily transportable than traditional plant-based drugs along new and harder to detect trade routes. The political implications of global shifts in population, natural resources, and industrialisation may include a lowering of governmental commitment to human rights, leaving Europe isolated with regard to upholding individual freedoms and protections against coercion. There is a danger that, in this global environment, the gradual strengthening of progressive drugs policies may be reversed.

There is a connection here to the megatrend of shifting health challenges. A smaller population of working-age people will be asked to support healthcare for a growing older cohort. In an international political climate that may have less compassion for those who are seen to transgress social norms, will the next generation be prepared to support services for an ageing population of people who use drugs?

Working life

The changing nature of work may lead to an increase in early retirement and social isolation, which could result in greater alcohol and drug use among older people. For younger people, shifts in work patterns will expand social networks at home and abroad. This growth in professional relationships will also enable greater sharing of knowledge and insights from other countries. Of course, it will also increase awareness of new drugs and present opportunities to experiment. New work patterns may also blur the boundaries between home and work, placing more demands on people who consequently seek opportunities to relieve stress.

New modes of governing and consumer changes

New governing systems may also result in more participatory democracy through mechanisms like expanded citizens' assemblies. Deliberations in these forums tend to have more liberal outcomes than parliamentary systems and could contribute to policies like legalisation of drugs. Any such legislative change must take into account the shifts in market dynamics and distribution patterns made possible by the internet. It is not clear what a legislative response to a quickly growing online drug market might be and there is concern that the response will be far slower than technological change.

National Drugs Forum 2021   continued

Demographic changes and policy shifts in other European countries may increase pressure for the liberalisation of drug laws and increasing usage of a wider variety of drugs. While this will be challenging, regulation of substances that are currently illegal creates opportunities to regulate markets, educate users, and reduce criminal activity.

As conventional commercial enterprises seek new markets in a changing legal environment, regulators will face unforeseen challenges in managing very new, aggressive, and agile corporate entities. Consumption patterns will not be totally shaped by the increased availability of currently illegal drugs. Successful implementation of alcohol control measures may provoke a response from the industry to reclaim markets lost, amplifying the regulatory challenges that will follow the liberalisation of drug laws.

Brian Galvin

1   Drugs Policy and Social Inclusion Unit (2021) *Mid-term review of the national drugs strategy, Reducing Harm, Supporting Recovery and strategic priorities 2021–2025.* Dublin: Department of Health. https://www.drugsandalcohol.ie/35183/

Publication of EU Drugs Action Plan 2021–2023

On 21 July 2021, the Council of the European Union (EU) (Foreign Affairs) approved the EU Drugs Action Plan 2021–2025, prepared under the Portuguese presidency of the EU.[1] The Action Plan is the mechanism through which the EU will implement the EU Drugs Strategy 2021–2025, which was approved by the Council of Europe in December 2020, and the content of which was discussed in a previous issue of *Drugnet*.[2,3]

Action Plan structure

The Action Plan is grounded in the strategy and therefore pursues the same aims and objectives; adopts the same approach; and is based on the same principles, values, and legal provisions.

> *The Strategy aims to protect and improve the well-being of society and of the individual, to protect and promote public health, to offer a high level of security and well-being for the general public and to increase health literacy. The Strategy takes an evidence-based, integrated, balanced and multidisciplinary approach to the drugs phenomenon at national, EU and international level. It also incorporates a gender equality and health equity perspective.* (p. 3)[1]

The 85 actions contained in the plan are described as 'evidence-based, scientifically sound, realistic, time-bound and measurable with a clear EU relevance and added value' (p. 3).[1] They are set out under the strategy's three policy areas (drug supply reduction: enhancing security; drug demand reduction: prevention, treatment, and care services; and addressing drug-related harm) and three cross-cutting themes (international cooperation; research, innovation, and foresight; and coordination, governance, and implementation). The plan sets out a timetable for each action's delivery and the stakeholders involved in their implementation. These include the Council of the EU; EU member states; the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA); Europol; and the European Medicines Agency, to name but a few.

A set of indicators based on existing reporting mechanisms is identified, which will facilitate 'the measurement of the overall effectiveness of the Action Plan' (p. 3).[1] The implementation of the strategy and Action Plan will be subject to an external evaluation, the findings of which will be published in March 2025 and used to inform the next cycle of strategy development.

Changing landscape

As well as supporting an increased focus on the consequences of drug use and its related harms, the 2021–2025 Strategy and Action Plan maintain a focus on addressing both supply and demand reduction activities. They also reflect how the drug landscape has evolved since the previous strategy was published in 2012.[4] For example, they take account of changing drug markets, increased drug-related violence, and environmental crime related to illicit drug production and trafficking. Below is a selection of actions (and their priority areas) with relevance to Ireland's national drugs strategy,[5] which illustrates some of the range of issues covered under the plan.

Strategic priorities and actions

Drug supply reduction: enhancing security

Priority area: Prevent drug-related crime with particular focus on the need to counter violence, limit corruption, and address the exploitation of vulnerable groups by addressing the underlying factors that lead to their involvement in illicit drug markets.

Action 9 (ii)(iii): Encourage comprehensive evidence-based strategies in neighbourhoods that experience high levels of drug availability and drug-related crime and support measures that create a more protective environment for communities affected by the consumption and sale of drugs or drug-related crime, in accordance with internationally recognised quality standards (UNODC/WHO International Standards on Drug Use Prevention).[6]

Drug demand reduction: prevention, treatment, and care services

Priority area: Disseminate the latest scientific evidence on prevention to decision-makers and practitioners and provide them with training.

Action 30: Promote and allocate sufficient funding for education, training, and continuous professional development for decision-makers, opinion leaders, and professionals on the latest scientific evidence on drug use and addiction prevention, including new consumption patterns, also using online tools, and in particular promote the implementation of the European Drug Prevention Quality Standards (EDPQS), the UNODC/WHO International Standards on Drug Use Prevention, and the European Prevention Curriculum (EUPC) training courses.

EU Action Plan   continued

Priority area: Reduce stigma.

Action 39: Develop and provide training for decision-makers, employers, and professionals about stigma linked to drug use, drug-use disorders, and mental health, and consider the impact that this stigma may have had on patients when delivering care. This should be done with the involvement of people who have experienced drug-related stigma.

Addressing drug-related harm

Priority area: Promote civil society participation and ensure sustainable funding.

Action 48: Promote and encourage the active and meaningful participation and involvement of civil society, including non-governmental organisations, young people, people who use drugs, clients of drug-related services, the scientific community, and other experts in the development, implementation, and evaluation of drug policies, and provide an appropriate level of resources for all drug services and for the involvement of civil society.

Priority area: Provide alternatives to coercive sanctions.

Action 49 (i): Scale up the availability, effective implementation, monitoring, and evaluation of measures provided as alternatives to coercive sanctions for drug-using offenders and for people in pretrial detention, arrested, charged with or convicted of drug-related offences, or people found in possession of drugs for personal use, such as (suspension of sentence with) treatment, rehabilitation and recovery, and social reintegration, in accordance with national legislation.

Concluding comment

The EU's Action Plan reflects the wide range of challenges facing the EU and its member states. There is a focus on improving alignment between member states' national strategies and those of the EU. There is currently close alignment between Ireland's national drugs strategy and that of the EU, which is set to continue with the forthcoming strategic priorities and action plan to be published by Government.

Lucy Dillon

1   Council of the European Union (2021) *EU drugs action plan 2021–2025.* Brussels: Council of the European Union. https://www.drugsandalcohol.ie/34446/

2   Council of the European Union (2020) *EU drugs strategy 2021–2025.* Brussels: Council of the European Union. https://www.drugsandalcohol.ie/33750/

3   Dillon L (2021) Publication of EU Drugs Strategy 2021–2025. *Drugnet Ireland*, 77 (Spring): 1–7. https://www.drugsandalcohol.ie/34279/

4   Council of the European Union (2012) *EU drugs strategy (2013–2020).* Brussels: Council of the European Union. https://www.drugsandalcohol.ie/19034/

5   Department of Health (2017) *Reducing Harm, Supporting Recovery: a health-led response to drug and alcohol use in Ireland 2017–2025.* Dublin: Department of Health. https://www.drugsandalcohol.ie/27603/

6   United Nations Office on Drugs and Crime (UNODC)/World Health Organization (WHO) (2018) *International standards on drug use prevention.* 2nd updated edn. Vienna: United Nations Office on Drugs and Crime. https://www.drugsandalcohol.ie/30048/

Global Drug Policy Index

On 8 November 2021, the Global Drug Policy Index (GDPI) was launched.[1] The GDPI is a composite index that scores and ranks countries on how their national drug policies and their implementation align with a set of indicators that reflect the United Nations (UN) recommendations on human rights, health, and development. These are laid down in the UN System Common Position on drugs and, more specifically, the related 2019 UN report, *What we have learned over the last ten years: a summary of knowledge acquired and produced by the UN system on drug-related matters.*[2,3]

Background

The GDPI is the output of the project 'The Global Drug Policy Index (GDPI): A bold new approach to improve policies, harm reduction funding, and the lives of people who use drugs', which was supported by the Robert Carr Fund and led by the Harm Reduction Consortium.[4] It has been developed by civil society and community organisations in partnership with academia. It is grounded in its developers' belief that global drug policies that are based on a 'war on drugs' narrative exacerbate harms and lead to widespread human rights violations. The Index is a tool to promote policy reforms in favour of more humane responses and sets out to provide a reliable accountability and evaluation mechanism in the field of drug policy.

Methodology

The GDPI was developed through a complex five-step methodological process (see Figure 1). The process involved consultations, identification of indicators, thematic policy clusters and dimensions, data collection, and analysis. Data were collected through desk-based research, a civil society survey, a survey of drug policy analysts, and other structured consultation with other stakeholders. Weighting was agreed for each indicator, policy cluster, and dimension through a complex process, which resulted in each country being awarded a score between 1 and 100. For a country to score 100, their drug policy and practice would need to be aligned with the recommendations contained in the UN documents mentioned above.[2,3]

In this first iteration, the GDPI focuses on 30 countries, selected based on criteria including geographical location, availability of data on drugs and drug policy, and the presence of civil society organisations that could use the Index without fear of reprisal.[5] Ireland is not among those included. The European countries represented are Hungary, Norway, Portugal, Russia, and the United Kingdom (UK).

Global Policy Index   continued

1.	2.	3.	4.	5.
Expert Consultations	**Interim Report**, creation of SAG, agreement on work programme	**Methodology Consolidation:** analysis of UN recommendations, creation of coding approach, generation of aggregation rules and weights	**Data Collection** via coding team, civil society survey, international experts survey & 'Delphi' process for weighting	**Data Analysis** & finalisation
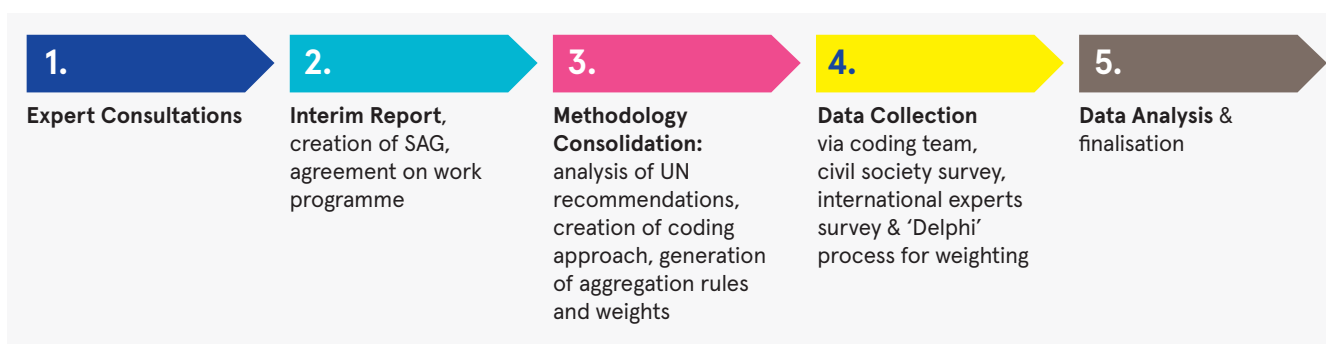
Source: *The Global Drug Policy Index 2021*, p. 29
SAG: Scientific Advisory Group

Figure 1: GDPI five-step methodological process

Scope of the GDPI

The Index is made up of 75 indicators that run across five dimensions:

- The absence of extreme sentencing and response to drugs, such as the death penalty
- The proportionality of the criminal justice response to drugs
- Funding, availability, and coverage of harm reduction interventions
- Availability of international controlled substances for pain relief
- Development.

Results

In addition to ranking the countries, the report identifies seven key takeaways from the Index.

1 The global dominance of drug policies based on repression and punishment has led to low scores overall, with a median score of just 48/100, and the top-ranking country (Norway) only reaching 74/100. The authors argue that most countries' drug policies are misaligned with their governments' obligations to promote health, human rights, and development, hence the relatively low scores (see Figure 2).

2 Standards and expectations from civil society experts on drug policy implementation vary from country to country. Given the role of civil society in providing the evidence on the implementation of a country's drug policy, the authors reflect on how this may impact on the scoring of some indicators.

3 Inequality is deeply seated in global drug policies, given their greater emphasis on human rights, harm reduction, and health. The five top-ranking countries scored three times as much as the five lowest-ranking countries. The authors attribute this in part to the colonial legacy of the 'war on drugs' approach.

4 Drug policies are inherently complex. A country's performance in the Index can only be fully understood by looking across and within each of the dimensions. The authors note that a country's performance in one dimension of drug policy may not necessarily mirror how well they are doing in another. They highlight the case of the UK, which has the highest score (84/100) on

avoiding police abuses, arbitrary arrests, and detentions, and ensuring fair trial rights, but is one of the lowest-ranking countries regarding experts' perception of the disproportionate impacts of the criminal justice response on women, marginalised ethnic communities, and low-income groups.

5 Drug policies disproportionately affect people marginalised because of their gender, ethnicity, sexual orientation, and socioeconomic status. In addition, the Index underscores how people who use drugs continue to be discriminated against by drug policies across the world.

6 There are wide disparities between what is written in national drug policies and how they are implemented on the ground. These disparities are particularly apparent in the areas of health (e.g. access to harm reduction interventions), decriminalisation, and alternatives to prison and punishment.

7 With a few exceptions, the meaningful participation of civil society and affected communities in drug policy processes remains severely limited.

Highest Ranking

74/100	#1	Norway
71/100	#2	New Zealand
70/100	#3	Portugal
69/100	#4	United Kingdom
65/100	#5	Australia

Lowest Ranking

26/100	#30	Brazil
28/100	#29	Uganda
29/100	#28	Indonesia
34/100	#27	Kenya
35/100	#26	Mexico

Source: *The Global Drug Policy Index 2021*, p. 34

Figure 2: Highest-ranking and lowest-ranking countries in the GDPI

Global Policy Index   continued

Lucy Dillon

1   Nougier M and Cots Fernández A (2021) *The Global Drug Policy Index 2021*. London: Harm Reduction Consortium. https://www.drugsandalcohol.ie/35122/

2   United Nations System Chief Executives Board for Coordination (2018) *United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration,* CEB/2018/2. New York: United Nations. Available online at: https://unsceb.org/sites/default/files/2021-01/2018%20Nov%20-%20UN%20system%20common%20position%20on%20drug%20policy.pdf

3   UN System Coordination Task Team on the Implementation of the UN System Common Position on Drug-related Matters (2019) *What we have learned over the last ten years: a summary of knowledge acquired and produced by the UN system on drug-related matters*. Vienna: United Nations. https://www.drugsandalcohol.ie/30372/

4   Members of the Harm Reduction Consortium are as follows: the European Network of People who Use Drugs (EuroNPUD); the Eurasian Harm Reduction Association (EHRA); the Eurasian Network of People who Use Drugs (ENPUD); the Global Drug Policy Observatory (GDPO) at Swansea University; Harm Reduction International (HRI); the International Drug Policy Consortium (IDPC); the Middle East and North Africa Harm Reduction Association (MENAHRA); the West Africa Drug Policy Network (WADPN); the Women and Harm Reduction International Network (WHRIN); and Youth RISE. For further information, visit: https://globaldrugpolicyindex.net/about

5   This first edition of the Index covers 30 countries from all regions of the world: Afghanistan, Argentina, Australia, Brazil, Canada, Colombia, Costa Rica, Georgia, Ghana, Hungary, India, Indonesia, Jamaica, Kenya, Kyrgyzstan, Lebanon, Mexico, Morocco, Mozambique, Nepal, New Zealand, North Macedonia, Norway, Portugal, Russia, Senegal, South Africa, Thailand, Uganda, and the United Kingdom. This list will be expanded in future iterations of the Index.

Focused policy assessment of the national drugs strategy

On 13 August 2021, as part of the 2021 Government spending review process, the *Focused policy assessment of Reducing Harm, Supporting Recovery: an analysis of expenditure and performance in the area of drug and alcohol misuse* was published.[1] This focused policy assessment (FPA) of the national drugs strategy[2] was prepared by staff of the Irish Government Economic and Evaluation Service (IGEES) based jointly in the Department of Health and the Department of Public Expenditure and Reform.

Aim of the focused policy assessment

The purpose of FPAs by the IGEES is to set out the rationale for a particular policy intervention; the public resources provided to support its delivery; the related outputs and services that are provided; and the achievements of the intervention relative to its stated goals. There are two main elements to the current review:

- **Drug-related public expenditure (labelled and unlabelled):** The review profiles labelled expenditure and presents the findings of the first effort to estimate unlabelled expenditure in an Irish context. This estimate is based on medical and judicial costs as well as lost productivity.

- **Reducing Harm, Supporting Recovery (RHSR) performance against its performance indicators (PIs):** The review maps the availability of data for the strategy's 29 PIs and analyses those that are available (for 12 PIs), in an attempt to assess the performance of RHSR under its five strategic goals.

The authors focused on the timeframe 2014–2020 in order that data could be analysed for comparison before and after the implementation of RHSR in 2017.

Drug-related public expenditure

Labelled public expenditure

Labelled drug-related expenditure is defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as 'the ex-ante planned public expenditure made by general government in the budget that reflects the public and voluntary commitment of a country in the field of drugs. In addition, it is any expenditure identified as drug-related in public accountancy documents'[3] (p. 23). In Ireland, it includes budget allocations for the Health Service Executive (HSE) Addiction Services and treatment services in prisons, for example. The authors report the expenditure data as they appear in Ireland's 2020 National Report for the EMCDDA[4] (see Table 1).

The authors note that while total expenditure appears to have decreased since 2016, this in fact reflects limitations in data reporting. Based on the available data, the largest increase in organisational spend over the period 2014–2019 was by the HSE Addiction Services – an increase of €17 million, an average year-on-year increase of 4% per annum.

Unlabelled public expenditure

A core part of the FPA is the work that went into developing an estimate of unlabelled expenditure on drug use in Ireland. Unlabelled drug-related expenditure is the 'non-planned or non-publicly announced ex-post public expenditure incurred by the general government in tackling drugs that is not identified as drug-related in the budget' (p. 24).[3] This would include, for example, the cost incurred for the imprisonment of people for drug-related offences.

While Irish estimates have been made for alcohol use,[5,6,7] they have not been made for other drugs. The authors argued that this presented 'an obstacle to assessing the cost-effectiveness of publicly funded interventions, since any examination of the value of measures to alleviate the clinical, social and environmental harms of illegal drugs ought to relate changes in inputs (planned programmes to tackle this issue) to changes in outputs and costs' (p. 20).[1]

Focused policy assessment   *continued*

Table 1: Public expenditure directly attributable to drug programmes (labelled), 2014–2019

Department/Agency	2014 (€m)	2015 (€m)	2016 (€m)	2017 (€m)	2018 (€m)	2019 (€m)
Health Research Board (HRB)	€0.908	€1.013	€1.247	€0.756	€0.786	€0.786
HSE Addiction Services	€86.122	€91.523	€93.43	€97.87	€99.828	€103.419
HSE Drugs and Alcohol Task Force Projects	€21.570	€22.064	€22.78	€22.14	€22.63	€22.920
An Garda Síochána*	€43.000	€43.000	€46.00	€47.00	€14.25	€13.17
Dept of Children and Youth Affairs	€19.548	€19.548	€20.05	€20.04	€20.46	€20.46
Dept of Justice	€18.762	€19.363	€20.56	€7.30	€6.95	–
Revenue Customs Service	€16.235	€17.445	€17.36	€17.36	€19.60	–
Dept of Social Protection (former FÁS area)	€14.063	€13.900	€16.41	€17.98	€17.22	€20.07
Dept of Health	€7.266	€7.323	€6.08	€5.54	€6.015	€5.955
Irish Prison Service	€4.200	€4.235	€4.40	€4.20	–	–
Dept of Education and Skills	€0.748	€0.748	€0.77	€0.76	€0.76	€0.72
Total	€232.422	€240.162	€249.087	€240.95**	€208.499**	€187.50**

Source: Health Research Board (2021)[4]

* After 2017, An Garda Síochána moved from reporting on 'policing/investigation costs' to 'policing/investigation costs of Garda National Drugs and Organised Crime' only.

** The €53m decrease in expenditure between 2017 and 2019 reflects limitations in reporting of expenditure from An Garda Síochána, Department of Justice and Equality, Irish Prison Service, and Revenue Customs Service, rather than a reduction in expenditure as such.

Methodological approach

To develop the estimate, the authors focused on drug-related costs in prisons and acute hospitals. The selection was based on the assumption that they would account for a relatively large proportion of unlabelled expenditure. In addition, they examined a selection of economic costs (productivity losses associated with hospital treatment and imprisonment) and societal costs (premature drug-related death).

The review estimates unlabelled costs using both cross-sectional and longitudinal approaches. However, for the purpose of this summary, the focus is on the former, as it examines costs on an annual basis and therefore relates to the annual budgetary cycle as per labelled expenditure. The approach taken for each area of interest is described here in its simplest terms.

- **Prison and criminal justice costs:** Costs related to drug offences (importation, manufacture or possession) and drug-related crime were examined. Identifying drug-related crime presented methodological challenges as it required estimating the causal link between drug use and other types of crime, i.e. what proportion of crimes such as theft or public order offences can be attributed to drugs and therefore be defined as drug-related crime? To address this challenge, the authors adopted a framework of drug attribution fractions (DAFs) developed in the United States, and which estimate the proportion of different types of crime that are attributable to illicit drug use.[8] DAFs were combined with information about the duration of sentences

for people imprisoned for drug-related offences and controlled drug offences. An estimate of average costs per offence as well as a range of other parameters were used to provide an estimate of drug-related crime costs.

- **Healthcare costs:** Acute hospital costs were estimated for admissions directly related to drug use, as well as admissions for health problems associated with drug use. DAFs were also used as part of the model, which included parameters on healthcare resource use and costs for the various conditions.

- **Productivity losses:** Time spent in prison or hospital and premature death due to drug misuse represent a loss in economic output. The authors took a 'human capital approach' (p. 25)[1] in an effort to assess the costs involved. They estimated the costs of displaced paid labour, using median annual earnings and employment rates by age and gender, and analysed this with the relevant data source for prisons, acute hospitals, and premature deaths.

Results

Table 2 provides the estimates of the unlabelled costs associated with problem drug use under each of the four headings examined through cross-sectional analysis. (Note that the findings of the longitudinal analysis can be found on page 27 of the review.) The annual direct costs of hospital treatment, criminal offences, and prison committals for a cohort of affected individuals in Ireland is estimated to be approximately €87 million, and when indirect productivity costs are included (mainly as a result of premature deaths) this rises to over €147 million.

Focused policy assessment   continued

Table 2: Estimates of annual unlabelled drug-related expenditure, based on cross-sectional analysis

Source of expenditure	Estimate (€)
Hospital expenditure	**€21,982,647**
% of which are drug-related admissions	59%
% of which are drug-implicated admissions	41%
Prison expenditure	**€44,338,862**
% of which are controlled drug offences	43%
% of which is drug-related crime	57%
Criminal justice system expenditure	**€20,391,062**
% of which are controlled drug offences	34%
% of which is drug-related crime	66%
Productivity costs	**€60,707,970**
% of which are prison related	38%
% of which are premature death related	52%
% of which are hospital treatment related	10%
Total unlabelled direct costs	**€86,712,571**
Total unlabelled direct and indirect costs	**€147,420,542**

Source: Adapted from Bruton *et al.* (2021), Table 6 (p. 27)[1]

Limitations
Limitations to these estimates are covered in detail in the review. They relate to the data available to conduct the analysis as well as a recognition that there is a range of other methodological approaches that if utilised would have produced different estimates. However, the authors argue that the aim of their analysis 'was to characterise, rather than precisely estimate, the different types of unlabelled expenditure and productivity costs associated with problem drug use' (p. 27).[1]

Concluding comment on expenditure analysis
The data available on drug-related public expenditure are limited. However, the findings suggest that the unlabelled costs 'contribute significantly' to the overall economic burden of problem drug use and are therefore an 'important component of any policy-orientated analysis of the marginal costs and effects of changes to the provision of addiction and treatment services' (p. 27).[1] The same message is true for labelled expenditure.

Performance indicator analysis
The FPA aimed to assess the performance of RHSR by analysing the data available for the PIs under each of its five strategic goals. There were three phases to this work: data scoping, collection, and analysis. Data scoping found that there were significant limitations in the availability of data. The reasons for this included that the data did not exist, it could not be accessed, or did not fit an appropriate timeframe. Where possible, proxy data were used but overall data were found

for only 12 of the 29 PIs. Data were provided by the Health Research Board (HRB), HSE, Revenue, An Garda Síochána, Central Statistics Office (CSO), and the European School Survey Project on Alcohol and Other Drugs (ESPAD) and Health Behaviour in School-aged Children (HBSC) surveys. Data were collated and charts created using Excel software, which facilitated a trend analysis of each indicator where possible.

Results
Despite the limitations, some of the key findings under each strategic goal identified in the discussion of the review are noted here.

Goal 1: Promote and protect health and wellbeing
Available data for this goal focus on rates of substance use among children and young people. The findings would suggest that young people's drug use is reducing or 'holding steady' (p. 68). Nevertheless, the authors identify heavy episodic drinking among 15–16-year-olds as being of concern. They flag the Drug Prevalence Survey as an important source of information for this goal.[9] However, the latest wave of the survey had not been published at the time the review was written.

Goal 2: Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery
The review draws extensively on data from the National Drug Treatment Reporting System (NDTRS) for this goal. Key findings included:

• Since December 2018, over 90% of problematic substance users had accessed treatment in NDTRS services within

Focused policy assessment

a month of assessment for those aged 18 and over, and a week for those under the age of 18. This measure does not include the numbers of people waiting for assessment.

- 'Successful exits' from treatment averaged at 47% from 2014 to 2019, although there was variation across different substance and treatment types.

- The median number of years between starting to use drugs and entering treatment (lag) for those cases recording a successful exit dropped from 20 to 17 years in 2018, and remained at 17 years in 2019. This lag to treatment time may vary significantly by treatment type.

- Access to opiate substitution treatment (OST) rose steadily between 2014 and 2020. In 2014, the number in receipt of OST was approximately 9,300, rising to 9,974 by the end of 2019; in June 2020, it was 10,465. This latest increase can in part be explained by the services' response to the Covid-19 pandemic.

There is a gap in knowledge about problematic substance users who are not in contact with services. The authors argue that 'understanding the unmet need for services is important in interpreting much of the results under Goal 2 and as such the conclusions that can be drawn are constrained by this' (p. 69).[1]

Goal 3: Address the harms of drug markets and reduce access to drugs for harmful use
Key findings in relation to drug markets and access to drugs include:

- There was a downward trend in the number of recorded offences for cultivation or manufacture of drugs from 345 in 2014 to 192 in 2019.[10]

- The trend for offences for importation of drugs has remained relatively stable over the period 2014–2019.[10]

- Possession offences (possession for sale and supply and possession for personal use) have been increasing since 2015.[10]

- There has been an increase in the quantity (kg) of drugs seized in recent years, while the number of seizures has increased since 2017.

- Rates of driving while over the legal alcohol limit have reduced since 2017. However, the number of offences for driving while under the influence of drugs has risen over the same period. This is likely, at least in part, to be linked to changes in the testing system.[10]

Goal 4: Support participation of individuals, families, and communities
Due to poor availability of data, the only measure reported under Goal 4 was the uptake of treatment by members of the Irish Travelling, LGBTQI, and homeless communities. According to NDTRS data, members of the Travelling community increasingly do not take up treatment after being assessed (from 6% in 2014 to 10% in 2019); a similar trend was found among people who are homeless. Uptake of treatment for cases of individuals who are homosexual and bisexual has remained stable over the period.

Goal 5: Develop sound and comprehensive evidence-informed policies and actions
The only data to be analysed under Goal 5 came from the NDTRS. Between 2014 and 2019, there has been a small increase in the number of services providing treatment; however, the number who submit data to the NDTRS has been consistent at approximately 600 over the period.

Concluding comment on PI analysis
Similar to the expenditure analysis, the overarching message from the analysis of the PIs was that 'limitations in the availability of data has constrained the conclusions that can be drawn on the progress made under each goal, and in turn the overall performance of RHSR' (p. 70).[1] The authors also raised the question of attribution. Drug use and its causes are complex; therefore, any changes found are not necessarily attributable to RHSR.

Overall conclusions
The authors also draw conclusions based on their findings. These include:

- The available evidence base on the costs of drug and alcohol misuse is limited by data availability and is estimated using varied methodological approaches. There is a need to improve the reporting of labelled expenditure across Government Departments and to gain consensus about the best approach to estimating unlabelled expenditure in this area. The authors suggest that there is a need to unpack the expenditure data in a more systematic way to fully understand its limitations.

- The findings indicate that 'unlabelled expenditure and productivity costs contribute significantly to the overall economic burden of problem drug and alcohol use' (p. 6).[1] Therefore, it is an important element of any analysis to look at the value of policies in this field in terms of changes that may be brought about.

- Limitations in the availability and quality of data on the PIs have constrained the conclusions that could be drawn on the performance of the strategy. While some data will become available in the next phase of the strategy, in some cases PIs will need to be revised in order to more accurately reflect performance under that goal.

- The proportion of labelled expenditure could not be broken down by either that spent on health-led responses as opposed to criminal-led responses, or by strategic goal of RHSR. In addition, the limitations in the detail and quality of expenditure data (labelled and unlabelled) meant that the authors were unable to make an assessment of what had been achieved for expenditure to date by RHSR. The authors argue that addressing the limitations of the datasets are necessary steps for improved monitoring and future evaluation of RHSR and public expenditure on drug and alcohol programmes more generally.

Despite its limitations, this review represents a valuable step towards generating the economic evidence base upon which public policy on drug use can be evaluated. Overall, it highlights the need to improve the data collection process, to adopt PIs that are measurable for the remainder of the strategy's lifetime, and to agree the optimal methodological approach to analysing expenditure and PI-related data.

Focused policy assessment

continued

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1   Bruton L, Gibney S, Hynes T, Collins D and Moran P (2021) *Spending review 2021. Focused policy assessment of Reducing Harm, Supporting Recovery: an analysis of expenditure and performance in the area of drug and alcohol misuse.* Dublin: Government of Ireland. https://www.drugsandalcohol.ie/34729/

2   Department of Health (2017) *Reducing Harm, Supporting Recovery: a health-led response to drug and alcohol use in Ireland 2017–2025.* Dublin: Department of Health. https://www.drugsandalcohol.ie/27603/

3   Bretteville-Jensen AL, Costa Storti C, Kattau T, Mikulic S, Trigueiros F, Papamalis F, *et al.* (EMCDDA) (2017) *Public expenditure on supply reduction policies.* Brussels: Council of Europe. http://www.drugsandalcohol.ie/27458/

4   Health Research Board (2021) *Focal Point Ireland: national report for 2021 – drug policy.* Dublin: Health Research Board. https://www.drugsandalcohol.ie/25262/

5   Mongan D and Long J (2016) *Alcohol in Ireland: consumption, harm, cost and policy response.* HRB Overview Series 10. Dublin: Health Research Board. https://www.drugsandalcohol.ie/25697/

6   Hope A (2014) *Alcohol literature review.* Dublin: Department of Health. https://www.drugsandalcohol.ie/25324

7   Byrne S (2010) *Costs to society of problem alcohol use in Ireland: a report for the Health Service Executive.* Dublin: Health Service Executive. https://www.drugsandalcohol.ie/15781/

8   National Drug Intelligence Center (2011) *The economic impact of illicit drug use on American society.* Washington DC: US Department of Justice National Drug Intelligence Center. Available online at: https://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf

9   Mongan D, Millar SR and Galvin B (2021) *The 2019–20 Irish National Drug and Alcohol Survey: main findings.* Dublin: Health Research Board. https://www.drugsandalcohol.ie/34287/

10 The Central Statistics Office (CSO) publishes recorded crime statistics based on the provision of PULSE data by An Garda Síochána. Data are reported quarterly. The CSO publishes these data under the category 'under reservation'. This categorisation indicates that the quality of these statistics do not meet the standards required of official statistics published by the CSO.

National drugs strategy: midterm review and new strategic priorities

A midterm review of Ireland's national drugs strategy was published on 17 November 2021, entitled *Mid-term review of the national drugs strategy, Reducing Harm, Supporting Recovery and strategic priorities 2021–2025.*[1] It draws on a range of evidence sources to inform the strategic priorities and delivery structure for the remainder of the strategy's lifetime.

Context of review

Reducing Harm, Supporting Recovery included an action plan for the period 2017–2020.[2] This approach provided the opportunity for stakeholders to assess the progress of the strategy and its action plan at a midterm point. This assessment combined with any new and emerging issues were to be used to inform the development of actions for the second phase of the strategy's lifetime from 2021 to 2025. This approach was a recommendation of the rapid expert review that was carried out on the National Drugs Strategy 2009–2016.[3] It was found that having a longer-term action plan meant the actions could not be reactive to change in the drug situation over time, which contributed to an overall perception by stakeholders of a decline in that strategy's relevance and momentum over its duration.

Evidence sources

The midterm review presents evidence from five sources:

1   Examination of progress of the actions in the strategy for 2017–2020 (traffic light format)[4]

2   Stakeholder feedback, including a review of oversight structures (see accompanying Box)

3   Focused policy assessment of expenditure on drug and alcohol services[5]

4   Data on trends and indicators on drug and alcohol use[6]

5   Rapid assessment of the impact of the Covid-19 pandemic on drug and alcohol services[7,8]

These evidence sources are covered individually in articles in this or previous issues of *Drugnet Ireland*.

Stakeholder feedback on national drugs strategy

As part of the midterm review of the national drugs strategy, the Department of Health collected feedback from stakeholders represented on the National Oversight Committee (NOC) through 10 'engagement sessions' (p. 7).[1] Submissions were also received from 'groups outside the NOC' but no further information on how this information was collected is provided in the report. The engagement sessions were structured around three questions:

- How well is the strategy delivering on its goals?

- Are there specific areas/priorities that the strategy should focus on for the period 2021–2025?

- Are there ways in which the structures for the delivery of the strategy could be improved/strengthened?

Findings of review
The findings make up a significant part of the midterm review document (pp. 7–21). They are presented thematically and cover a wide range of topics, including those related to the structure of the strategy and its implementation bodies; ongoing and emerging needs; and monitoring, research, and evaluation associated with the strategy. It is beyond the scope

National drugs strategy midterm review   continued

of this article to present all of the issues covered; however, a selection of them are featured below.

- **The health-led approach:** Having the needs of the individual at the centre of the strategy was seen as key. The health-led approach was perceived to be a success. However, it was seen to be linked to the work of law enforcement to reduce the supply and availability of illicit drugs.

- **Evolving drug markets:** Stakeholders recognised that drug markets and drugs are continuously evolving and that keeping on top of new substances is an ongoing requirement. Resources such as the Early Warning and Emerging Trends subcommittee are seen as useful in this context. There was support for sustaining and increasing cooperation at an international level.

- **Alternative approaches to imprisonment:** There was support for the implementation of the Health Diversion Programme and the ongoing operation of the Drug Treatment Court. Progress on the Health Diversion Programme was seen as slow, while it was suggested that the Drug Treatment Court should undergo an independent review.

- **Alcohol:** Reducing Harm, Supporting Recovery is the first national drugs strategy to cover both alcohol and other drugs. However, there was criticism that alcohol did not receive adequate attention in the action plan for the period 2017–2020 and that this should be addressed in the remainder of the strategy's lifetime.

- **Alignment with other strategies:** The needs of a person who uses drugs tend to be complex and multifaceted. Government policies have been developing since 2017 and the report argues that the associated strategies need to be aligned as much as possible to meet these complex needs. These include national and international strategies across the range of sectors.

- **Collaboration:** Overall, the strategy was seen to have facilitated improved collaboration between relevant departments, agencies, and services. However, opportunities for improvement included the formation of a 'real partnership' (p. 12) between state agencies and affected communities, which in turn increases cooperation between youth services and drug services to meet the needs of 14–18-year-olds.

- **Drug and Alcohol Task Forces (DATFs):** There was a call for a strengthening of the role of DATFs. DATFs argued for a more visible role in the actions contained in the strategy. For example, they 'could bring together the community, family and service users which could have a positive impact on communication and participation and could also assist in identifying emerging needs' (p. 14).

- **Support for families and communities:** Ongoing support is required for building the capacity of communities to respond to the drugs situation. There is an increasing need to strengthen the response on drug-related intimidation and violence, which has such a negative impact on many communities.

There are many other topics covered in this section of the review; for example, research, stigma, diversity and inclusion, prevention and education, and dual diagnosis.

New strategic priorities and delivery structure

The main outcome of the midterm review is the development of six new strategic priorities for the remainder of the strategy. In addition to the five evidence sources listed above, the priorities were informed by an examination of other key strategic documents. These include the European Union (EU) Drugs Strategy 2021–2025; Sláintecare Implementation Strategy and Action Plan 2021–2023; Healthy Ireland Strategic Action Plan 2021–2025; and Programme for Government commitments.

Strategic priorities

The six strategic priorities will be delivered through specific actions, while progress will be measured though outcome indicators. An agreed list of actions and indicators will be developed for each priority. The six priorities are outlined below.

1   **To strengthen the prevention of drug and alcohol use and the associated harms among children and young people:** This will cover a variety of settings (school, community, and family) and will focus on increasing resilience and strengthening life skills and healthy life choices. Activity under this priority will be informed by the European Prevention Curriculum (EUPC) and the International Standards on Drug Use Prevention.[9,10]

2   **To enhance access to and delivery of drug and alcohol services in the community:** Delivery of this priority will be supported through the development of a drug services care plan across the six health regions. Particular focus will be put on ensuring access to services for women, people in rural areas, ethnic minorities, and the LGBTI+ community. This priority will consider models of care for people who use drugs and have comorbidities. It also aims to address the stigma linked to drug use and drug addiction and its impact on access and delivery of health services.

3   **To develop integrated care pathways for high-risk drug users to achieve better health outcomes:** This group includes people who are homeless, offenders, stimulant users, and people who inject drugs. It is argued that integrated care pathways that connect care settings (general practitioners, primary/community care providers, community specialist teams, and hospital-based specialists) are required to deliver the best outcomes for this cohort. A key outcome indicator will be the reduction in drug-related deaths among these people. The review identifies the experience of the Dublin Covid-19 homeless response as providing a template for the kind of integrated care response required. This priority will also involve strengthening harm reduction responses to high-risk drug use associated with the night-time economy and music festivals, including proposals for drug monitoring.

National drugs strategy midterm review   continued

4 **To address the social determinants and consequences of drug use in disadvantaged communities, including the Travelling community:** This priority will also tackle the criminality and antisocial behaviour associated with the drug trade and the negative impact it has on the communities in which it is based. To address these issues, action is required across Government to promote community development and community safety. Ensuring synergy with the Sláintecare Healthy Communities programme to address health inequalities will be a key objective.

5 **To promote alternatives to coercive sanctions for drug-related offences:** This priority will reinforce the health-led approach to people who use drugs, which is at the core of the national drugs strategy. The main focus will be on the rollout of the Health Diversion Programme for people in possession of drugs for personal use. Other initiatives, such as the Drug Treatment Courts, will also be supported. A particular emphasis will be on the exchange of best practice on alternatives to coercive sanctions with EU member states.

6 **To strengthen evidence-informed and outcomes-focused practice, services, policies, and strategy implementation:** This priority will facilitate the exchange of knowledge and expertise. Learning the lessons of the response to the Covid-19 pandemic will be a key theme. It will strengthen Ireland's contribution to best practice at EU level, in collaboration with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Health Research Board (HRB) Reitox national focal point. Service innovation will be identified from the network of drug and alcohol task forces.

Horizontal themes

The review also identifies five horizontal themes that will support delivery of the strategic priorities:

1 Involvement of service users in the design and delivery of services based on a human rights perspective and the promotion of health literacy

2 Active and meaningful participation of civil society in the development, implementation, and evaluation of policies and services

3 Good governance, accountability, and mutual respect by all partners

4 Cross-sectoral funding and the targeting of additional resources

5 Public sector equality and human rights duty[11]

Revised delivery structure

The findings of the review have led to changes being made to the structures supporting the implementation of the strategy (see Figure 1). The standing subcommittee and other subcommittees in place up until this midpoint in the strategy will be replaced by a strategic implementation group (SIG) for each of the priorities as well as a research subcommittee. The research subcommittee will oversee the research outputs of the strategy, including the national drug and alcohol survey, in conjunction with the HRB. The SIGs will reinforce cross-agency working and have an independent chair who will be a member of and report back to the National Oversight Committee. A service user and a nominee from both civil society and the task force network will be included in each SIG's membership. The Early Warning and Emerging Trends subcommittee will remain in place in keeping with the previous structure.
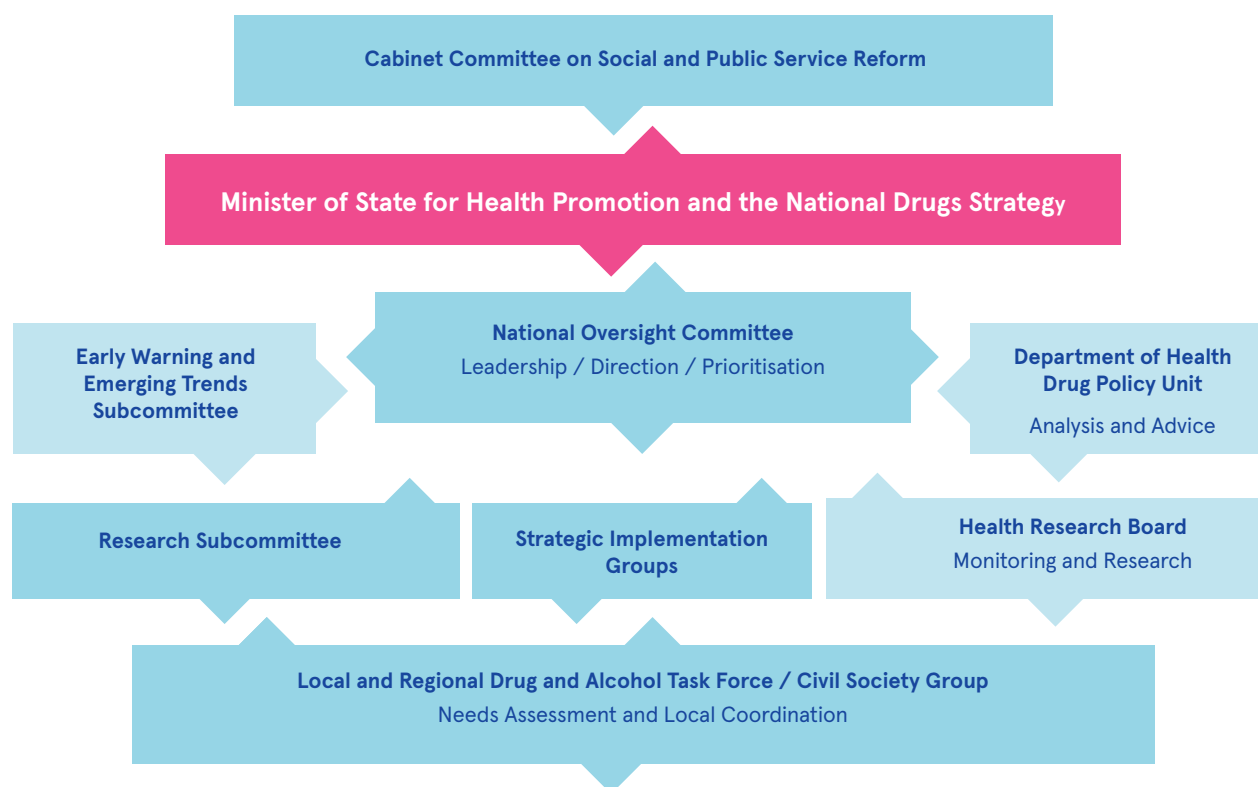

Figure 1: Coordination of bodies for the implementation of the national drugs strategy, 2021–2025 (p. 37)[1]

National drugs strategy midterm review   continued

Lucy Dillon

1   Drugs Policy and Social Inclusion Unit (2021) *Mid-term review of the national drugs strategy, Reducing Harm, Supporting Recovery and strategic priorities 2021–2025*. Dublin: Department of Health. https://www.drugsandalcohol.ie/35183/

2   Department of Health (2017) *Reducing Harm, Supporting Recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. https://www.drugsandalcohol.ie/27603/

3   Griffiths P, Strang J and Singleton N (2016) *Report of the rapid expert review of the national drugs strategy 2009–2016*. Dublin: Department of Health. https://www.drugsandalcohol.ie/27289/

4   Drugs Policy and Social Inclusion Unit (2020) *Reducing Harm, Supporting Recovery: progress report 2020*. Dublin: Department of Health. https://www.drugsandalcohol.ie/34857/

5   Bruton L, Gibney S, Hynes T, Collins D and Moran P (2021) *Spending review 2021. Focused policy assessment of Reducing Harm, Supporting Recovery: an analysis of expenditure and performance in the area of drug and alcohol misuse*. Dublin: Government of Ireland. https://www.drugsandalcohol.ie/34729/

6   Mongan D, Millar SR and Galvin B (2021) *The 2019–20 Irish National Drug and Alcohol Survey: main findings*. Dublin: Health Research Board. https://www.drugsandalcohol.ie/34287/

7   Bruton L, Featherstone T, Gibney S and Department of Health (2021) *Impact of COVID-19 on drug and alcohol services and people who use drugs in Ireland: a report of survey findings*. Dublin: Government of Ireland. https://www.drugsandalcohol.ie/34128/

8   Galvin B (2021) Impact of Covid-19 on drug and alcohol services and people who use drugs in Ireland: a report of survey findings. *Drugnet Ireland*, 78 (Summer): 14–15. https://www.drugsandalcohol.ie/34742/

9   European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019) *European prevention curriculum: a handbook for decision-makers, opinion-makers and policy-makers in science-based prevention of substance use*. Luxembourg: Publications Office of the European Union. https://www.drugsandalcohol.ie/31119/

10 United Nations Office on Drugs and Crime (UNODC)/World Health Organization (WHO) (2018) *International standards on drug use prevention*. 2nd updated edn. Vienna: United Nations Office on Drugs and Crime. https://www.drugsandalcohol.ie/30048/

11 All public bodies in Ireland have a responsibility to promote equality, prevent discrimination, and protect the human rights of their employees, customers, service users, and everyone affected by their policies and plans. This is a legal obligation, called the public sector equality and human rights duty, and it originated in Section 42 of the Irish Human Rights and Equality Commission Act 2014. For further information, visit: https://www.ihrec.ie/our-work/public-sector-duty/

Report of the Night-Time Economy Taskforce

The *Report of the Night-Time Economy Taskforce* was published in September 2021 in response to a sector badly impacted by the Covid-19 pandemic.[1] Pubs, clubs, and other businesses dependent on the night-time economy closed for long periods of time in response to national and regional lockdowns. This report is a result of collaboration from a range of Government Departments and agencies whose remit covers aspects of the night-time economy. These include the Department of Tourism, Culture, Arts, Gaeltacht, Sport and Media; the Lord Mayors of Dublin and Cork; the Department of Justice; the Department of the Environment, Climate and Communications; the Department of Transport; the Department of Rural and Community Development; the Department of Housing, Local Government and Heritage; the Department of Enterprise, Trade and Employment; the National Transport Authority; An Garda Síochána; Fáilte Ireland, and more. An intensive stakeholder engagement process with relevant sectors and interested parties with a role in the sector also contributed to the contents of the report.

Recommendations to revive the sector

In the report, a range of actions (36 in total) is recommended in order to revive the sector, defined as 'the diverse social, cultural and economic activity occurring during specified evening and night-time hours' (6 pm to 6 am) (p. 8). The recommendations include encouraging diversity and inclusivity, modernising licensing laws, creating a strong sense of safety, creating new and dynamic structures to develop vibrant and tailor-made local night-time economies, among others, but ultimately to maintain supports for the night-time economy as it makes the journey out of Covid-19 restrictions.

Key challenges and recommendations from the report were to extend opening hours in the national cultural institutions, to use more existing venues for late-night use, and to encourage more outdoor activities. Existing licensing arrangements are referred to several times in the report as a key challenge for the sector, and recommendations are made to modernise and streamline licensing arrangements and application processes to help businesses selling alcohol to grow and potentially diversify. By reforming liquor licensing, the taskforce believes that it will make it easier for cultural venues such as theatres, galleries, and exhibition spaces to get licences. Thus, the range of night-time and cultural offerings can be broadened and diversified.

Sale of Alcohol Bill

The taskforce welcomed the proposed Sale of Alcohol Bill governing Ireland's licensing laws that was expected to be published in 2021 and indeed was shortly after the report's publication. The Bill intends to modernise and update Ireland's licensing laws, thereby supporting the night-time economy. The Bill aims to repeal the Licensing Acts and the Registration of Clubs Acts in their entirety and to replace them with updated and streamlined provisions more suited to the 21st century. Key reforms will include:

- **New proposed licences:** The Department of Justice will work with stakeholders to develop these new licences but they will include arrangements for catering, guesthouses, and nightclubs.

Night-Time Economy Taskforce

continued

- **Nightclubs and late bars:** There will be annual permits for nightclubs and late bars, rather than the existing process of having to apply for special exemption orders.

- **Trading hours:** There will be an examination of trading hours for alcohol sales for consumption on premises but also in off-licences to order to streamline the processes; there will be provision for more appropriate extensions as part of the reformed licensing package; and trading hours, particularly on a Sunday, will also be examined.

- **Modernising application systems:** The application system will be modernised, reducing costs for businesses and reducing pressure on the Courts system. It is the intention of this legislative reform to significantly reduce Court appearances.

The taskforce expects that the proposed amendments in the Bill will encourage diversity and new economic opportunities in the night-time economy. In the interim, the taskforce proposes the abolition of the special exemption orders process.

Alcohol-free venues

The taskforce highlights that in its endeavour to revive the sector it should not mean an increase in antisocial behaviour or misuse of alcohol and/or misuse of drugs. The consultation process raised the importance of the provision of alcohol-free venues; recommendations are therefore made for more venues and cultural activities that do not involve the sale of alcohol to be encouraged and supported, particularly café culture.

Other recommendations

Other challenges and recommendations in the taskforce report include:

- There should be enhancement and use of the public realm, that is, innovative use of public open spaces, including supporting and incentivising businesses to open late.

- Noise regulation, an inevitable knock-on effect of a vibrant night-time economy, should be considered. A noise regulatory review should be undertaken to consider the most effective approach to addressing this issue.

- The public event permit application process should be standardised for events involving less than 5,000 people and which falls outside the realm of the Planning Acts.

- A pilot project of night-time economy advisors and night-time economy committees in six cities/towns across Ireland should be established.

- The issue of safety at night was also raised throughout the consultation process. Safeguards should be put in place to protect women and other vulnerable people engaged in night-time economy activities. Community safety partnerships and joint policing committees should include night-time economy issues in their operations, and best practice safety campaigns for promoting across businesses operating in the night-time economy throughout the country should be implemented.

- Public transport also features as an essential support for the sector. New 24-hour routes in Dublin City and additional transport services in rural areas should be established.

- Short and longer (post Covid-19) actions should support the night-time economy sector, including funding to support extended hours of opening of cultural institutions in the short term and longer term, recognising the importance of solutions and ideas coming from the ground up with interventions to stimulate night-time economy activity being based on the needs of the town/city area identified.

Conclusion

Further consultations with key stakeholders, Government Departments, and agencies are required to address the wide range of challenges and opportunities associated with the night-time economy. A representative implementation group will be established to review progress on the recommendations contained in the report.

Anne Doyle

1   Night-Time Economy Taskforce (2021) *Report of the Night-Time Economy Taskforce*. Dublin: Department of Tourism, Culture, Arts, Gaeltacht, Sport and Media. https://www.drugsandalcohol.ie/34846/

Making the European Region SAFER: developments in alcohol control policies, 2010–2019

A report by the World Health Organization (WHO), *Making the WHO European Region SAFER*, provides an overview of alcohol-attributable burden of disease in the WHO European Region.[1] It also updates the changes in alcohol consumption between 2010 and 2016 and provides guidance for countries to implement high-impact alcohol policies.

The report analyses the implementation of alcohol control policies of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (EAPA), focusing on the five high-impact strategies of the WHO-led SAFER initiative:

1 **S**trengthen restrictions on alcohol availability

2 **A**dvance and enforce drink-driving countermeasures

3 **F**acilitate access to screening, brief interventions, and treatment

4 **E**nforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion

5 **R**aise prices on alcohol through excise taxes and pricing policies.

Alcohol use in WHO European Region
According to the report, almost no progress was made in the WHO European Region towards implementing these evidence-based, effective alcohol control measures, while levels of consumption remained higher than in any other WHO region worldwide. Although, overall, there was a decrease in per capita alcohol consumption in the WHO European Region (from 11.2 litres per capita in 2010 to 9.8 litres in 2016), these improvements were limited to mainly countries in the eastern part of the region, where the level of alcohol-attributable harms remains very high. Of the 51 member states of the region, 34 countries reported decreases in alcohol consumption between 2010 and 2016. However, Ireland was one of 17 countries where an increase was noted. Ireland ranked fifth for levels of alcohol use in member states in 2016, a 5.6% increase from 2010. Although the impact of Covid-19 may have led to an overall reduction in alcohol consumption in the region, the report advises that current projections estimate that there will be little change in alcohol consumption in the next decade.

Prevalence of heavy episodic drinking (HED), defined as 60 grams or more of pure alcohol on at least one occasion over the previous 30 days, declined by 16.3% on average between 2010 and 2016; the overall prevalence of HED was 26.4% in the adult (15+ years) population. However, Ireland was one of a number of countries that reported higher than the member state average for HED.

Alcohol-attributable mortality
Overall, there was a decrease from 2010 to 2016, although one in 10 deaths among adults in the WHO European Region were alcohol attributable (i.e. deaths that would not have occurred in the absence of alcohol use). Among those aged 20–24 years, this increased to one in four deaths (23.3%). Of alcohol-attributable deaths, 14.3% were caused by cancer. In Ireland, there was little change in the percentage of alcohol-attributable fractions of all-cause deaths between 2010 and 2016.

Overall, a decrease in alcohol-attributable disability-adjusted life years (DALYs) was noted from 2010 (40 million) to over 30 million in 2016 in the WHO European Region. The largest proportions of alcohol-attributable mortality were observed in Eastern European countries. However, these were also the countries with the largest relative reductions in alcohol-attributable mortality and alcohol consumption between 2010 and 2016. The report noted that Eastern European countries experienced greater harm despite similar or lower levels of drinking.

Implementation of SAFER initiative
The average implementation of the WHO's SAFER effective and cost-effective measures for alcohol policies in the WHO European Region was poor. In 2016, of the five SAFER key areas, only drink-driving countermeasures were well implemented in the WHO European Region (80%). However, implementation of other measures was generally poor, specifically those related to the WHO 'best buys' (i.e. increasing taxes on alcohol, banning alcohol advertising, and restricting the availability of alcohol) and health service responses (i.e. provision of screening and brief interventions for alcohol and treatment of alcohol use disorders). Pricing policies were the worst-performing policy area in the region (17%) in 2016, despite being the most cost-effective type of policy and recognised as a best buy measure to reduce the disease burden. In fact, in the region, overall, alcohol had become increasingly affordable due to a failure to adjust alcohol taxes for inflation. Furthermore, a snapshot of the policy indicators for the year 2019 showed that little progress had been made between 2016 and 2019 in the implementation of alcohol control measures.

Conclusion
The report concludes that more decisive action is needed to reduce alcohol intake as a modifiable risk factor and alcohol-attributable harms as a completely preventable component of the disease burden. Covid-19 has disrupted our way of living immensely and an increase in alcohol consumption could be caused by rising levels of anxiety and other mental health problems related to stress. However, it is still too early to gauge the long-term impact of Covid-19 on people's drinking patterns.

Although commercial operators are making the case for less, not more, regulation of alcohol, the available evidence strongly opposes the notion that economies can recover while neglecting the health of their populations through inadequate regulation of alcohol. The SAFER initiative underlines that a healthy economy is driven by a healthy population and that to improve the health of all Europeans we need a reinvigorated commitment to tackling all causes of preventable ill-health, including alcohol. WHO's European Programme of Work 2020–2025 envisages a world where the vulnerable are protected, no one is left behind, and people are enabled to live safer, healthier, and better lives.

Anne Doyle

1   WHO Regional Office for Europe (2021) *Making the WHO European Region SAFER: developments in alcohol control policies, 2010–2019*. Copenhagen: WHO Regional Office for Europe. https://www.drugsandalcohol.ie/34060/

i-mark initiative – supporting independence from alcohol industry influence

The i-mark initiative of supporting independence from alcohol industry influence was developed by the Irish Community Action on Alcohol Network (ICAAN). ICAAN is encouraging organisations to sign up to the initiative, join the movement, and use the i-mark logo in their work. In doing so, organisations can demonstrate their independence from alcohol industry influence and funding.

Rationale for initiative

The i-mark was developed in response to concerns about the conflict between the motives of the alcohol industry and the health and wellbeing of the population as well as the growing influence of the alcohol industry in the areas of partnership, policy, and school-based education.

These connections allow the alcohol industry to gain access to Government and non-governmental organisations and to provide an opportunity to promote solutions to alcohol-related harms and to undermine proven effective measures. Corporate philanthropy and sponsorship have also been used as a way of gaining support from the charity, community, and voluntary sectors while also building trust among the public.

i-mark toolkit

The accompanying i-mark toolkit has been developed as a resource aiming to empower and support organisations by informing them of the impact the alcohol industry has in influencing alcohol policies and actions. Through the toolkit, ICAAN supports those organisations that sign up to the i-mark to be independent from the alcohol industry. This is achieved by means of:

- Education – on the conflict of interest in working with the alcohol industry
- Measures – to be taken to reduce the influence of the alcohol industry
- Connections – how organisations can work together to reduce alcohol harm.

The toolkit includes a checklist of questions for organisations contemplating using alcohol industry-funded educational resources or accepting funding from the alcohol industry. These questions aim to build awareness and encourage organisations to think about the potential consequences and impact of accepting funding or using their resources.

The toolkit also includes examples of alcohol industry misinformation and confusion regarding alcohol harms.

Examples in the toolkit include research reviewing an alcohol industry-funded campaign, intended to highlight alcohol-related harm, which found that the campaign was focused on public opinion rather than scientific evidence.[1] International evidence reveals how the alcohol industry provides misleading information about the cancer risks relating to alcohol and of the risks of alcohol consumption during pregnancy.[2]

In Ireland, the alcohol industry's determined campaign against the Public Health (Alcohol) Act 2018 is evident from the lobbying register record of the number of meetings between drinks industry lobbyists and Government ministers, senior officials, and Oireachtas members during the year in which the Act was passed.

Work of ICAAN

ICAAN is convened and supported by Alcohol Forum Ireland since 2017 and their joint mission is to 'create and inspire change by working with individuals, families and communities to prevent and reduce the harm caused by alcohol'.[3] ICAAN is part of a growing global movement working to reduce the influence of the alcohol industry on people's lives and the lives of their children. In promoting the i-mark, ICAAN is engaging the charity, community, voluntary, statutory, and education sectors in why it is needed.

Support for i-mark

The initiative has been supported and indeed launched by global expert, Professor Thomas Babor, alcohol policy adviser to the World Health Organization (WHO) as well as editor of the *Journal of Studies on Alcohol and Drugs*. i-mark is also supported and promoted globally by Movendi International, an independent global movement that aims to 'strengthen and empower civil society to tackle alcohol and other drugs as serious obstacles to development on personal, community, societal and global levels'.[4]

Anne Doyle

1   Petticrew M, Maani Hessari N, Knai C and Weiderpass E (2018) How alcohol industry organisations mislead the public about alcohol and cancer. *Drug Alcohol Rev,* 37(3): 293–303. https://www.drugsandalcohol.ie/27944/

2   Lim AWY, van Schalkwyk MCI, Maani Hessari N and Petticrew MP (2019) Pregnancy, fertility, breastfeeding, and alcohol consumption: an analysis of framing and completeness of information disseminated by alcohol industry-funded organizations. *J Stud Alcohol Drugs*, 80(5): 524–533. https://www.drugsandalcohol.ie/31220/

3   Alcohol Forum (2018) About Alcohol Forum – Our Mission. Letterkenny, Co Donegal: Alcohol Forum. Available online at: https://alcoholforum.org/about-us/

4   Movendi International (n.d.) Development Through Alcohol Prevention. Stockholm: Movendi International. Available online at: https://movendi.ngo/

To sign up

For further information and to sign up for the i-mark, visit

https://alcoholforum.org/i-mark

Alcohol marketing during the 2020 Six Nations Championship: a frequency analysis

November 2021 saw the implementation of Section 15 of the Public Health (Alcohol) Act 2018, which prohibits alcohol advertising in or on a sporting area in Ireland. This component of the Act along with other measures yet to commence, including content of advertising and a broadcast watershed, are intended to limit the exposure of alcohol marketing to children and young people in order to reduce the promotion of alcohol. This forms part of Ireland's commitment to reduce overall alcohol use and to protect children from alcohol marketing.

Study objectives

To highlight the extent of alcohol marketing during popular sporting events prior to the implementation of Section 15, Alcohol Action Ireland in partnership with the Institute of Alcohol Studies (IAS) in London and the Scottish Health Action on Alcohol Problems (SHAAP) have published a report examining the frequency and nature of alcohol marketing (verbal and visual references to alcohol) during televised broadcasts of the 2020 Six Nations Championship, an international rugby union tournament.[1] The tournament is currently broadcast in more than 180 countries worldwide, reaching a combined audience of over 125 million.

The authors sought to examine how Section 15 of the Public Health (Alcohol) Act 2018 might influence alcohol marketing practice during televised sport and also to examine how France's Évin Law impacts on the frequency and nature of marketing during the tournament. The Évin Law prohibits alcohol advertising in France in sporting events since 1991. In the United Kingdom (UK), there is no legislative restrictions on alcohol sport sponsorship and activities are self-regulated by the alcohol industry instead.

Methods

Content analysis of four matches was undertaken. These involved two played in Ireland (vs Scotland and vs Wales); one in Scotland (UK) (vs England); and one in France (vs England).

Findings

The authors found that in the match played in the UK, alcohol marketing was most frequent, with an average of five alcohol references per broadcast minute (961 alcohol references or one every 12 seconds). The two matches played in Ireland closely followed, with an average of four alcohol references per minute (754 [vs Wales] and 690 [vs Scotland] or one alcohol reference every 16 seconds and every 15 seconds, respectively), while in France, there was one alcohol reference every minute (193 alcohol references). There were no age restriction warnings in any of the broadcasts and a minority had clearly visible, responsible drinking messages.

The majority of alcohol references were observed within the sporting area, during game time and in high-profile locations, such as static logos on the pitch and logos on the ball and goalposts. In Ireland and Scotland, alcohol references contained explicit branding; however, in France, 'alibi' marketing was used in order to adhere to the Évin Law. Examples of this are using the word 'Greatness' as opposed to the brand name Guinness in the familiar fonts and colours.

Conclusions

The findings suggest that for Ireland, implementation of Section 15 has the potential to reduce alcohol marketing during sporting events. It prohibits some frequently used marketing activities, for example, the highly visible static logo in the middle of the pitch that was commonly shown. However, the report also indicates that alcohol marketing already appears in a variety of other locations that are not restricted by Section 15 controls, for example, pitch-side advertising and advertising placed around the stadium structure. These places, which fall outside the sporting area stipulated by Section 15 of the Act, allow for alcohol advertising to be displayed in prominent areas, meaning that alcohol marketing is still very visible during sporting events.

The results also highlight how the Évin Law in France was evaded through the use of alibi marketing. Questions therefore remain over the monitoring and enforcement of the French law, a finding which has implications for the changing context in Ireland and any consideration of controls in the UK. For policymakers and regulators in Ireland overseeing the restrictions, the report highlights important matters, specifically whether alibi marketing will also be restricted under the wording of the legislation and what arrangements are in place to monitor and enforce the restrictions.

Anne Doyle

1   Purves R and Critchlow N (2021) *Alcohol marketing during the 2020 Six Nations Championship: a frequency analysis*. Stirling: Institute for Social Marketing and Health. https://www.drugsandalcohol.ie/34911/

PREVALENCE AND CURRENT SITUATION

Adolescent Addiction Service report, 2021

The Adolescent Addiction Service (AAS) of the Health Service Executive (HSE) provides support and treatment in relation to alcohol and drug use for young people and families from the Dublin suburbs of Ballyfermot, Clondalkin, Palmerstown, Lucan, and Inchicore. Services provided include advice, assessment, counselling, family therapy, professional consultations, and medications if required. In 2021, AAS published a report detailing referrals for 2020.[1]

Referrals

In 2020, AAS worked with 40 young people and their families, with a mean age of 15.4 years (range: 14–19 years). This figure includes new referrals, re-referrals, and continuances. In comparison to 2019, referrals were down by 18%. However, the decline in numbers should be viewed within the circumstances of the Covid-19 pandemic. The majority of young people were male (82%), while 13% were non-Irish nationals. In terms of referral areas, the greatest numbers of referrals were from Clondalkin followed by Lucan, Ballyfermot, Palmerstown, and Inchicore.

Drug and alcohol use

Cannabis (weed) continued to be the main substance used by clients, with an overall use rate at 100%, while alcohol use was at 69% (see Figure 1). Other substances of use included cocaine (26%), benzodiazepines (24%), and amphetamines (7%). Solvents and head-shop-type products did not feature among young people's substance use in 2020.

Other issues

Other issues that presented related to absconding, indebtedness, and holding, distributing or dealing drugs. Some young people had social work involvement and 39% had been assigned a juvenile liaison officer at some stage. The majority of young people (95%) were seen by a family therapist only, with 5% having a psychiatric assessment. No young person was prescribed medication within the service in 2020.

Conclusions

The report authors noted that, as in previous years, most young people had established patterns of substance use prior to referral and, as a consequence, some struggle to maintain a drug-free status. Nevertheless, most achieve stability and several remain abstinent. They concluded that there is a need for parents and non-parental adults to identify young people within risk groups at an early stage and to elevate concern for them.
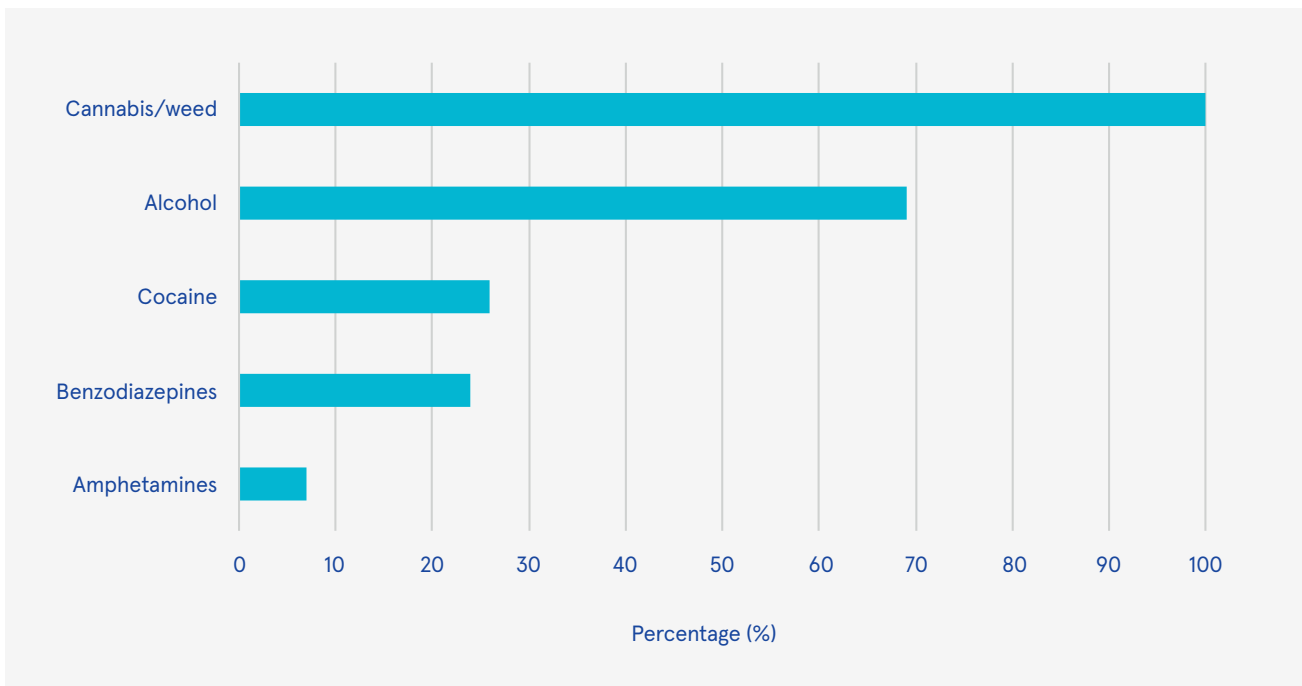
Source: HSE AAS (2021)

Figure 1: Main substances used by AAS clients, 2020

Seán Millar

1   Adolescent Addiction Service (2021) *Adolescent Addiction Service report 2021*. Dublin: Health Service Executive. https://www.drugsandalcohol.ie/34099/

Awareness of alcohol marketing one year after initial implementation of Ireland's Public Health (Alcohol) Act and during the Covid-19 pandemic

Following a protracted process, the Public Health (Alcohol) Act was signed into law in October 2018. The Act introduced new controls on alcohol marketing (which commenced in November 2019) with restrictions on some outdoor and cinema advertising as well as a ban on public transport advertising. Widespread evidence indicates that exposure to alcohol marketing is causally linked to consumption, including higher-risk drinking; however, to date, much of the research has focused on younger people. There is comparatively less understanding about the reach and impact of marketing on adults, including vulnerable groups. There is also a lack of consumer research examining the impact that legislation has on marketing awareness and the association with consumption.

A 2021 study by Critchlow and Moodie examined marketing awareness using repeat cross-sectional surveys in two waves.[1] Wave 1 was carried out in October 2019 one year after the initial implementation but before the restrictions were commenced, and wave 2 in October 2020. As well as examining the impact that marketing controls implemented in November 2019 had on marketing awareness among adult consumers, the study also examined the impact of the Covid-19 pandemic on alcohol marketing awareness. The authors also examined whether alcohol marketing awareness is associated with higher-risk alcohol consumption. Alcohol use – measured as frequency of consumption, standard drinks consumed on a typical drinking occasion, and frequency of heavy episodic drinking (HED) – was recorded through the Alcohol Use Disorders Identification Test-Concise (AUDIT-C).

Changes in alcohol consumption

The study found no difference between waves for the proportion of participants who were current drinkers, the proportion of current drinkers who reported at least monthly HED, and the proportion of drinkers categorised as higher risk.

Changes in where alcohol marketing was seen

When recalling where alcohol marketing was seen in the past month, respondents' awareness decreased from 94.1% in wave 1 participants to 93.8% in wave 2 participants, for nine of the 13 marketing activities measured, albeit with small effect sizes. These decreases included activities at least partly restricted in November 2019. They included:

- Awareness of alcohol marketing on public transport decreased from 65% in wave 1 to 55% in wave 2.
- Awareness of marketing through posters and billboards decreased from 77% to 69% between waves.
- Awareness of alcohol marketing in the cinema decreased from 37% to 27%.

No change was observed for catch-up or streaming services, social media, special price offers, and branded merchandise.

Changes in how often alcohol marketing was seen

When recalling how often alcohol marketing was seen in the past month, there was a significant decrease in aggregate past-month awareness between wave 1 and wave 2. However, again, the effect sizes were small. As with recalling where alcohol marketing was observed, the decrease in frequency of alcohol marketing was observed in nine of the 13 activities measured at both waves. Awareness was lower in 2020 compared with 2019 in public transport, posters and billboards, and cinema. No change was observed for catch-up or streaming services, social media, radio, and branded merchandise.

However, awareness of alcohol marketing remained high, with the majority of participants recalling at least one form of alcohol marketing; at least one-half reported seeing 74 or more instances in the past month.

Association between alcohol marketing and consumption

Among current drinkers, there was an association between marketing awareness and higher-risk drinking across waves. In particular, current drinkers who reported medium or high past-month awareness were more likely to report at least monthly HED than current drinkers reporting low awareness.

Discussion

This study found that overall awareness and frequency of marketing activities subject to new restrictions from November 2019 decreased.

The Covid-19 pandemic had an impact in reducing where and how often respondents recalled alcohol marketing in activities that were not subject to new legislative restrictions. This decrease was evident in marketing awareness during sporting events, as the pandemic led to cancellations and limited or no spectators. Other activities, such as adverts on catch-up and streaming services or social media, saw no decrease, which was expected as they are viewed within the home. These findings highlight how alcohol marketing was still able to reach consumers during the pandemic and may also partially explain the sustained levels of alcohol consumption throughout the pandemic found in this study.

Despite the overall reduction in awareness and frequency of alcohol marketing reported at both waves, at least one-half of the participants reported seeing marketing 2–3 times per day or more in the past month; over nine out of 10 participants recalled seeing at least one form of marketing at wave 2; and increased awareness was associated with at least monthly HED and higher-risk drinking. These trends are consistent with research that suggests adults are important targets for alcohol marketing. They also support Ireland's approach for introducing measures that reduce population-level exposure to marketing as well as targeted restrictions among young people.

Awareness of alcohol marketing

continued

The authors recommend a precautionary interpretation of the findings, as the initial controls and the Covid-19 restrictions likely contributed to decreases in awareness. Despite the limitations, this is the first study to examine awareness of alcohol marketing before and after the introduction of the new legislation and how the pandemic influenced alcohol marketing awareness among adults. It thus contributes new evidence about adults' experience of alcohol marketing.

Anne Doyle

1   Critchlow N and Moodie C (2021) Awareness of alcohol marketing one year after initial implementation of Ireland's Public Health (Alcohol) Act and during the COVID-19 pandemic. *J Public Health*, Early online. https://www.drugsandalcohol.ie/34954/

Prison visiting committees annual reports, 2019

A visiting committee is appointed to each prison in Ireland under the Prisons (Visiting Committees) Act 1925 and the Prisons (Visiting Committees) Order 1925. Members of the 12 visiting committees are appointed by the Minister for Justice for a term not exceeding three years. The function of prison visiting committees is to visit, at frequent intervals, the prison to which they are appointed and hear any complaints that may be made to them by any prisoner. They report to the Minister for Justice regarding any abuses observed or found, and any repairs which they think are urgently needed. Prison visiting committee members have free access, either collectively or individually, to every part of the prison to which their committee is appointed. Information from prison visiting committee reports relating to drug use in prisons for 2019 is summarised below.[1]

Mountjoy Prison, Dublin
In its report, the Mountjoy Visiting Committee noted that the risks of substance abuse are the most pervasive and persistent problem spoken about on a weekly basis in the prison by staff and prisoners. Physical outbursts, injury to prisoners and on occasion staff, fear and intimidation in prison, and involving family members in the community, are all a feature of this major challenge for the prison service. A number of factors, including lack of sufficient drug treatment programmes, insufficient capacity in staffing resources in therapeutic services, and safe drug-free accommodation while in prison and on release, are militating against those who might wish to avail of drug treatment programmes. The committee observed the need for a multiagency integrated approach to rehabilitation prison services identified in the strategic plan 2018–2020, and that this requires greater coordination and prioritising, particularly in the provision of services for vulnerable prisoners and those with addiction difficulties.

Dóchas Centre, Dublin
The Dóchas Visiting Committee noted in its report that the issue of illegal substance use continues to be a problem. There have been several instances where women have brought drugs into the prison on return from temporary release which were then passed on to other women in the centre. These resulted in some women becoming ill, having seizures, and on occasion

being hospitalised. The issue of drug use continues to be a major cause of concern to the prison governor and staff and appears to be on the increase.

Wheatfield Prison, Dublin
The Wheatfield Place of Detention Visiting Committee's report observed that the Wheatfield yards are large spaces. Although the yards are covered with netting in order to prevent drugs and objects being thrown over the perimeter wall, this continues to be a considerable difficulty for the authorities in Wheatfield Prison. The committee recommended that more netting and a solution to the security of the perimeter wall are essential to prevent illicit contraband entering the prison. The committee also noted that illicit drugs continue to be a serious and ongoing difficulty both for the prison authorities and also for prisoners and their families. Despite the best efforts of the prison authorities, scanners, sniffer dogs, X-ray and bags searches, and the perimeter wall being monitored daily, drugs continue to enter the prison.

Cloverhill Prison, Dublin
In its report, the Cloverhill Visiting Committee noted that the issue of drugs and security measures at Cloverhill remains a deep concern. In particular, access to drugs from one source, namely the wall in the exercise yard of the prison, continues to be a considerable problem. The committee proposed that additional serious and concentrated resources be made available to deter these attempts to supply illegal substances to inmates.

Cloverhill has a large number of prisoners with drug-related conditions and the numbers of prisoners attending the methadone clinic continues to be high. While figures can vary, the prison medical centre reported that attendance numbers can range from 150 to 190 inmates. Because of the vital role of addiction counselling in the recovery and future rehabilitation of prisoners, the committee recommended, as a priority, that the number of counselling staff be increased to allow prisoners to avail of the service at the earliest possible stage of their remand period.

Arbour Hill Prison, Dublin
The Arbour Hill Visiting Committee's report noted that incidents relating to drugs within the prison remained exceptionally low in 2019, and complimented the prison management and staff on this matter. Arbour Hill remains fully committed to ensuring that the prison remains drug-free. All prisoners are fully aware that they are expected to be 100 per cent drug-free and access to the prison's facilities and services depend on this. Random drug testing is part of the day-to-day routine at the prison.

Prison visiting committees reports   continued

Cork Prison, Cork

The Cork Prison Visiting Committee's report heard that one of the big issues affecting Cork Prison in 2019 was the availability of drugs within the prison. The committee suggested that the purchase of a full-body scan X-ray should be investigated, as this might help to reduce the number of drugs coming into the prison.

Shelton Abbey Prison, Co. Wicklow

The Shelton Abbey Visiting Committee's report noted that a full-time addiction counsellor was appointed in 2017, who is respected by offenders and regarded as a trusted listener, and who continues an induction/awareness meeting with all new committals. A number of addiction-related programmes took place at Shelton Abbey during 2019.

Midlands Prison, Co. Laois

The Midlands Prison Visiting Committee was informed that a general practitioner (GP) addiction specialist holds weekly sessions as part of the drug treatment service within the prison. In addition, the addiction counselling service in the prison is supported by Merchants Quay Ireland and includes one-to-one counselling and assessments. Nevertheless, the committee noted that there are never more than two addiction counsellors available in the prison – the largest prison in Ireland – at any one time and suggested that this is woefully inadequate and must inevitably lead to delays and support in the treatment of some very vulnerable prisoners.

Seán Millar

1   Department of Justice (2021) Prison Visiting Committee annual reports 2019 [Arbour Hill Prison, Castlerea Prison, Cloverhill Prison, Cork Prison, Dóchas Centre, Limerick Prison, Loughan House, Midlands Prison, Mountjoy Prison, Portlaoise Prison, Shelton Abbey Prison, Wheatfield Prison]. Dublin: Department of Justice. https://www.drugsandalcohol.ie/33654/

Students' perceptions of Responding to Excessive Alcohol Consumption in Third-level (REACT)

Responding to Excessive Alcohol Consumption in Third-level (REACT) is an award and accreditation scheme for third-level institutions that carry out a set of activities to reduce alcohol-related harm among its students in Ireland.[1,2,3] A new study has been published based on qualitative data collected as part of the programme's evaluation, entitled 'College students' perspectives on an alcohol prevention programme and student drinking – a focus group study'.[4]

The REACT programme

In 2014, the Health Service Executive (HSE) commissioned a research team to develop a public health intervention to address alcohol use among third-level students. REACT is a multicomponent intervention which has established an award and accreditation system for institutions that make 'significant changes within their campuses to tackle the growing issue of excessive alcohol consumption among students' (p. 2).[2] As such, it is an environmental rather than an educational initiative. Participating institutions are required to carry out activities from a suite of mandatory and optional action points.[3] Examples of the mandatory action points are to develop a college alcohol policy; train relevant staff in brief intervention therapy on alcohol misuse; encourage incoming students to take an online brief intervention tool; and form a steering committee to be chaired by a senior college official with representation from students, staff, Gardaí, the local council, and the Local Drugs and Alcohol Task Force. By August 2019, some 10 institutions had received the REACT award.[5]

Study aim

When reviewing the national and international literature, Calnan and Davoren[4] found limited previous research on students' perspectives of interventions designed to reduce alcohol consumption and related harms among college students. However, they found growing consensus in the literature that good intervention development takes account of the views of the target audience to ensure the interventions are 'engaging, relevant and useable' (p. 2). Their study aimed to fill this gap by examining students' perceptions of alcohol prevention measures and consumption more generally.

Methodology

Qualitative focus groups were carried out in two colleges participating in the REACT programme in 2018: one rural institute of technology and one urban-based university. Participants were purposively sampled to include young undergraduates, mature students, international students, and students who are members of a club or society. Purposive sampling as a method produces a sample that can map the range of experiences in relation to a certain topic, based on expert knowledge of the population and topic of interest. The authors selected the two institutions to capture the variation in college settings. Different categories of students were selected, as earlier research from the REACT evaluation found differences in alcohol consumption based on age and nationality of students, as well as their membership of a college club or society.

To inform the discussion, participants received information about the REACT programme prior to the focus group. Topics covered in the groups included the REACT programme, college drinking more generally, and what activities participants would recommend to address students' hazardous drinking.

Theoretical framework

The authors placed the study's findings within the context of the international literature on students' alcohol use and prevention and the Irish alcohol policy landscape. While a detailed description of these is beyond the scope of this article, the theoretical framework adopted by the authors should be considered. A social-ecological model of prevention, as used by the Centers for Disease Control and Prevention (CDC),[6] identifies four levels of influences:

Third-level alcohol consumption

continued

- Societal (e.g. national policy on alcohol regulation, societal attitudes to alcohol)
- Community (e.g. easy availability of alcohol, institutional policies related to alcohol, college setting)
- Relational (e.g. peer group or family influences on alcohol-related behaviours)
- Individual (e.g. age, nationality, beliefs about alcohol norms).

This model recognises that the causes and solutions to college students' excessive drinking require a comprehensive approach that takes account of each of the four levels outlined above.

Findings

The study's findings illustrate the complex nature of alcohol use among college students, its role in Irish culture, and the challenges facing prevention interventions in the third-level context. Three broad themes were found in the analysis and some of the key findings are outlined below.

1. Perceptions of student drinking

- **Pervasiveness of alcohol:** Drinking was perceived to be endemic in third-level institutions. It is facilitated by numerous community-level factors, such as easy access to cheap alcohol in supermarkets, a high density of pubs in the environs of campuses, and a tendency in some cases for underage drinking to go unmonitored.

- **Transient nature of drinking:** While endemic in college, heavy drinking was also perceived to be a transient phase for many students. Patterns of heavy use were not necessarily consistent throughout college and students described them as dynamic and open to change. Participants' experiences highlighted the heterogeneity within the student population – while mature or international students tended to drink more moderately or not at all, some of the younger Irish undergraduates also had this pattern of use. Alcohol-free events had also been organised by some college societies. The authors suggest that this could indicate a possible shift in the drinking culture among this population and that there might be an openness to change.

- **Intractable problem:** Students recognised the need for alcohol prevention measures. However, some expressed doubts and scepticism that programmes like REACT, which focus on the college level, will have an impact. For example, they raised the issue of displacement. While college campuses may clamp down on the availability of alcohol, students will access drink elsewhere. Off-campus drivers need to be addressed as well, for example, the high density of alcohol outlets in the community and the growing culture of pre-drinking (drinking cheap alcohol at home before going out).

2. Importance of lived environment

A recurring theme was that there is a need for more alcohol-free spaces for students to socialise. Socialising was perceived to be core to the college experience and the study found 'a genuine desire for alternative settings that are less predicated on the consumption of alcohol' (p. 11). This related both to places to socialise and student accommodation.

3. Responsibility for controlling student drinking

Students varied in who they thought was responsible for addressing students' drinking patterns, and therefore the measures they proposed to address the issue. Younger students tended to focus on personal responsibility, while mature students focused on the college's responsibility. Where younger students focused on personal responsibility, the authors suggest 'these students may embody one of the central tensions of the so-called "neo-liberal social order"[7] … having to navigate a world where alcohol is ubiquitous and aggressively marketed but still perceiving themselves as self-regulating, responsible consumers' (p. 16).[4] They note that it also resonates with the proliferation of the 'responsible drinking' messages characteristic of alcohol-industry-funded campaigns. Where students perceived the college to have responsibility for addressing problems associated with student drinking, the interventions suggested included a mandatory alcohol education module for students; monitoring absenteeism; enforcing the legal age limit for the sale of alcohol; and providing alcohol-free accommodation, social events, and settings.

Discussion

In their discussion, the authors note how participants collectively acknowledged the multiple layers of influence as laid out in the CDC framework on both student alcohol consumption and the interventions required to address it. Based on their findings, the authors suggest that stakeholders who want to reduce hazardous drinking among students need to reframe the question they ask:

> *… not how can they reduce excessive alcohol consumption, but rather how can they create or engineer environments that enable a diverse student population to connect and engage with each other, to express themselves and have fun, in spaces beyond the narrow confines of alcohol-infused environments'* (p. 17)[4]

Among the implications of their findings for the REACT programme are the following:

- There should be a focus not just on the college but also the wider community in which it is based. An optional action of REACT is to map the density of licensed premises. The authors suggest this would be useful information with which to lobby local authorities to reduce the high density and mitigate potential displacement effects among students.

- There should be more emphasis on establishing alcohol-free alternatives for student socialising settings and activities, as well as accommodation.

- When designing interventions, student representation is very important. REACT should broaden the student voice represented to reflect the heterogeneity among students.

Concluding comment

This study provides valuable insights into the heterogeneity within the student population in relation to drinking habits and therefore the required responses. It identifies opportunities to influence the endemic nature of drinking in colleges, with interventions such as those that provide more access to alcohol-free settings and activities, while remaining cognisant of the student need to socialise and connect. The REACT programme provides a valuable opportunity to learn about what works in third-level institutions, with a particular focus on environmental prevention.

Third-level alcohol consumption

continued

Lucy Dillon

1   For further details on the REACT programme, contact Dr Michael Byrne, head of Student Health Services, University College Cork. M.Byrne@ucc.ie or visit https://www.ucc.ie/en/esprit/research/react/

2   Davoren MP, Calnan S, Mulcahy J, Lynch E, Perry IJ and Byrne M (2018) Responding to excessive alcohol consumption in third-level (REACT): a study protocol. *BMC Health Serv Res*, 18(1): 364. https://www.drugsandalcohol.ie/29015/

3   Dillon L (2018) Responding to excessive alcohol consumption in third-level (REACT): a study protocol. *Drugnet Ireland*, 67 (Autumn): 24–26. https://www.drugsandalcohol.ie/29937/

4   Calnan S and Davoren MP (2021) College students' perspectives on an alcohol prevention programme and student drinking – a focus group study. *Nord Stud Alcohol Drugs,* Early online. https://www.drugsandalcohol.ie/34130/

5   Department of Education (2019) *Minister Mitchell O'Connor opens the inaugural REACT (Responding to Excessive Consumption of Alcohol in Third Level) awards in DCU* [Press release]. 28 August. Dublin: Department of Education. Available online at: https://www.education.ie/en/Press-Events/Press-Releases/2019-press-releases/PR19-08-28.html

6   Centers for Disease Control and Prevention (CDC) (2002) *The social-ecological model: a framework for violence prevention.* Atlanta, GA: Centers for Disease Control and Prevention. https://www.cdc.gov/ViolencePrevention/pdf/SEM_Framewrk-a.pdf

7   Griffin C, Bengry-Howell A, Hackley C, Mistral W and Szmigin I (2009). 'Every time I do it I absolutely annihilate myself': loss of (self)consciousness and loss of memory in young people's drinking narratives. *Sociology*, 43(3): 457–476.

RESPONSES

A plan to tackle the underlying causes of addiction and open drug dealing in Ballymun, Dublin

Based on the 2016 Census, the Trinity National Deprivation Index ranked Ballymun in Dublin as one of the most disadvantaged communities, if not the most disadvantaged community, in the Republic of Ireland.[1] Ballymun has a long history of drug and heroin use dating back to the 1980s; it remains the community with the highest level of people with problematic opiate use in the country – 10 times greater than the national average.[2] Also of note, Ballymun has suffered from serious criminality in recent years associated with open drug dealing and a surge in crack cocaine usage.[3]

A report[4] published in 2021 identified three key areas (prevention, desistance, and suppression) that should be addressed in order to implement a comprehensive approach for dealing with addiction and drug-related criminality in Ballymun. Specific recommendations related to these areas are listed below.

Prevention

- Ten senior social work positions should be provided to the child protection team for Ballymun in order to address the concerns from Tusla's internal audit report of 2019, which found that children at risk of significant harm were not receiving an effective service.[5]

- A new programme to work with young people who have dropped out of the education system should be established.

- The Ballymun Network for Assisting Children and Young People should set up and train its own multisystemic therapy team, staffed from a variety of agencies working in Ballymun, with the network acting as the steering committee. This service should be available for young people involved in serious criminality, but also for young people at high risk but who have not yet become involved in crime.

- Dublin City Council should not be housing additional families, who need significant supports, in temporary or permanent housing in Ballymun, while the supports needed by these families are not available.

Desistance

- Strive is a pilot programme that came into operation in 2015. It attempts to reduce crime in the Shangan and Coultry neighbourhoods of Ballymun by targeting the most harmful offenders in those areas.

- As Strive has reduced crime in the Shangan and Coultry neighbourhoods, the capacity of the programme should be increased to cover the entire Ballymun area.

Suppression

- Additional Gardaí should be deployed to Ballymun Garda Station to effectively police open drug dealing, crime hotspots, and to case manage prolific offenders in the Strive programme.

- Open drug dealing should be tackled, as it stigmatises the community; leads people to withdraw from community life; normalises drug dealing, drug use, and violence; and draws people from outside the community into Ballymun to buy and use drugs.

- A planned and coordinated approach to crime hotspots should be introduced. The Gardaí, Dublin City Council, and the community should work together to identify the worst hotspots and develop a tailored plan for each one. Frequent, sustained, and visible policing will be required.

Drug dealing in Ballymun   continued

Seán Millar

1 Teljeur C, Darker C, Barry J and O'Dowd T (2019) *The Trinity National Deprivation Index for health and health services research 2016*. Dublin: Trinity College Dublin. https://www.drugsandalcohol.ie/34675/

2 Hay G, Jaddoa A, Oyston J, Webster J, Van Hout MC and Rael dos Santos A (2017) *Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods*. Dublin: National Advisory Committee on Drugs and Alcohol. https://www.drugsandalcohol.ie/27233/

3 O'Reilly L and Mac Cionnaith C (2019) *Crack cocaine use in Ballymun: an evidence base for interventions*. Dublin: Ballymun Youth Action Project. https://www.drugsandalcohol.ie/31345/

4 Montague A (2021) *Ballymun – a brighter future. A plan to tackle the underlying causes of addiction and crime and to tackle open drug dealing*. Dublin: Ballymun Local Drugs and Alcohol Task Force. https://www.drugsandalcohol.ie/33970/

5 Tusla – Child and Family Agency (2020) *Quarterly service performance and activity report: Quarter 3 2020*. Dublin: Tusla.

Ana Liffey Drug Project annual report, 2019

The Ana Liffey Drug Project (ALDP) is a 'low-threshold, harm reduction' project working with people who are actively using drugs and experiencing associated problems. ALDP has been offering harm reduction services to people in the north inner-city area of Dublin since 1982, from premises at Middle Abbey Street. ALDP offers a wide variety of low-threshold, harm reduction services that provide pathways for drug users out of their current circumstance, including addiction and homelessness.

The services offered in Dublin include:

- Open access
- Assertive outreach
- Needle and syringe programme
- Medical services
- Stabilisation group
- Detox group
- Harm reduction group
- Treatment options group
- Assessment for residential treatment
- Key working and case management
- Prison in-reach.

Mid-West region

The ALDP Mid-West region provides harm reduction services in Limerick city and three counties to people affected by problem substance use, their families, and the wider community. The counties served are Limerick, Clare, and North Tipperary. The ALDP Online and Digital Services team also offers support and information to the general public and to people who use drugs, as well as to other agencies that work with problem drug users.

Annual report

The ALDP annual report was published in 2020.[1] It noted that in 2019, Dublin open access services provided help to 574 individuals who attended the service 11,374 times. The majority of people were homeless and many were polydrug users with mental and physical health problems. Key working and case management was provided to 151 individuals, while 423 people attended treatment option groups 1,139 times. In 2019, some 261 individuals availed of the needle and syringe programme, receiving 912 interventions. ALDP also provided in-reach services to Mountjoy Prison, where 54 individuals attended groups run in this setting.

In the Mid-West region, ALDP served a similar cohort of people: 356 people were registered with the service in 2019. Of these, 58 individuals attended the open access service, 78 clients accessed the case management service, and 278 people accessed the ALDP needle and syringe programme.

Between July 2018 and January 2019, ALDP also provided a needle and syringe programme in the Northeast region, primarily in Navan, Dundalk, and Drogheda. The project provided sterile injecting and smoking paraphernalia to people who use drugs as a support to the Health Service Executive (HSE) in the area.

Seán Millar

1 Ana Liffey Drug Project (2020) *Ana Liffey Drug Project annual report 2019*. Dublin: Ana Liffey Drug Project. https://www.drugsandalcohol.ie/33726/

Merchants Quay Ireland annual review, 2019

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and those that use drugs. There are 22 MQI locations in 12 counties in the Republic of Ireland (see Figure 1). MQI aims to offer accessible, high-quality, and effective services to people dealing with homelessness and addiction in order to meet their complex needs in a non-judgemental and compassionate way. This article highlights services provided by MQI to people who use drugs in Ireland in 2019.[1]

Addiction services

Health Promotion Unit

This unit provides people who use drugs with information about the risks associated with drug use and the means to minimize such risks. MQI offers them a pathway into treatment and the possibility of living a life without drugs. The main focus is on reducing the harms associated with injecting drug use; fostering the motivation to become abstinent; and giving advice on HIV, hepatitis B virus, and hepatitis C virus infection prevention. In 2019, some 3,140 individuals used the service, an increase of 14.5% compared with 2018.

Family Support Group

MQI runs a Family Support Group (FSG), which meets every week and provides a forum where parents of those who use drugs, as well as other close relatives and friends, are offered support and advice on a range of issues. Participants provide support for each other and the group is continually open to new members. The weekly FSG meetings had been linked to the National Family Support Network (defunct since April 2021), which had offered an opportunity to raise issues at a national level.

Midlands services

Drug and Alcohol Treatment Supports Project

MQI's Drug and Alcohol Treatment Supports (DATS) team provides a community-based drug and alcohol treatment support service for individuals over 18 years of age and their families in the Midlands area (Counties Longford, Westmeath, Laois, and Offaly). Each county has a dedicated drug and alcohol worker to coordinate the care of individuals and families experiencing problems due to drug and/or alcohol use. In this region, MQI saw a total of 787 clients in 2019, an 11.5% increase on 2018.

Rehab and detox treatment services

The St Francis Farm (SFF) Rehabilitation Service offers a 13-bed therapeutic facility with a 14-week rehabilitation programme set on a working farm in Tullow, Co. Carlow. At SFF, MQI provides a safe environment where service users can explore the reasons for their drug use, adjust to life without drugs, learn effective coping mechanisms, and make positive choices about their future.

The 10-bed residential detoxification service at SFF delivers methadone and combined methadone/benzodiazepine detoxes for both men and women. The detox activity programme includes individual care planning, therapeutic group work, psychoeducational workshops, fitness training, and farm-work activities.

Source: MQI annual review, 2017

(1) Dublin; (2) Co. Wicklow; (3) St Francis Farm, Co. Carlow; (4) Cork Prison; (5) Limerick Prison; (6) Co. Offaly; (7) Co. Westmeath; (8) Portlaoise, Co. Laois; (9) Co. Longford; (10) Castlerea Prison, Co. Roscommon; (11) Loughran House, Co. Cavan; (12) Leixlip, Co. Kildare.

Figure 1: MQI locations in the Republic of Ireland

At High Park, Drumcondra, Co. Dublin, MQI operates a 14-week residential programme in a 13-bed facility. The emphasis is on assisting clients to gain insight into the issues that underpin their problematic drug use and on developing practical measures to prevent relapse, remain drug-free, and sustain recovery. In 2019, the total number of admissions across High Park and SFF was 181.

Prison-based services

Addiction Counselling Service and Mountjoy Drug Treatment Programme

MQI, in partnership with the Irish Prison Service, delivers a national prison-based Addiction Counselling Service (ACS) aimed at prisoners with drug and alcohol problems in 11 Irish prisons. This service provides structured assessments, one-to-one counselling, therapeutic group work, and multidisciplinary care, in addition to release-planning interventions with clearly defined treatment plans and goals. Services offered include:

- Brief interventions
- Motivational interviewing and motivational enhancement therapy
- A 12-step facilitation programme
- Relapse prevention and overdose reduction
- Cognitive behavioural therapy
- Harm reduction approaches
- Individual care planning and release planning.

A total of 2,371 unique clients were supported through in-prison counselling in 2019.

Seán Millar

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1   Merchants Quay Ireland (MQI) (2020) *Merchants Quay Ireland annual review 2019*. Dublin: MQI.
    https://www.drugsandalcohol.ie/33295/

DOVE Service, Rotunda Hospital annual report, 2019

The Danger of Viral Exposure (DOVE) Service in the Rotunda Hospital, Dublin was established to meet the specific needs of pregnant women who have or are at risk of blood-borne or sexually transmitted bacterial or viral infections in pregnancy. Exposure may also occur through illicit drug use. Figures from the service for 2019 were published in the hospital's annual report in 2020.[1]
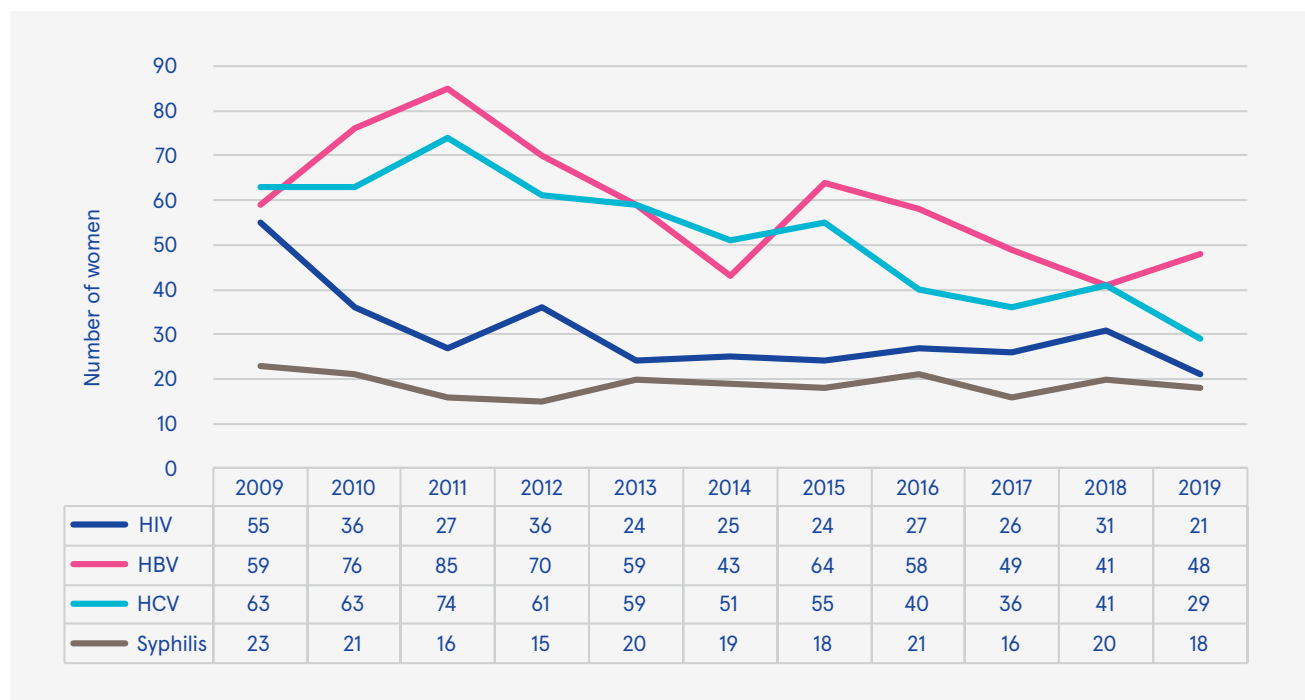
Clinical activity

Figure 1 shows the number of women who booked into the DOVE Service for antenatal care each year during the period 2009–2019. It also shows the diagnosis of viral disease for these women. During 2019, some 112 women booked into the DOVE Service for antenatal care. Of these:

- 21 (19%) women were positive for HIV infection.
- 48 (43%) women were positive for hepatitis B (HBV) surface antigen.
- 29 (26%) women were positive for hepatitis C (HCV) antibody.
- 18 (16%) women had positive treponemal serology (syphilis).

In addition to the figures presented above, a number of women attended the service for diagnosis and treatment of human papillomavirus (HPV), herpes simplex virus, chlamydia, and gonorrhoea.

It should be noted that these numbers refer to patients who booked for care during 2019. Table 1 summarises the outcome of patients who actually delivered during 2019. Of these patients, 27 were HIV-positive, 44 were HBV-positive, 39 were HCV-positive, and 15 had syphilis. During 2019, some 105 women were referred to the drug liaison midwife (DLM) service, including 33 women who had a history of opiate addiction and were engaged in a methadone maintenance programme. Eight of these women commenced treatment because of pregnancy. There was a total of 56 deliveries to mothers under the DLM service in 2019.

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
HIV	55	36	27	36	24	25	24	27	26	31	21
HBV	59	76	85	70	59	43	64	58	49	41	48
HCV	63	63	74	61	59	51	55	40	36	41	29
Syphilis	23	21	16	15	20	19	18	21	16	20	18

Source: The Rotunda Hospital (2020)

Figure 1: DOVE Service bookings by year, 2009–2019

DOVE Service continued

Table 1: Deliveries to mothers attending the DOVE Service who were positive for HIV, HBV, HCV or syphilis, or who were attending the drug liaison midwife, 2019

Mother's status	HIV–positive	HBV–positive	HCV–positive***	Syphilis–positive	DLM
Total mothers delivered	27	44	39	15	56
Total mothers delivered <500 g (including miscarriage)	0	2	0	0	0
Total mothers delivered >500 g	27	42	39	15	56
Live infants	28*	43*	38*	15	54
Miscarriage	0	2	0	0	0
Stillbirth	0	0	2	0	3
Infants <37 weeks' gestation	6	4	9	3	13
Infants >37 weeks' gestation	22	39	31	12	44
Caesarean section	11	14	10	5	17
HIV, HBV, HCV or syphilis–positive infants	0	0**	1**	0	–
Maternal median age	33	32	34	37	–

Source: The Rotunda Hospital (2020)
* One set of twins.
** Final serology test not yet available for all infants.
*** The difference in the numbers in the table is because one section is 'bookings' and one is 'births' (the bookings will deliver in 2019 and 2020) and the births will have booked in 2018 and 2019.
DLM = drug liaison midwife.

Seán Millar

1   The Rotunda Hospital (2020) *The Rotunda Hospital Dublin annual report 2019*. Dublin: The Rotunda Hospital. https://www.drugsandalcohol.ie/34266/

Quality standards and civil society

The Civil Society Forum on Drugs (CSFD) has published a new report, entitled *Quality standards of civil society involvement in drug policies*.[1] It presents a set of quality standards for policymakers and civil society actors to work towards meaningful collaboration and effective policymaking.

Background
The CSFD is an expert group of 45 civil society organisations in the European Commission that supports the commission in its drug policy formulation and implementation.[2] Among its work carried out to date is in supporting and promoting quality standards. Its previous publications on the topic include *Guidelines and recommendations for the implementation of minimum quality standards in drug demand reduction in the European Union by civil society organisations (CSOs),*[3] and the *CSFD advocacy plan for the promotion and implementation of minimum quality standards in drug demand reduction*.[4] The authors define civil society involvement as follows.

Civil society involvement can be understood in a narrow sense by decision-makers; that is, they are solely seen as a mechanism to help policy-makers to implement decisions. But civil society is more than a mere tool of implementation. One of its greatest strengths is innovation, creativity and a vibrant connection to the most affected communities. It can enrich decision-makers with new ideas and new perspectives for future processes. Civil society can serve as a connector between the policy and the actual needs. It can add authenticity and legitimacy to policy processes. (p. 14)[1]

Quality standards
The current report lays out a new set of quality standards for civil society's involvement in policymaking 'to guide both decision-makers and civil society on how to create mechanisms that facilitate the building of dialogue and partnership between them' (p. 6).[1] They are structured around a planning–intervention–evaluation cycle with the CSO involvement in the policy process conceptualised as an intervention which involves both decision-makers and civil society (see Figure 1) (p. 6).[1]

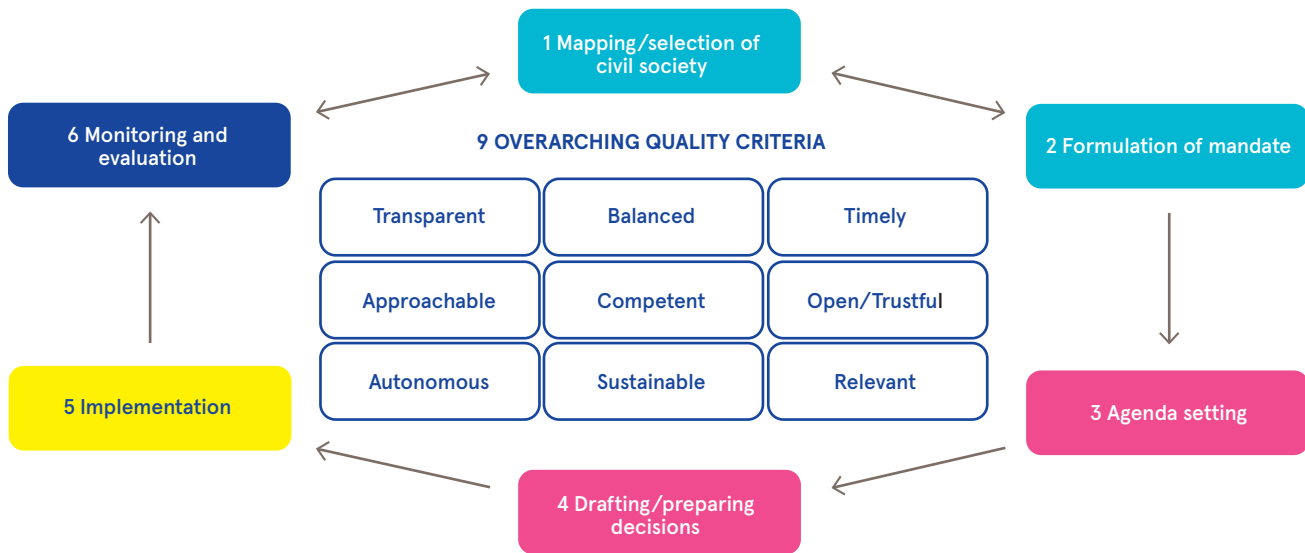# Quality standards and civil society   continued

Figure 1: The planning–implementation–evaluation cycle of civil society involvement

Quality standards are attached to each of the six steps outlined, all of which are underpinned by the nine overarching quality criteria (see Figure 1). The report presents a detailed set of quality standards and the thinking that underpins them. While the report presents the standards and specific actions for each group, this article only presents the overarching quality standards here.

1. Mapping and selecting civil society participants

For policymakers:

- An assessment of relevant civil society actors is conducted.
- Relevant civil society actors are selected to participate in policymaking.

For civil society actors:

- The actor is relevant, knowledgeable, and able to contribute in a meaningful way to decision-making.

2. Mandate formulation

For policymakers and civil society actors:

- Decision-makers involve civil society in the development of a common mandate for the civil society involvement mechanism/forum.

3. Agenda setting

For policymakers:

- Civil society is consulted in setting the agenda of policymaking.

For civil society actors:

- Civil society gives a competent, balanced, and transparent contribution to the agenda.

4. Drafting and preparing policy decisions

For policymakers:

- Decisions are prepared with the meaningful involvement of civil society.

For civil society actors:

- Civil society engages in a serious and professional way by ensuring a collaborative approach.

5. Implementation of policy decisions

For policymakers:

- Civil society actors are involved in the implementation of policy actions.

For civil society actors:

- Civil society actors implement drug policy interventions in a transparent and accountable way.

6. Monitoring and evaluation

For policymakers:

- Civil society provides relevant and meaningful input to the monitoring and evaluation of drug policies.

For civil society actors:

- Civil society contributes in a competent and professional way to the evaluation of drug policies.

Lucy Dillon

1   Sarosi P, Fulga V, de Boer Y and Keane M (2021) *Quality standards of civil society involvement in drug policies: report of the Civil Society Forum on Drugs*. Amsterdam: Correlation – European Harm Reduction Network. https://www.drugsandalcohol.ie/34368/

2   For further information on CSFD, visit: http://www.civilsocietyforumondrugs.eu/

3   Civil Society Forum on Drugs (2020) *Guidelines and recommendations for the implementation of minimum quality standards in drug demand reduction in the European Union by civil society organisations (CSOs)*. Amsterdam: Civil Society Forum on Drugs. https://www.drugsandalcohol.ie/34040/

4   Civil Society Forum on Drugs (2021) *CSFD advocacy plan for the promotion & implementation of minimum quality standards in drug demand reduction*. Amsterdam: Civil Society Forum on Drugs. https://www.drugsandalcohol.ie/33833/

Guide to implementing quality standards in drug demand reduction

In September 2021, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published a manual offering practical advice to professionals implementing quality assurance in the area of drug demand reduction, entitled *Implementing quality standards for drug services and systems: a six-step guide to support quality assurance.*[1] The manual provides an overview of quality standards and how they fit within the broader area of quality assurance processes, as well as a six-step guide for those planning to implement them as part of a quality assurance project.

Quality assurance and quality standards

Quality standards are one of a suite of activities for implementing quality assurance. Definitions are provided on page 5 of the manual.[1]

> *Quality assurance is a process which involves continuous monitoring and striving to improve quality and outcomes. The concept includes the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; design of activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps.*

> *Quality standards are one of the tools used in the quality assurance process. Based on the WHO [World Health Organization] definition, quality assurance systems in drug demand reduction focus on the extent to which drug-related interventions, services or systems improve outcomes. Quality standards are principles and sets of rules, often set by recognised national or international bodies, that may be used to implement interventions. A quality standard may be described as a statement of expected requirements. It can refer to content issues, processes or to structural aspects. Typically, the standards proposed in the health field are evidence-based, and provide clear and aspirational, yet measurable, statements related to content, processes or structural aspects of quality assurance, such as environment and staffing composition.*

Strategic context

Since 2013, developing and implementing quality standards has been an explicit priority for the European Union (EU) as reflected in its drug strategies and action plans.[2,3,4,5] Under strategic priority 6 of the current EU Action Plan (to ensure access to and strengthen treatment and care services), there is an action to 'continue and further develop the implementation of the EU minimum quality standards adopted by the Council in 2015[4] and evidence-based guidelines in national guidelines and programmes' (Action 38, p. 13).[5] In response to this action, the EMCDDA published the current manual.

Aim of the manual

While the manual is primarily targeted at those responsible for commissioning, planning, or providing quality assurance processes, the authors argue that it may also be of interest to other stakeholders, such as service users or advocacy groups. Its overall aim is 'to provide a practical introduction to the area of quality standards and quality assurance mechanisms and the key steps involved in their implementation in drug services and systems' (p. 3). In doing so, the manual is not prescriptive. It highlights that there is no single correct way to implement quality assurance processes, rather those implementing the process need to consider a variety of factors to identify the best approach to meet their needs. It also recognises the wide range of quality standards available. Some may be general standards that cover all aspects of a national health or education system, while others relate specifically to drug-related services. They also vary from those developed at international, national, and local levels.

The six steps

The manual identifies six steps which outline a full cycle for stakeholders to consider when implementing quality assurance processes and standards. The authors acknowledge the need to take a flexible approach to these steps, recognising that steps will vary in their level of importance depending on the type of assessment being carried out and its focus. The six steps and some of the questions that need to be asked at each stage are as follows.

1   **Diagnosis:** What is the problem the quality assurance project will address?

2   **Scoping:** What are the goals and who to involve? Who needs to lead the project and who are the key stakeholders? What resources are required to deliver the project?

3   **Mapping and selection:** What standards apply and how can they be verified? Which are the most appropriate quality standards to use given the circumstances?

4   **Assessing systems and services:** How to evaluate whether the systems or services meet the standards being applied or do they need to be improved? What data are required to make this assessment and how will they be verified?

5   **Drafting an improvement plan and disseminating results:** When, where and to whom to communicate? How can the recommendations of the report be discussed with key stakeholders?

6   **Preparing for the next cycle:** How can it be ensured that a continuous cycle of evaluation is in place?

Concluding comment

The aim of quality assurance processes and the associated implementation of quality standards is to improve the quality of services provided and the outcomes achieved. This in turn supports a system in which the best value for money is achieved for all stakeholders. When discussing the manual, EMCDDA director Alexis Goosdeel outlined the benefits of quality assurance.

> *Quality assurance mechanisms can help professionals work better and improve services for patients, clients, staff and communities, also encouraging user involvement, transparency and accountability. Good quality drug demand reduction interventions, based on evidence and firmly located in human rights, can help improve people's lives and life chances. At a*

Quality standards in drug demand reduction   continued

time when there is more need than ever to ensure continuity in the financing of drug services, well-documented evidence of the quality and evaluation of these services is a must.[6]

Lucy Dillon

1   European Monitoring Centre for Drugs and Drug Addiction (2021) *Implementing quality standards for drug services and systems: a six-step guide to support quality assurance.* Luxembourg: Publications Office of the European Union. https://www.drugsandalcohol.ie/34895/

2   Council of the European Union (2012) *EU drugs strategy (2013–2020).* Brussels: Council of the European Union. https://www.drugsandalcohol.ie/19034/

3   Council of the European Union (2015) *Council conclusions on the implementation of the EU Action Plan on Drugs 2013–2016 regarding minimum quality standards in drug demand reduction in the European Union,* 11985/15. Brussels: Council of the European Union. https://www.drugsandalcohol.ie/24317/

4   Council of the European Union (2020) *EU drugs strategy 2021–2025.* Brussels: Council of the European Union. https://www.drugsandalcohol.ie/33750/

5   Council of the European Union (2021) *EU drugs action plan 2021–2025.* Brussels: Council of the European Union. https://www.drugsandalcohol.ie/34446/

6   European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2021) *Six steps to improve the quality of drug services and systems – EMCDDA launches new practical manual for decision-makers* [Press release]. Lisbon: EMCDDA. Available online at: https://www.emcdda.europa.eu/news/2021/six-steps-improve-quality-drug-services-and-systems_en

Tabor Group annual report, 2020

The Tabor Group is a provider of residential addiction treatment services in Ireland. It aims to offer hope, healing, and recovery to clients suffering from addictions through integrated and caring services. In addition to two residential facilities, the organisation provides a continuing care programme to clients who have completed treatment in order to assist with their recovery as well as a community-based programme. Its family support programme offers counselling to families whose loved ones are struggling with an addiction. In 2021, the Tabor Group published its annual report for 2020.[1] This article highlights services provided by the Tabor Group to individuals with a substance use addiction in 2020.

Tabor Lodge: residential addiction treatment centre

Tabor Lodge is a residential addiction treatment centre for the treatment of people addicted to alcohol, drugs, gambling, and food. It is situated 15 miles south of Cork city. Tabor Lodge is guided by the Minnesota Model of addiction treatment in delivering its treatment programme. This model is characterised by the understanding that addiction is primarily a substance use disorder. The primary focus of the treatment programme is to educate clients on the dynamics of this disorder as they manifest in the life of the individual. Another important focus of the treatment programme is to assist clients develop the skills necessary to manage their disorder while going forward in their lives.

A total of 149 clients (67% male) were admitted to Tabor Lodge for residential treatment of addiction in 2020; 55% were aged between 25 and 44 years and 40% were employed. Sixty-two per cent of clients admitted to Tabor Lodge reported alcohol as their main reason for referral. The report noted that 26% of clients cited cocaine as their specific drug of choice, an increase of 7% compared with 2019.

Tabor Fellowship: integrated recovery programme

Tabor Fellowship is located at Spur Hill in Doughcloyne on the outskirts of Cork city. Its integrated recovery programme is based on the Hazelden Minnesota Model and promotes total abstinence. The aim is to build on and consolidate the work of recovery already begun in primary treatment – even if that treatment was not in the recent past and the client is struggling to maintain sobriety.

In 2020, some 76 clients (70% male) were admitted to Tabor Fellowship for extended treatment; 42% were aged between 25 and 34 years and 18% of those treated were homeless. The report observed that the specific drug of choice of those admitted to Tabor Fellowship in 2020 were alcohol (89%), cannabis (57%), and cocaine (54%).

Seán Millar

1   Tabor Group (2021) *Tabor Group annual report 2020.* Cork: Tabor Group. https://www.drugsandalcohol.ie/34276/

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National Drugs Library

Recent publications

RESPONSES

Efficacy and safety of electronic cigarettes as a smoking cessation intervention: a systematic review and network meta-analysis

Quigley JM, Walsh C, Lee C, Long J, Kennelly H, McCarthy A and Kavanagh P (2021) *Tobacco Prevention & Cessation*, 7: 69.
https://www.drugsandalcohol.ie/35203/

This systematic review of randomized controlled trials (RCTs) evaluated the efficacy and safety of electronic cigarettes (e-cigarettes, ENDS) in helping people who smoke to achieve abstinence compared with electronic non-nicotine delivery systems (ENNDS, no nicotine) or any smoking cessation comparator treatment or combination of treatments at 24–26 weeks and at 52 weeks.

This systematic review and NMA [network meta-analysis] indicates that there is no clear evidence of a difference in effect between nicotine containing e-cigarettes and NRT [nicotine replacement therapy] on incidences of smoking cessation at 24–26 weeks, and substantial uncertainty remains.

'Pints or half-pints': gender, functional democratization, and the consumption of drink in Ireland

Connolly J (2021) *British Journal of Sociology*, 72(5): 1246–1259.
https://www.drugsandalcohol.ie/35034/

This paper examines the relationship between the gender power balance, changes in the consumption of alcohol and changing social interdependences. The empirical setting is Ireland circa 1900 up to the present. Drawing from the works of Norbert Elias, I explain how a lessening of the power inequality between men and women was more moderate and limited up to the 1960s. The effect of this was that emancipatory changes around drinking were mainly confined to women from specific social cohorts. As the reduction in gender power inequality accelerated post 1960 it initially increased tensions between the genders, reflected in new power struggles over the social spaces in which drinking occurred and in the type of glass one should drink from.

Family 'turning point' experiences and the process of youth becoming homeless

Mayock P, Parker S and Murphy A (2021) *Child & Family Social Work*, 26(3): 415-424.
https://www.drugsandalcohol.ie/34787/

This paper examines the family 'turning point' experiences embedded in the life stories of homeless youth. The study, which was biographical and longitudinal, aimed to generate an in-depth understanding of the nature of homelessness, how it emerged and its impacts on the lives of young people. Conducted in Ireland, 40 youth aged 16–24 years were recruited at baseline, with all interviews commencing with an invitation to young people to tell their 'life story'.

Analysis of participants' life story narratives revealed three major family turning point experiences associated with *parental absence and separation*, *bereavement* and *acute interruptions to family life*. These turning points, the effects of which had a temporal character, reveal the rippling impact of family ruptures on the lives of young people who embarked on a path of leaving home and becoming homeless. The implications of the findings for enhancing engagement with the families of young people who experience homelessness are discussed.

Recent publications   continued

PREVALENCE AND CURRENT SITUATION

Impact of changes in controlled drugs legislation on benzodiazepine receptor agonist prescribing in Ireland: a repeated cross-sectional study

Cadogan CA, Bradley CP and Bennett K (2021) *European Journal of Clinical Pharmacology,* 77(6): 903–912.
https://www.drugsandalcohol.ie/35167/

This study aimed to examine the impact of new controlled drugs legislation introduced in May 2017 on benzodiazepine receptor agonist (BZRA) prescribing in Ireland.

This study indicates that introduction of new legislation had limited impact on BZRA prescribing on the main public health scheme in Ireland. Interventions targeting specific population subgroups may be required to achieve sustained reductions in prescribing.

Prescribing patterns of medicinal cannabis for epilepsy

Gilligan M and Widdess-Walsh P (2021) *Prescribing patterns of medicinal cannabis for epilepsy. Irish Medical Journal,* 114(10): 487.
https://www.drugsandalcohol.ie/35376/

This project aims to survey prescribers of medicinal cannabis for epilepsy in Ireland in 2019. We sent an anonymous survey to all adult and paediatric consultant neurologists in the Republic of Ireland in 2019. The survey included questions regarding the product prescribed, indication, estimated efficacy, and adverse effects.

Our survey revealed a small number of medicinal cannabis prescribers for epilepsy in the Republic of Ireland, suggesting a limited clinical exposure in the country to date. Resurvey at future intervals is recommended as product availability and familiarity increases, to guide clinical use and prescription programs.

The discursive construction of HIV stigma in Irish print media

Vaughan E and Power M (2021) *Health,* Early online.
https://www.drugsandalcohol.ie/34945/

This paper reports on a critical discourse analysis of news media coverage of HIV in the Republic of Ireland between 2006 and 2016.

The findings suggest that media discourses on HIV have the potential to other people living with HIV and generate stigma by invoking a dynamic of blame and shame frequently implicated in the stigma process.

Exploring models of care and the perceived impact in an offender rehabilitation program

Carolan C, O'Flynn A and Guerin S (2021) *International Journal of Offender Therapy and Comparative Criminology,* Early online.
https://www.drugsandalcohol.ie/34946/

This study explores the perceived model of service provided by an offender rehabilitation service and the perceived impact that this service has on the lives of its clients.

The findings suggest that participants perceive the organization to be operating a strengths-based approach and this is perceived as having the potential to have a range of positive effects for clients. Some contrasting views were also identified within the participant groups and these are discussed in this paper. The results of this study complement the existing research and have several implications for future research in this area.

Harmful alcohol consumption in elite sports players in Ireland

Murray K, Murphy C, Herlihy A, McCaffrey J, Codd M and Murray FE (2021) *Irish Journal of Medical Science,* Early online.
https://www.drugsandalcohol.ie/35019/

We aimed to assess alcohol consumption, harms and behaviours in an elite Irish sporting population (Gaelic footballers and hurlers).

Excess alcohol consumption, alcohol related harms and binge drinking are prevalent in an elite sporting population, particularly during the off-season. Specific strategies are required to reduce alcohol related harms, particularly amongst high-risk groups during the off-season.

Inkspots and ice cream cones: a model of recovery contagion and growth

Best D and Ivers J-H (2021) *Addiction Research & Theory,* Early online.
https://www.drugsandalcohol.ie/34988/

This paper builds on [adding specificity and precision to recovery models] by suggesting that not only can recovery capital have a residual impact on the community but that our understanding of this approach can be significantly enhanced with reference to John Braithwaite's model of macro-criminology and in particular the concept of ink spots to explain spread. The paper integrates the contagion ideas of recovery with the cascade effects Braithwaite describes to explain crime reductions and concludes with a discussion of the potential of concepts like collective efficacy and social contagion to be used to supplement public health approaches to the implementation of recovery-oriented interventions at a systems level. While there has been a huge growth in the 'evidence base' around recovery in recent years, there remain two primary gaps that this paper attempts to address.

Recent publications continued

Comparing cannabis use disorder in the general population with cannabis treatment seekers using multi-source national datasets: who receives treatment?

Mongan D, Carew AM, O'Neill D, Millar SR, Lyons S, Galvin B and Smyth BP (2022) *European Addiction Research,* 28: 103–112.
https://www.drugsandalcohol.ie/34957/

This study aimed to estimate the size of the potential population in Ireland that may be in need of cannabis treatment and the percentage of people with cannabis use disorder (CUD) who actually access treatment. We also compared the profile of those with CUD in the general population to those who receive treatment for their cannabis use to explore whether certain subgroups are more or less likely to enter treatment.

Our findings suggest that earlier users and those with more complex or disadvantaged lives are more likely to seek treatment. A broad population health approach that engages multiple sectors such as health, social welfare, and education is recommended to ensure that there is increased opportunity for people with CUD to be identified and signposted towards treatment.

Estimating need for alcohol treatment in Ireland using national treatment surveillance data

Carew AM, O'Neill D, Lyons S and Smyth BP (2021) *Irish Journal of Medical Science*.
https://www.drugsandalcohol.ie/34924/

This study analyses routine national surveillance data on alcohol treatment to measure how treatment need is being met.

Despite high rates of alcohol consumption and dependence, the rate of treatment entry nationally is sub-optimal, although there are wide geographic variations. There is a need to better understand the reasons for low treatment entry rates in Ireland for people with alcohol dependence. Monitoring and surveillance play a key role in measuring the successful efforts to reduce the harm of alcohol.

Relationships between patterns of cannabis use, abuse and dependence and recent stimulant use: evidence from two national surveys in Ireland

Millar SR, Mongan D, O'Dwyer C, Smyth BP, Perry IJ and Galvin B (2021) *PLoS ONE,* 16(8): e0255745.
https://www.drugsandalcohol.ie/34684/

In this research we determined relationships between patterns of cannabis use and recent stimulant use, drawing on data from two large nationally representative surveys. We also explored how frequency of cannabis use relates to stimulant use and whether subjects with a cannabis use disorder (CUD) – defined as cannabis abuse or dependence – are more likely to be recent users of cocaine or ecstasy.

Findings from this study suggest a relationship between patterns and frequency of cannabis use and recent use of stimulants and an association between CUD and stimulant use. As the use of cannabis with stimulants may increase the risk of negative health consequences, education in community and medical settings about polydrug use and its increased risks may be warranted.

The unmet rehabilitation needs in an inclusion health integrated care programme for homeless adults in Dublin, Ireland

Carroll Á, O'Brien S, Harrington D, Ní Cheallaigh C, Lawlee A-M and Sukumar P (2021) *International Journal of Environmental Research and Public Health,* 18(15): 7917.
https://www.drugsandalcohol.ie/34735/

People who become homeless have higher morbidity and mortality, use a disproportionate amount of healthcare resources, and generate a large volume of potentially preventable healthcare and other costs compared to more privileged individuals. Although access to rehabilitation is a human right under Article 26 of the United Nations Convention on the Rights of Persons with Disabilities, the rehabilitation needs of individuals with homelessness have not been explored, and this project's purpose was to establish a baseline of need for this cohort.

The results of this study show that the rehabilitative needs of this cohort are significant and are not being met through traditional models of care. We are currently exploring innovative ways to provide appropriate services to these individuals.

Trends in strong opioid prescribing in Ireland: a repeated cross-sectional analysis of a national pharmacy claims database between 2010 and 2019

Norris BA, Smith A, Doran S and Barry M (2021) *Pharmacoepidemiology and Drug Safety,* 30(8): 1003–1011.
https://www.drugsandalcohol.ie/34688/

This study investigated strong opioid prescribing in Irish General Medical Services (GMS) patients over a 10-year period.

This study found an overall increase in strong opioid prescribing in Ireland between 2010 and 2019, particularly in older adults. Tramadol was the most frequently prescribed product, with oxycodone and tapentadol prescribing increasing markedly over the study period.

Recent publications   continued

The dialectics of heroin and methadone in Ireland

Saris AJ (2021) *Irish Journal of Psychological Medicine,* Early online.
https://www.drugsandalcohol.ie/34759/

In this paper, I reflect on two of my intertwined research interests. The first is my professional engagement with researching drug use and abuse in Ireland, especially heroin addiction, in applied ethnographic projects, generally answering a specific set of questions on how services for 'drug addiction' work. My second interest is the historical construction of 'addiction' and the discursive intersections that produce various kinds of power, subjects, and techniques around this concept.

I find the dialectical relationship between heroin and methadone in Ireland, especially the emergence of heroin 'injecting rooms', as a window into how drugs are social things. Drugs and the bodies who take them live in complex moral worlds, not as inert objects surrounded by abstract human creations. These worlds are an integral part of how 'addiction' works and how drugs treating addiction are actually used. Without a deeper understanding of such complexities we will continue to miss key issues in the lives of people we hope to help.

Dialectical behaviour therapy skills training for individuals with substance use disorder: a systematic review

Warner N and Murphy M (2022) *Drug and Alcohol Review,*
41(2): 501–516.
https://www.drugsandalcohol.ie/34686/

Dialectical behaviour therapy skills training (DBT–ST) is currently being implemented as a standalone intervention for substance use disorders (SUD), despite limited empirical evidence to support its efficacy in this context. This review aimed to investigate the feasibility, acceptability and efficacy of DBT–ST for SUD.

Despite offering preliminary support for DBT–ST for SUD, the lack of controls, small samples and inconsistent adaptations of DBT–ST across studies limits capacity to draw causal conclusions or make specific recommendations.

POLICY

'We don't have any answers within the current framework': tensions within cannabis policy change in Ireland

O'Ralaigh C and Morton S (2021) *Drugs and Alcohol Today,* Early online.
https://www.drugsandalcohol.ie/35298/

This study aims to explore policymaker's attitudes towards the decriminalisation and legal regulation of cannabis for recreational use in the midst of an unfolding policy process, examining the degree which a 'policy window' might be open for the implementation of cannabis policy change.

Irish policymakers indicated broad support for the decriminalisation of cannabis. The legal regulation of cannabis received more qualified support. Existing policy was heavily criticised with criminalisation identified as a clear failure. Of particular interest was the willingness of policymakers to offer opinions which contrasted with the policy positions of their organisations. While a policy window did open – and close – subsequent governmental commitments to examine the issue of drugs policy in a more deliberative process in the near future highlight the incremental nature of policy change.