Focal Point Ireland: national report for 2021 – Drug policy Ireland

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

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This document was prepared for publication by the staff of the HRB National Drugs Library.

Please use the following citation:

Health Research Board. Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (2022) *Focal Point Ireland: national report for 2021 – Drug policy*. Dublin: Health Research Board.

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(2022) Focal Point Ireland: national report for 2021 – Legal framework

(2022) Focal Point Ireland: national report for 2021 – Treatment

(2022) Focal Point Ireland: national report for 2021 – Drug markets and crime

(2022) Focal Point Ireland: national report for 2021 – Prevention

(2022) Focal Point Ireland: national report for 2021 – Prison

(2022) Focal Point Ireland: national report for 2021 – Harms and harms reduction

(2022) Focal Point Ireland: national report for 2021 – Drugs

Table of Contents

T0. Summary

Summary of T1.1 National drugs strategies

Ireland's national drugs strategy, entitled *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025,* was launched in July 2017 (Department of Health 2017). The strategy is structured around cross-cutting goals and emphasises a health-led approach to addressing the drug situation in Ireland (Department of Community 2009). It is the first integrated drug and alcohol strategy in Ireland. It defines substance misuse as "the harmful or hazardous use of psychoactive substances, including alcohol, illegal drugs and the abuse of prescription medicines" (Department of Health 2017) (p. 7).

The strategy covers an eight-year period (2017–2025) and is accompanied by a shorter-term action plan (2017–2020) (Department of Health 2017). The strategy's vision is for "a healthier and safer Ireland, where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life" (Department of Health 2017) (p. 8).

The strategy's five strategic goals are to:

1. Promote and protect health and well-being
2. Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery
3. Address the harms of drug markets and reduce access to drugs for harmful use
4. Support participation of individuals, families, and communities
5. Develop sound and comprehensive evidence-informed policies and actions.

A final substantive chapter of the strategy focuses on what is termed "strengthening the performance of the strategy" (Department of Health 2017) (p. 73). There are two key elements to this: performance measurement, and the structures supporting the implementation of the strategy.

Government Departments with responsibility for implementing various actions in the strategy include: Health (overall responsibility); Education; Children, Equality, Disability, Integration and Youth; Social Protection; Housing, Local Government and Heritage; Justice; and Transport.

The *Programme for Government* adopted in June 2020 supports the ongoing approach of the national drugs strategy while committing to some new actions which are also aligned with the strategy (Fianna Fail*, et al.* 2020). A new action plan to cover the remainder of the strategy is under development but had yet to be published at the time of writing (September 2021).

Summary of T1.2 Drug strategy evaluation

Progress reports on Ireland's national drugs strategy, *Reducing Harm, Supporting Recovery: Progress 2018 and Planned Activity 2019*, are published annually (Drugs Policy Unit Department of Health 2019), (Drugs Policy and Social Inclusion Unit 2020), (Drugs Policy and Social Inclusion Unit 2021). These reports are structured around the strategic action plan for 2017–2020 which is included in the national drugs strategy document. The Drugs Policy and Social Inclusion Unit at the Department of Health is responsible for collating feedback from stakeholders on their progress in delivering on their

allocated actions and the progress report is the output of this work. The information reported is descriptive – it describes activities undertaken in working towards each goal and its associated outputs but does not cover outcomes. A summary table in the 2020 progress report (published in 2021) presents the status of actions for each goal prescribed in 2017 (see Table 1.2.2.1 in Section T1.2.2). In addition to the progress report, the Drugs Policy and Social Inclusion Unit has carried out a midterm review of the strategy. It had not been published at the time of writing (September 2021). This midterm review will reflect on progress in implementing the 2017 strategy and will inform the generation of a new set of actions planned for the period 2021–2025, actions that will address newly emerging needs and challenges.

In relation to Ireland's previous national drugs strategy (2009–2016), there was no final report or evaluation of the strategy that ended in 2016 (Department of Community 2009). Neither was there a progress report on the national drugs strategy published for 2016 (these progress reports had been published for some years of the strategy (2011–15)). A rapid expert review of Ireland's national drugs strategy was carried out as part of the development of the current drugs strategy (Griffiths*, et al.* 2016). This expert review was not a full evaluation, but it did provide some valuable insights, and its findings are summarised in Section T1.2.2 of this workbook.

A focused policy assessment (FPA) that explores the national drugs strategy through an analysis of expenditure and effectiveness in line with the strategy's performance indicators was published in August 2021 (Bruton*, et al.* 2021). It was prepared by staff of the Irish Government Economic and Evaluation Service (IGEES) based in the Department of Health and the Department of Public Expenditure and Reform. Despite its limitations, it represents a valuable step toward 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 performance indicators that are measurable for the remainder of the strategy's lifetime, and to agree the optimal methodological approach to analysing expenditure and performance indicator-related data. The findings of the FPA paper are discussed in section T3.1 of this workbook.

Summary of T1.3 Drug policy coordination

Drug policy coordination in Ireland is as laid out in the national drugs strategy *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* (Department of Health 2017). While there are proposals to adapt these structures from the end of 2021, below is the structure for delivery at the time of writing (September 2021).

- The Minister for Health has overall ministerial responsibility for the national drugs strategy. The Department of Health also has a Minister of State for Public Health, Wellbeing and the National Drugs Strategy (formerly the Minister of State for Health Promotion and the National Drugs Strategy as per Figure 1.3.1.1).
- The National Oversight Committee is a senior official-level committee comprising senior members of the statutory, community, and voluntary sectors, and including the expertise of both a clinical and an academic representative.
- A Standing Subcommittee supports the implementation of the national drugs strategy and promotes coordination between national, local, and regional levels. It is chaired by a senior

official in the Department of Health. Membership includes representatives from the statutory, community, and voluntary sectors.

- The National Oversight Committee can establish subcommittees to address specific issues and draw on any expertise necessary to support it in delivering its functions.
- The Drugs Policy and Social Inclusion Unit at the Department of Health supports the Ministers, National Oversight Committee, and subcommittees; analyses the implications of research findings for policy and design of initiatives to tackle the drug problem; and advises on the commissioning of new research and the development of new data sources.
- The Health Research Board (HRB) is the European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA's) national focal point. It manages the commissioning of any research.
- The Early Warning and Emerging Trends Committee receives, shares, and monitors information from national and European Union (EU) sources.
- Local and regional Drug and Alcohol Task Forces (LDATFs and RDATFs) focus on assessing the extent and nature of the drug and alcohol problem in their areas, and on coordinating action at local level, so that there is a targeted response to the drug problem in local communities. LDATFs and RDATFs are represented on the national committees.

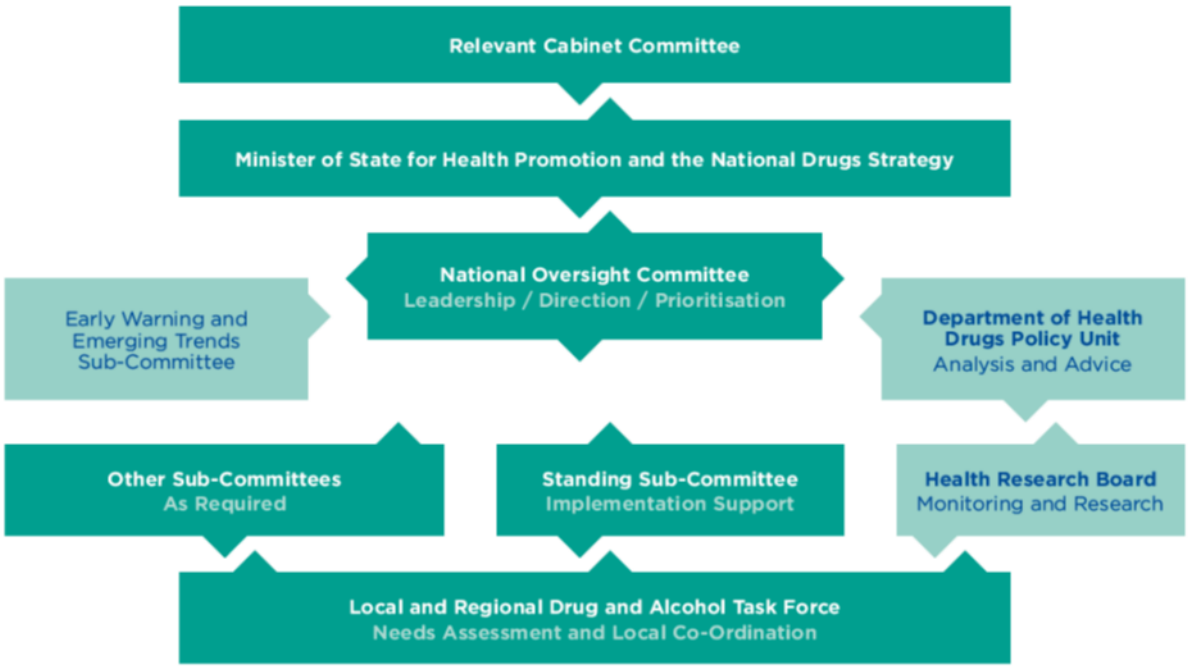


Figure T1.3.1.1 Coordination of bodies involved in the implementation of the national drugs strategy

Source: Structures supporting implementation of Reducing Harm, Supporting Recovery (Figure 11, p. 79) (Department of Health 2017).

Summary of T1.4 Drug-related public expenditure

The Minister for Health has overall responsibility for the national drugs strategy, whereas a wide range of Government Departments, State agencies, and the community and voluntary sector have

responsibility for delivering on its actions. There is no centrally held or ring-fenced budget allocated to the national drugs strategy. Instead, delivery of the strategy is funded by each Department securing the budget for the activities it is responsible for, and which it has committed to deliver. The Government Departments secure the budgets for these activities as part of Ireland's annual national budgetary process.

In its simplest terms, Government Departments engage in bilateral negotiations with the Department of Public Expenditure and Reform (DPER) about their budgets for the following year. Following detailed negotiations with Government Departments, the DPER agrees on proposed Estimates for Public Services for approval by Cabinet. These estimates are then voted on by Ireland's parliament.

Table 1.4.1 provides a summary of Ireland's labelled expenditure for the period 2014–2020. The total expenditure for 2020 (rounded up to three decimal places) was €233.203 million. In August 2021 a focused policy assessment of the national drugs strategy was published (Bruton*, et al.* 2021). Developing an estimate of Ireland's unlabelled drug-related public expenditure formed part of this report. A summary of its findings is in section T3.1 of this workbook.

Table 1.4.1. Public expenditure directly attributable to drug programmes (labelled), 2014–2020

Department/ Agency [1]	2014 (€m)	2015 (€m)	2016 (€m)	2017 (€m)	2018 (€m)	2019 (€m)	2020 (€m)
Health Research Board	€0.908	€1.013	€1.247	€0.756	€0.786	€0.786	€0.883
HSE Addiction Services	€86.122	€91.523	€93.43	€97.87	€99.828	€103.419	€105.653
HSE Drugs and Alcohol Task Force Projects	€21.570	€22.064	€22.78	€22.14	€22.63	€22.92	€22.436
An Garda Síochána[2]	€43.000	€43.000	€46.00	€47.00	€14.25	€13.17	€13.218
D/Children, Equality, Disability, Integration and Youth	€19.548	€19.548	€20.05	€20.04	€20.46	€20.46	€39.4
D/Justice	€18.762	€19.363	€20.56	€7.30	€6.95	-	€7.688
Revenue Customs Service	€16.235	€17.445	€17.36	€17.36	€19.60	-	€16.554
D/Social Protection (former FÁS area)	€14.063	€13.900	€16.41	€17.98	€17.22	€20.07	€20.789
D/Health	€7.266	€7.323	€6.08	€5.54	€6.015	€5.955	€5.974
Irish Prison Service	€4.200	€4.235	€4.40	€4.20	-	-	-
D/Education	€0.748	€0.748	€0.77	€0.76	€0.76	€0.72	€0.319
D/Further & Higher Education, Research, Innovation & Science	-	-	-	-	-	-	€0.289
Total	**€232.422**	**€240.162**	**€249.087**	**[3]€240.95**	**[3]€208.499**	**[3]€187.50**	**€233.203**

[1] *The department or agency's name as at the time of writing (September 2021) is listed here.*

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

[3] *The €53 million decrease in expenditure between 2017 and 2019 reflects limitations in reporting of expenditure from An Garda Siochana, Department of Justice, Irish Prison Service, and Revenue's Customs Service, rather than a reduction in expenditure per se.*

Summary of T1.3.1 New developments

Below are the main policy developments or updates on policy in Ireland since the 2020 National Report:

1. Focused policy assessment on Ireland's national drugs strategy
2. Drug policy changes in response to the COVID-19 pandemic
3. Legislation against the coercion and use of minors in the sale and supply of drugs
4. Updates on implementation of the Public Health (Alcohol) Act 2018
5. Health Diversion Approach to possession of drugs for personal use.
6. Establishment of a pilot supervised injecting facility

1. Focused policy assessment on Ireland's 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.

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.

2. Drug policy changes in response to the COVID-19 pandemic

The drug policy changes made to harm-reduction services in Ireland in response to the COVID-19 pandemic, and which have been kept to date (September 2021), are:

- **Opioid substitution therapy (OST):** Changes were made that make it easier to access an OST programme.
- **Naloxone:** Access pathways to the opioid antagonist naloxone were relaxed.

3. Legislation against the coercion and use of minors in the sale and supply of drugs

The Programme for Government made a commitment to legislate against the coercion and use of minors in the sale and supply of drugs (Fianna Fail*, et al.* 2020). In January 2021, the Minister for Justice and the Minister of State for Law Reform announced the publication of the General Scheme of the Criminal Justice (Exploitation of Children in the Commission of Offences) Bill, marking the first stage of the process of introducing new legislation in Ireland. If enacted, the Bill will outlaw the grooming of children into crime by creating specific offences where an adult compels, coerces, induces, or invites a child to engage in criminal activity.

Other new proposed legislation is detailed in section T3.4 of the Legal Framework workbook.

4. Updates on implementation of the Public Health (Alcohol) Act 2018

The Public Health (Alcohol) Act 2018 was signed into law in October 2018. It is the first piece of legislation to identify alcohol use as a public health issue. The aim of the Act is to reduce alcohol consumption in Ireland and the harms it causes at a population level, and the Act provides for a suite of evidence-based measures to deliver on this aim. Changes in the implementation of key provisions of this Act since the 2020 National Report relate to minimum unit pricing (MUP), structural separation, and restrictions on the sale and supply of alcohol.

5. Health Diversion Approach to possession of drugs for personal use

On 2 August 2019, the Irish Government announced the launch of a Health Diversion Approach to the possession of drugs for personal use (Harris 2019, 2 August). This approach will offer alternatives to criminal prosecution for the first two instances in which people are found in possession of drugs for their personal use. An implementation, monitoring, and evaluation group was established in late 2019 to examine the need for legislative change, the operational details, and the phasing of the implementation. The group is chaired by the Department of Health and its membership includes the Health Service Executive (HSE), An Garda Síochána (AGS), and the Department of Justice. The group began its work in Q4 2019 with the aim of phasing in the Health Diversion Approach in Q3 2020. Due to the COVID-19 pandemic this date was deferred and the Health Diversion Approach is now due to be adopted in five locations in late 2021 (personal communication, Drugs Policy and Social Inclusion Unit, Department of Health, July 2021).

6. Establishment of a pilot supervised injecting facility

The establishment of a pilot supervised injecting facility is a commitment given in the Programme for Government (Fianna Fail*, et al.* 2020). This same action was proposed as part of the national drugs strategy, *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* (Department of Health 2017). Despite the relevant legislation having been enacted in 2017, the service has yet to open. There was a lengthy process involved in initially securing planning permission (on a temporary basis of three years) in December 2019. However, this was appealed to Ireland's High Court and in July 2021 this planning permission was revoked. It is understood that the reason planning permission was revoked was not because it was for a supervised injecting centre, rather because of technical and legal issues with the planning process. The High Court's decision was also influenced by the failure to address adequately strongly held opposition lodged by a school near to the site.

Summary of T4.1 Additional important sources of information

Additional sources of information covered in Section T4.1 are:

1. New priorities for the British–Irish Council
2. Coordination, framing, and innovation: the political sophistication of public health advocates in Ireland
3. Irish drug policy alternatives: a qualitative study
4. Systematic review of media coverage on new psychoactive substances in Ireland 2000–2010.

T1. National profile

T1.1 National drugs strategies

T1.1.1 Titles and dates of all national drugs strategies and supporting action plans

Time frame	Title and web link	Scope (main substances/addictions addressed)
2017–2025	*Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* https://www.drugsandalcohol.ie/27603/	Illicit drugs and alcohol
2009–2016	*National Drugs Strategy (interim) 2009–2016* https://www.drugsandalcohol.ie/12388/	Illicit drugs
2001–2008	*Building on Experience: National Drugs Strategy 2001 – 2008* https://www.drugsandalcohol.ie/5187/	Illicit drugs
Not defined, published in 1997; precursor to the 2001–2008 national drugs strategy	*Second Report of the Ministerial Task Force for Measures to Reduce the Demand for Drugs* http://www.drugsandalcohol.ie/5114/	Illicit drugs
Not defined, published in 1996; precursor to the 2001–2008 national drugs strategy	*First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* http://www.drugsandalcohol.ie/5058/	Illicit drugs
Not defined, published in 1991	*Government Strategy to Prevent Drug Misuse* https://www.drugsandalcohol.ie/5108/	Illicit drugs

T1.1.2 Summary of current national drugs strategy

Ireland's national drugs strategy, entitled *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* was launched in July 2017 (Department of Health 2017). While the strategy is structured around cross-cutting goals rather than the pillars of the previous national drugs strategy (2009–2016), its content largely follows on from that of the previous strategy (Department of Community 2009). It reflects the commitment made by Government in May 2016 "to pursue a health-led rather than a criminal justice approach to drug use" (Government of Ireland 2016) (p. 56), a commitment that is reiterated in the current Irish

Government's Programme for Government published in 2020 (Fianna Fail*, et al.* 2020). The national drugs strategy covers an eight-year period (2017–2025) and is accompanied by a shorter-term action plan (2017–2020) (Department of Health 2017). A new action plan to cover the remainder of the strategy is under development but had yet to be published at the time of writing (September 2021).

The implementation structure is detailed in Section T1.3. An overview is as follows:

- Overall responsibility for the national drugs strategy rests with the Minister for Health and the Minister of State, Department of Health, who also has responsibility for public health and well-being.
- Government Departments with responsibility for implementing various actions in the national drugs strategy include: Health; Education; Children, Equality, Disability, Integration and Youth; Social Protection; Housing, Local Government and Heritage; Justice; and Transport.
- The following statutory bodies are responsible for implementing actions in the national drugs strategy: the Health Service Executive (HSE); the HRB; Child and Adolescent Mental Health Services (CAMHS); Tusla – the Child and Family Agency; the Irish Prison Service; local authorities; AGS; the Revenue Commissioners' Customs and Excise service, the State Laboratory; the Medical Bureau of Road Safety; and the Probation Service.
- Certain agencies within the community and voluntary sector are also responsible for implementing actions. These include LDATFs and RDATFs; the Union for Improved Services, Communication and Education (UISCE; a service users' forum), and the National Family Support Network.

Substance coverage

This is the first strategy to move towards an integrated approach to illicit drug and alcohol use. There has been a long-standing debate in Ireland on the question of whether alcohol and illicit drug use should and could be addressed in the same strategy. In 2009, the Government made a commitment to produce "a combined National Substance Misuse Strategy to cover both alcohol and drugs" (Department of Community 2009) (p. 5), but in practice, alcohol policy has largely been implemented separately. The current strategy defines substance misuse as "the harmful or hazardous use of psychoactive substances, including alcohol, illegal drugs and the abuse of prescription medicines" (Department of Health 2017) (p. 7). There is an explicit commitment to ensure that "an integrated public health approach to drugs and alcohol is delivered as a key priority" (Department of Health 2017) (p. 22). The strategy complements the Public Health (Alcohol) Act 2018 and reinforces some of the key elements of the alcohol-focused 2012 *Steering Group Report on a National Substance Misuse Strategy* (Department of Health 2012b). While the current strategy places much more of a focus on alcohol when compared with previous national drugs strategies, illicit drug use is the primary focus of many of the actions of the 2017–2020 action plan. A new action plan to cover the remainder of the strategy is under development but had yet to be published at the time of writing (September 2021).

Overview of the strategy: vision, values, and goals

The strategy is underpinned by a set of core values and is structured around a vision and five goals. Each goal has a set of objectives, accompanying actions, and performance indicators. While not explicitly structured around pillars, as the previous national drugs strategy was, the current strategy

covers the themes of the previous strategy: supply reduction, prevention, treatment, rehabilitation, and research. However, there is an additional focus on the role of people who use drugs, their families, and communities, and taking a more health-led approach.

Vision

The strategy's vision is for "A healthier and safer Ireland, where public health and safety is protected and the harms caused to individuals, families and communities by substance misuse are reduced and every person affected by substance use is empowered to improve their health and wellbeing and quality of life" (Department of Health 2017) (p. 8).

Values

To deliver on this vision, the strategy is underpinned by six values:

- *Compassion:* A humane, compassionate approach focused on harm reduction which recognises that substance misuse is a healthcare issue
- *Respect*: Respect for the right of each individual to receive person-centred care based on his or her specific needs and to be involved in the development of their care plan
- *Equity:* A commitment to ensuring that people have access to high-quality services and support regardless of where they live or who they are
- *Inclusion:* Diversity is valued, the needs of particular groups are accommodated, and wide-ranging participation is promoted
- *Partnership:* Support for maintaining a partnership approach between statutory, community, and voluntary bodies and wider society to address drug and alcohol issues
- *Evidence informed:* Support for the use of high-quality evidence to inform effective policies and actions in order to address drug and alcohol problems.

Goals

The five strategic goals and their accompanying objectives are to:

1. Promote and protect health and well-being:

   1.1 Promote healthier lifestyles within society

   1.2 Prevent the use of drugs and alcohol at a young age

   1.3 Develop harm-reduction interventions targeting at-risk groups

2. Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery:

   2.1 To attain better health and social outcomes for people who experience harm from substance misuse and meet their recovery and rehabilitation needs

   2.2 Reduce harm among high-risk users

3. Address the harms of drug markets and reduce access to drugs for harmful use:

   3.1 Provide a comprehensive and responsive misuse of drugs control framework which ensures the proper control, management, and regulation of the supply of drugs

3.2 Implement effective law enforcement and supply reduction strategies and actions to prevent, disrupt, or otherwise reduce the availability of illicit drugs

3.3 Develop effective monitoring for, and responses to, evolving trends, public health threats, and the emergence of new drug markets

4. Support participation of individuals, families, and communities:

   4.1 Strengthen the resilience of communities and build their capacity to respond

   4.2 Enable participation of both users of services and their families

5. Develop sound and comprehensive evidence-informed policies and actions

   5.1 Support high-quality monitoring, evaluation and research to ensure evidence-informed policies and practice.

Another substantive chapter focuses on what is termed "strengthening the performance of the strategy" (Department of Health 2017) (p.73). There are two key elements to this: measuring performance and the structures supporting the implementation of the strategy. The strategic action plan for 2017–2020 is embedded in the main strategy document and contains 50 actions, with a list of statutory, community, and voluntary partners with responsibility for their delivery. Throughout the strategy there is a focus on synergising with other relevant strategies. A list of 21 "relevant interconnected strategies and policies", (Department of Health 2017) (p. 99) is cited in the document, with a number of the actions linked directly to those of other Government strategies.

The Programme for Government launched in June 2020 supports the ongoing approach of the national drugs strategy, while committing to some additional actions which are also aligned with the strategy (Fianna Fail*, et al.* 2020). These were described in detail in the 2020 National Report. The new actions include:

- Improving the link between the delivery of the national drugs strategy and mental health policy
- Maintaining the increased and improved access to opioid substitution services achieved during the COVID-19 pandemic
- Examining the regulations and legislation that apply to cannabis use for medical conditions and palliative care
- Holding a citizens' assembly to consider matters relating to drug use
- Legislating against the coercion and use of minors in the sale and supply of drugs
- Establishing a 24-hour helpline, using the FRANK helpline service in the United Kingdom as a model
- Examining the potential for an information campaign on the health impacts of steroid use, particularly on young men
- Addressing the needs of women who face barriers to accessing and sustaining addiction treatment, arising from an absence of childcare or the presence of domestic violence
- Increasing support for step-down accommodation to prevent high-risk single people and families from exiting treatment into homelessness

- Resourcing of harm reduction and education campaigns aimed at increasing awareness of the risks of drug use and the contribution of drugs to criminality.

Three of the actions in the Programme for Government indicate a move from exploring an issue in the 2017-2020 strategic action plan to a commitment to becoming a policy position. If fully enacted, these policies will:

- Increase and support drug-quality testing services, particularly at festivals
- Support the roll-out of access to, and training in, opioid antidotes
- Implement an alternative approach to the possession of drugs for personal use and carry out a review its first year of implementation.

Overall, the current Programme for Government indicates an ongoing commitment to a health-led approach to meet the needs of people who use drugs, undertaking a set of actions that are similar to those within the national drugs strategy, and that are to be delivered under existing structures. The shorter-term three-year strategic action plan launched in 2017 expired at the end of 2020. Another is due for publication in 2021, but it had not yet been published at the time of writing (September 2021). The Programme for Government would indicate that the new action plan for 2021 and onwards will be closely aligned with its predecessor.

T1.1.3 National strategy/action plans on policing, public security & law enforcement

Each year, the Garda Commissioner is required to prepare an annual Policing Plan under Section 22 of the Garda Síochána Act 2005, as amended. The Policing Plan sets out the actions and activities that AGS will undertake in a given year, along with the levels of performance to be achieved. The Policing Authority then approves that plan with the consent of the Minister for Justice. The most recent Policing Plan (for 2021) is outlined in Section T1.3.1a of the *Drug markets and crime workbook*. AGS will report monthly to the Policing Authority on the progress made against the Policing Plan, and the monthly reports will be published by the Authority.

- An Garda Síochána Strategic Planning Unit (2021) *An Garda Síochána Annual Policing Plan 2021*. Dublin: Policing Authority of Ireland. https://www.drugsandalcohol.ie/34825/

T1.1.4 Additional national strategy/action plans for other substances and addictions

Table 1.1.4.1 Additional national strategy documents for other substances and addictions

Alcohol
Strategy title *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025*
Web address https://www.drugsandalcohol.ie/27603/

Table 1.1.4.1 Additional national strategy documents for other substances and addictions
Tobacco
Strategy title *Tobacco Free Ireland*
Web address https://www.drugsandalcohol.ie/20655/
Image and performance enhancing drugs
Strategy title None
Web address
Gambling
Strategy title None
Web address
Gaming
Strategy title None Web address
Internet
Strategy title None Web address
Other addictions
Strategy title None Web address
*please include extra lines as necessary

T1.1.5. Are there drug strategies/action plans also at the regional level?

LDATFs and RDATFs are required to assess the extent and nature of the drug problem in their areas and coordinate action at local level so that there is a targeted response to the drug problem in local communities. They comprise representatives from a range of relevant agencies, such as the HSE, AGS, the Probation and Welfare Service, Education and Training Boards, local authorities, and the

youth service, as well as elected public representatives and voluntary and community sector representatives.

The Task Forces are required to have a local drugs strategy for addressing the drug-related needs in their area. However, these are not systematically published and therefore many are not available for analysis.

The 2019 National Report stated that the guidance handbook for Task Forces was under review, and this continued to be the case in 2020. The 2019 National Report also stated that it was expected that the local drugs strategies would be one of the issues addressed. A personal communication from the Department of Health Drug Policy and Social Inclusion Unit stated that "Drug and Alcohol Task Forces were set up on an ad hoc non-statutory basis and many are not incorporated as limited companies or charities and have no legal status. In view of recent changes in governance requirements in Ireland, and to strengthen the effectiveness of the structures of Task Forces, it is intended to introduce a Governance Code for Task Forces in 2020. Work on the revision of the Task Force Handbook has been deferred until the completion of this exercise. The Governance Code will assist Task Forces [to] become more effective in their operations and in prioritising and [reducing] problem drug use in their areas" (personal communication, Drug Policy and Social Inclusion Unit, August 2020). More recent comment on this from the Minister of State with responsibility for Public Health, Wellbeing and the National Drugs Strategy in January 2021 included the elaboration that "adherence to the code will require a new regime of governance and documentation for task forces. It is anticipated that Task Forces will be required to sign up to the Charities Regulator governance code. The code sets minimum standards for the board of a registered charity or limited company to ensure they effectively manage and control their organisations" (Feighan 2021, 27 January).

T1.1.6. Does the capital city of your country have a drug strategy/action plan?

No, the capital city does not have its own drug strategy/action plan.

T1.1.7 Elements of content of the EU drug strategy 2013-2020 and of the EU drug action plans (2013-16 and 2017-20) that were directly reflected Ireland's most recent national drug strategy

Under the third Goal of Ireland's national drugs strategy – to address the harms of drug markets and reduce access to drugs for harmful use – the strategy acknowledges Ireland's support for the EU's strategic position on drugs:

"Ireland participated at UNGASS [United Nations General Assembly Special Session on Drugs] as a member state of the EU and supported the key strategic position of the EU on drugs policy, which welcomes a steady transition towards a more balanced global approach that includes aspects of public health-based policies, while continuing to pursue efforts to counter transnational organised crime and drug trafficking" (Department of Health 2017) (p. 54).

Overall approach

The development of Ireland's national drugs strategy and action plan was guided by national priorities, the input of stakeholders, and the findings of the *Report of the Rapid Expert Review of the National Drugs Strategy 2009–2016* (see Section T1.2.2 for a summary of the review) (Griffiths*, et al.* 2016). While the Department of Health did not set out to mirror the EU's 2013–2020 strategy when developing Ireland's national drugs strategy for 2017 to 2025, there is significant overlap between

the two. There continues to be close alignment with the latest EU strategy (2021-2025) which indicates a move by the EU towards an increased focus on health and drug-related harm (Council of the European Union 2020) in its overarching goals and policy areas and in the objectives and strategic priorities. Ireland's national drugs strategy reflects a similarly balanced approach to addressing both supply and demand-reduction activities, although the Irish strategy tends to place relatively more emphasis on addressing the latter (a health-led approach) than the former (a criminal justice-led approach). Very similar priorities are identified across the board, including in the areas of prevention, treatment, harm reduction, rehabilitation/recovery/reintegration, drug markets, legislation, law enforcement, and drug monitoring. Given the move by the EU towards a strategy with an increased focus on health and drug-related harm, the strategies are now more closely aligned. When welcoming the new EU strategy, the Minister of State for Public Health, Wellbeing and the National Drugs Strategy said that Ireland had advocated for this increased focus on health:

"I welcome the new focus on the health needs of people who use drugs in the EU strategy, which mirrors the health-led approach in our national strategy, Reducing Harming, Supporting Recovery. Ireland strongly advocated for the inclusion of harm reduction in the strategy, along with traditional policies to reduce the supply and the demand for drugs" (Department of Health 2021).

Both strategies emphasise the need for an evidence-based approach. Indeed, this is one of the five key goals of the Irish strategy.

EU partners

The Irish strategy explicitly aligns itself with the EU and other international partners on a range of activities; for example, on intercepting drugs – and precursors for diversion to the manufacture of drugs – being trafficked to Ireland, and on early warning and emerging trends networks. As part of an action to strengthen Ireland's drug monitoring system, the Irish strategy commits to using EMCDDA protocols to monitor the drug situation and to be able to respond to new data monitoring requests from the EU.

Human rights and health-led approach

The fundamentals of EU law and the values of the EU underpin the EU strategy, within which is a strong commitment to upholding human rights. There are a number of features of the Irish strategy that indicate a more human rights-based approach than were in previous Irish strategies. These include that it takes a health-led approach to drug use; is underpinned by the values of compassion, respect, equity, inclusion, and partnership; is evidence informed; and incorporates human rights in some elements (for example, introducing supervised injecting facilities and exploring approaches to the possession of small quantities of drugs). However, the language in the Irish strategy is framed around the health-led approach rather than using the language of human rights. Human rights are only specifically mentioned once in the Irish strategy document, and this is in relation to developing a Quality Assurance Framework for the delivery of services.

Performance measurement

Ireland's action plan for 2017–2020 identified 50 strategic actions, how they were to be delivered, the lead agency with responsibility for each action, and the relevant partners. However, unlike the EU's action plan, it did not provide timetables, indicators, or data collection/assessment mechanisms for each action. While not linked to specific actions, a selection of performance indicators is presented under each goal in the 2017 action plan (Department of Health 2017).

Ongoing alignment

The alignment between the Irish and EU strategies is expected to continue. Both the EU and Ireland are due to release new action plans for the period from 2021, action plans by which they are to deliver on their respective strategies. The Minister of State for Public Health, Wellbeing and the National Drugs Strategy has said that there will be synergy between the Irish and EU action plans:

"The EU Drugs Strategy and the forthcoming action plan are very timely as it will inform the mid-term review of actions in the national drugs strategy. Ireland cannot address the drugs issue in isolation from our European colleagues. I want to ensure that there is a synergy between the EU and national strategies and to avail of the opportunities provided in the EU strategy to share learning and good practice between Member States" (Department of Health 2021).

T1.1.8. Optional. Please provide any additional information you feel is important to understand the governance of drug issues within your country.

No information.

T1.2 Evaluation of national drugs strategies

T1.2.1 Evaluations of national drugs strategies and supporting action plans

Progress reports on the current national drugs strategy have been published for the years 2018, 2019 and 2020 (Drugs Policy Unit Department of Health 2019) (Drugs Policy and Social Inclusion Unit 2020) (Drugs Policy and Social Inclusion Unit 2021). The three-year strategic action plan that was launched in 2017 expired at the end of 2020. A review of it at midterm in the eight-year national drugs strategy is being used to inform development of the new action plan applicable for the remainder of the strategy (personal communication, Drug Policy and Social Inclusion Unit, July 2021).The review and new action plan had yet to be published at the time of writing (September 2021).

No progress reports on the National Drugs Strategy (2009–2016) were published in 2016 or 2017, nor was there a summative report or evaluation on that strategy upon its completion. However, the *Report of the Rapid Expert Review of the National Drugs Strategy 2009–2016* (Department of Community 2009) provided a resource that contributed to the development of the current national drugs strategy (Griffiths*, et al.* 2016). This report did not provide an evaluation of the strategy, but it did provide some valuable insights. It is summarised in Section T1.2.2, along with the most recent progress report and the recently published focused policy assessment on the strategy (Bruton*, et al.* 2021).

Titles and links to progress reports on the current national drugs strategy are as follows:

- *Reducing Harm, Supporting Recovery: Progress Report 2019* (Drugs Policy and Social Inclusion Unit 2020) https://www.drugsandalcohol.ie/34530/
- *Reducing Harm, Supporting Recovery: Progress 2018 and Planned Activity 2019* (Drugs Policy Unit Department of Health 2019) https://www.drugsandalcohol.ie/30660/

Titles and links to progress reports on the previous national drugs strategy are as follows:

- *National Drugs Strategy 2009–2016: Progress Report to End 2015* (Department of Health 2016) https://www.drugsandalcohol.ie/25365/
- *National Drugs Strategy 2009–2016: Progress Report to End 2014* (Department of Health 2015) https://www.drugsandalcohol.ie/23935/
- *National Drugs Strategy 2009–2016: Progress Report to End 2013* (Department of Health 2014) https://www.drugsandalcohol.ie/21621/
- *National Drugs Strategy 2009–2016: Progress Report to End 2012* (Department of Health 2013) https://www.drugsandalcohol.ie/20159/
- *National Drugs Strategy 2009–16: Implementation of Actions Progress Report End 2011* (Department of Health 2012a) https://www.drugsandalcohol.ie/17109/

T1.2.2. Results of the latest strategy evaluation

Several reports on Ireland's national drugs strategies have been published. In the following subsections these are considered in reverse chronological order.

- ***Focused policy assessment of Reducing Harm, Supporting Recovery: an analysis of expenditure and performance in the area of drug and alcohol misuse. https://www.drugsandalcohol.ie/34729/***

A focused policy assessment (FPA) that explores the national drugs strategy through an analysis of expenditure and effectiveness in line with the strategy's performance indicators was published in August 2021 (Bruton*, et al.* 2021). It was prepared by staff of the Irish Government Economic and Evaluation Service (IGEES) based in the Department of Health and the Department of Public Expenditure and Reform. The purpose of the FPA was 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. The paper maps the availability of data for the strategy's 29 performance indicators and analyses those that are available (for 12 performance indicators), in an attempt to assess the performance of the national drugs strategy under its strategic goals. Despite its limitations, it represents a valuable step toward 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 performance indicators that are measurable for the remainder of the strategy's lifetime, and to agree the optimal methodological approach to analysing expenditure and performance indicator-related data. The findings of the FPA paper are discussed in section T3.1 of this workbook.

- ***Reducing Harm, Supporting Recovery: Progress Report 2020 (Drugs Policy and Social Inclusion Unit 2021)***

The most recent progress report on the current national drugs strategy was published in 2021 under the title *Reducing Harm, Supporting Recovery: Progress Report for 2020* (Drugs Policy and Social Inclusion Unit 2021). The report, like its predecessors in 2018 and 2019, is structured around the strategic action plan for 2017–2020 that was included in the main strategy document (Department of

Health 2017). That action plan contained 50 specific actions, with a brief description of how each was to be delivered. Lead agencies were also identified, as well as any associated partners with responsibility for the delivery of the respective actions. 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" (Department of Health 2017) (p. 73). 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 (Drugs Policy and Social Inclusion Unit 2020), (Drugs Policy Unit Department of Health 2019), (Drugs Policy and Social Inclusion Unit 2021).

As with the previous reports, the information reported for 2020 was descriptive and presented in table form. It 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 what these categorisations were based on. See Table 1.2.2.1 for a summary of this progress. The report only provided information for 45 of the 50 strategic actions.

Table 1.2.2.1 Summary of action status for 2020 for each strategic goal

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 well-being	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: *Reducing Harm Supporting Recovery: Progress Report for 2020* (Drugs Policy and Social Inclusion Unit 2021)

- ***Report of the Rapid Expert Review of the National Drugs Strategy 2009–2016***
  http://www.drugsandalcohol.ie/27289/

As reported in previous National Reports, no evaluation of Ireland's National Drugs Strategy 2009–2016 was carried out. There was, however, a rapid expert review of the strategy published in 2016 (Griffiths*, et al.* 2016). In late 2015, the then Minister of State with responsibility for Health Promotion and the National Drugs Strategy established a steering committee to provide him with

guidance and advice on the development of the new national drugs strategy. The work of this steering committee was informed by inputs that included a report from a group of international experts who undertook a high-level review of the National Drugs Strategy 2009–2016 (Department of Community 2009). The findings from their review were published in August 2016 under the title *Report of the Rapid Expert Review of the National Drugs Strategy 2009–2016* (Griffiths*, et al.* 2016). Its purpose was "to inform the development of the next national drugs strategy by providing a 'helicopter view' of and capturing some key learning points from the experiences of the national drugs strategy 2009–2016" (Griffiths*, et al.* 2016) (p. 1). The review highlighted the complexities involved in developing a drugs strategy in a landscape that is always evolving and in which "articulation between social, criminal, and health policy areas is vital" (Griffiths*, et al.* 2016) (p. 31).

The review team's terms of reference were to:

- Examine the progress and impact of the National Drugs Strategy 2009–2016 in the context of the objectives, key performance indicators, and actions set out in the strategy
- Identify deficits in the implementation of the strategy
- Summarise success factors or barriers to success
- Comment on Ireland's evolution in tackling the drug problem in light of international trends
- Identify key learning points arising from the strategy and highlight areas to consider for development in the new national drugs strategy
- Provide a draft and final report to the Department of Health.

The review was based on documentary evidence and on meetings and site visits held during a week-long visit to Ireland in January 2016. The review team met with a range of stakeholders, including Government officials, statutory and voluntary sector service providers, community members, and service users. It is important to note that this was not an evaluation of the National Drugs Strategy 2009–2016. Some of the key findings from the review are presented here.

National Drugs Strategy 2009–2016

The National Drugs Strategy 2009–2016 (Department of Community 2009) was described by Griffiths *et al*. as a "well-crafted and comprehensive version of a contemporary EU drug strategy" (Griffiths*, et al.* 2016) (p. 2). Overall, the people consulted by the authors considered the strategy to have been "a valuable instrument, both in respect to the structures and coordination mechanism it established, and in respect to its content which allowed priorities to be identified and targeted" (Griffiths*, et al.* 2016) (p. 6). It helped "facilitate multiagency working, encouraged stakeholder buy-in, and helped galvanise political support for drug issues" (Griffiths*, et al.* 2016) (p. 7). Over the course of the strategy, progress was made on many of the priority areas. In particular, it was successful in targeting resources and developing services for opioid users.

However, the review also found that while delivery of the strategy got off to a good start, over time, some of the positive changes delivered in the initial phases "became less apparent" (Griffiths*, et al.* 2016) (p. 6) and the "usefulness and appropriateness of the instrument declined" (Griffiths*, et al.* 2016) (p. 8). Areas that became problematic included "[meeting] changing needs, stakeholder participation, sustaining appropriate coordination mechanisms, and follow up and continuing relevance of actions" (Griffiths*, et al.* 2016) (p. 6). Griffiths *et al*. argued that it was inevitable that

changes would occur over the period of a drugs strategy, and it was therefore important that the strategy be adapted to meet these changes.

The review discussed areas in which the national drugs strategy had lost its momentum over time, including the following:

- The "strong role of community organisations" (Griffiths*, et al.* 2016) (p. 9) in both strategy development and delivery was identified as one of the key features of the Irish context. In the course of the review, the team found that in some areas of the national drugs strategy, the coordination between local, regional, and national levels became less effective over time. Roles and responsibilities became less clear and lines of communication blurred. This impacted on progress in a number of ways. One of these impacts was that opportunities to identify and adopt effective interventions were sometimes missed. "The need for effective engagement with local communities, needs-based service provision, and mechanisms to ensure the quality of services delivered across locations, came up repeatedly during discussion on the current strategy" (Griffiths*, et al.* 2016) (p. 10).
- The impact of the strategy – in particular, the impact on local structures, services, and practices – appeared to vary across geographical areas. This was influenced by "changes in the location of needs since the drafting of the last [national drugs] strategy; the difficulty of reconfiguring delivery structures in response to these changes; and practical and resource issues related to developing service models suitable for areas where the target population is more geographically dispersed" (Griffiths*, et al.* 2016) (p. 9).
- The policy and operational landscape changed considerably over the course of the strategy. New strategies and structures had been developed across related fields. This had brought about "some corresponding lack of clarity on the purpose and/or role of different structures or actors working in the area" (Griffiths*, et al.* 2016) (p. 6).
- The commitment to research, monitoring, and evidence-based interventions in the national drugs strategy was seen as one of its strengths. However, momentum in this area had faded over time. It was seen as having faced some "problematic coordination and structural issues" (Griffiths*, et al.* 2016) (p. 11), including inadequate resourcing, a lack of standardisation for data collection, and a lack of capacity to analyse data collected and to use it to inform strategic decisions.

Structure of the national drugs strategy

In order to take learning from the experience of the National Drugs Strategy 2009–2016, the review discussed the effects of three elements of the strategy's structure:

- The topic areas of the five pillars were described as "well chosen", as they contained all the main elements of a "modern balanced drug strategy" (Griffiths*, et al.* 2016) (p. 8). There were pros and cons to structuring the national drugs strategy around these pillars. Keeping similar areas together gave clarity to the main tenets of the strategy and having a "point of focus" (Griffiths*, et al.* 2016) (p. 7) encouraged joined-up working in some areas. However, it also impeded cross-pillar coordination at times, in particular when resources were limited or reduced. Where issues cut across more than one pillar, they sometimes lacked ownership and failed to be addressed. However, the overall view was that the benefits of the pillar approach outweighed the costs. Griffiths *et al*. suggested that the new strategy could be

designed in such a way that would maintain the clarity that comes from keeping similar areas grouped together, but that would also facilitate better cross-area working.

- Actions were embedded in the seven-year strategy (2009–2016). However, doing so was found to have particular limitations. The actions could not be reactive to change in the drug situation over time, and this contributed to an overall perception of a decline in the national drugs strategy's "relevance and momentum" (Griffiths*, et al.* 2016) (p. 6) over its duration.
- The National Drugs Strategy 2009–2016 included a set of key performance indicators (KPIs). These were to be used to measure progress over time. Their appropriateness as measures both for changes over time and for the strategic goals they were linked to was not always clear. Furthermore, the data required in order to measure them were not always available, and investment in monitoring the KPIs "appeared to decline" (Griffiths*, et al.* 2016) (p. 6) over the course of the strategy. The KPIs therefore did not fulfil their intended role. Griffiths *et al*. suggested that the strategy's objectives, actions, and KPIs need to be more clearly linked together and be better sequenced in order to ensure that they are achievable.

New national drugs strategy

Based on their findings, Griffiths *et al.* made a number of suggestions for the national drugs strategy post 2016. These included the following:

- **Separate the actions from the strategy:** Given the relatively long period of time covered by Ireland's drugs strategies, Griffiths *et al*. argued strongly for separating the strategy from the actions. The strategy document could lay out the vision, objectives, and structure for the duration of the strategy (2017–2025), and a separate, time-bound (for example, three years) action plan could support the strategy. This approach would allow for an opportunity to reflect on progress and changes in the landscape at a midpoint in the strategy's time frame and to make appropriate changes to the action plan.
- **Synergise with other strategies:** In order to minimise duplication and the waste of scarce resources, and to maximise the impact of the strategies, Griffiths *et al*. emphasised the importance of having clear "synergy and complementarity" (Griffiths*, et al.* 2016) (p. 31) between the new national drugs strategy and other related strategies. This would include strategies dealing with other substances (alcohol in particular), strategies dealing with the needs of specific populations, and strategies dealing with areas or social issues where drug use is an issue.
- **Ensure equality of access to provision according to need:** Griffiths *et al*. argued that equality of access is a concept that should cut across the national drugs strategy. High-quality interventions of proven effectiveness need to be universally available irrespective of the types of drugs being used, where the user lives, or which community the user belongs to.
- **Identify and roll out good practice:** In the course of the review, Griffiths *et al.* were presented with numerous examples of good practice, but it appeared that there were barriers to these practices being implemented nationally. The authors argued for "a clear mechanism for identifying good practice supporting programme evaluation, and encouraging wider implementation where this is appropriate" (Griffiths*, et al.* 2016) (p. 10). They suggested drawing on national and international practice and programmes in order to

develop a suite of approved interventions that have been proven to work and that partners would be able to draw from.

- **Monitor, research, and evaluate:** These are considered "an essential element of any strategic response in this area" (Griffiths*, et al.* 2016) (p. 31). This would help ensure that the strategy is responsive to changing needs and will deliver on its goals. Following on from this, there must be mechanisms in place to facilitate the analysis of what is found, as well as the provision of advice based on this evidence to relevant stakeholders. Stakeholders would then be able to spread good practice and identify problem areas.
- **Clarity of structural functions for implementation and delivery:** The strategy should have a clear focus on how it is to be implemented and delivered, including the organisational structure and the roles and responsibilities of the various stakeholders. To facilitate the delivery of the strategy, Griffiths *et al*. highlighted the importance of leadership (ideally at a ministerial level with the support of a committee) to provide drive and direction/prioritisation, and to ensure that resources are made available.
- **Alcohol:** The authors made special mention of alcohol as a theme that recurred throughout the review – the high prevalence of problems associated with it, the "interactions" (Griffiths*, et al.* 2016) (p. 6) between alcohol and other problem drugs, and alcohol's place in the forthcoming strategy. While Griffiths *et al*. did not identify a specific model to follow, they noted that what is important is that areas such as prevention and treatment, where a "cross-substance approach is essential" (Griffiths*, et al.* 2016) (p. 12), are adequately supported.

Specific issues for the new national drugs strategy

Section 4 of the review identified a long list of specific issues that the team considered important for inclusion in what would be the new national drugs strategy. Replicating the full list is beyond the scope of this workbook; however, issues in Ireland at the time, reflecting those in other EU member states, were: meeting the needs of an ageing cohort of opioid users; new psychoactive substances; concern about cannabis in its various forms, in particular its high-potency products; and the negative impact of criminalising users, especially young cannabis users. Issues that appeared to be of particular relevance to Ireland were problematic prescription drug use, the spread of opioid use to rural areas, drug-related intimidation, and homelessness and housing insecurity.

The review was not an evaluation of the national drugs strategy. Rather, its purpose was to take lessons from the strategy's delivery to inform what was the forthcoming national drugs strategy.

T1.2.3. Planned evaluations of the national drugs strategy

There is no plan currently in place for an overall evaluation of Ireland's national drugs strategy. Planned publications of interest are the midterm review, the action plan for 2021-2025 and the annual progress reports.

Midterm review

At the time of launching the national drugs strategy, it was planned to carry out a midterm evaluation during 2020, which would be used to inform any updated action plan for 2021–2025. While not a full evaluation, a midterm review has been undertaken, but at the time of writing (July 2021), it has yet to be published. This review will reflect on progress in implementing the strategy, with scope to develop the actions for 2021–2025 which will address emerging needs and new

challenges. It will allow policy to take into account the impact of COVID-19 on people who use drugs and on associated services, and to plan accordingly for the remaining years of the strategy.

Action plan for 2021-2025

Ireland's three-year strategic action plan launched in 2017 identified 50 strategic actions, how they were to be delivered, the lead agency with responsibility for each action, and the relevant partners. These actions were to be delivered between 2017 and 2020, and the strategy allowed for the introduction of new measures after 2020 in order to address issues that emerged during the strategy's initial implementation period. This new action plan (which is to cover the remainder of the current strategy's lifetime) is under development but is not available at the time of writing (September 2021). The current Programme for Government makes a number of commitments related to the strategy (Fianna Fail*, et al.* 2020). When examined alongside the strategic action plan (2017–2020), most of the commitments in the Programme for Government can be linked to existing actions and reflect progress made on their delivery since 2017. There are some actions that deal with new developments in Irish drug policy: a new topic; target group; or approach to addressing the needs of people who use drugs. The Programme for Government suggests that the new action plan for 2021 and onwards will be closely aligned with its predecessor.

Progress reports

As outlined in Section T1.2.2, annual progress reports that are structured around the strategic action plans are published during the lifetime of the strategy. Lead agencies responsible for delivering the strategic actions report on their progress annually to the Minister with responsibility for the national drugs strategy. This is then collated as a descriptive report of activities undertaken to implement the action plan.

T1.3 Drug policy coordination

T1.3.1 Coordination bodies involved in drug policy

The structure of the coordination and implementation of the current national drugs strategy set out to improve on previous structures by being more streamlined to better deliver on the key functions of the strategy, and by ensuring that participation in the strategy would be optimised in a way that avoids "duplication and overlap" (Department of Health 2017) (p. 76). While there are proposals to adapt these structures from the end of 2021, below is the structure for delivery at the time of writing (September 2021).

Ministerial responsibility: The Minister for Health continues to have overall responsibility for the national drugs strategy. In addition, the Department of Health has a Minister of State for Public Health, Wellbeing and the National Drugs Strategy (formerly the Minister of State for Health Promotion and the National Drug Strategy, as per figure T1.3.1.1)

National Oversight Committee: This is a senior official-level committee sponsored by the Minister of State for Public Health, Wellbeing and the National Drugs Strategy. Membership includes representatives from the statutory, community, and voluntary sectors, as well as both a clinical and an academic representative. Membership from the statutory sector is at the level of Assistant Secretary. The committee meets on a quarterly basis and has five main functions, as outlined in its terms of reference:

a) "To give leadership, direction, prioritisation and mobilisation of resources to support the implementation of the strategy

b) To measure performance in order to strengthen the delivery of drugs initiatives and to improve the impact on the drug problem

c) To monitor the drugs situation and oversee the implementation of a prioritised programme of research to address gaps in knowledge

d) To ensure that the lessons drawn from evidence and good practice inform the development of policy and initiatives to address the drug problem

e) To convene subcommittees, as required, to support implementation of the strategy" (Department of Health 2017) (p. 77).

Standing Subcommittee: A Standing Subcommittee supports the implementation of the national drugs strategy and promotes coordination between national, local, and regional levels. It meets on a monthly basis and is chaired by a senior official in the Department of Health. Membership includes representatives from the statutory, community, and voluntary sectors. Its terms of reference are to:

- Drive implementation of the national drugs strategy at national, local, and regional levels
- Develop, implement, and monitor responses to drug-related intimidation as a matter of priority
- Support and monitor the role of Drug and Alcohol Task Forces (DATFs) in coordinating local and regional implementation of the national drugs strategy, with a view to strengthening the Task Force interagency model
- Improve performance, promote good practice, and build capacity to respond to the drug problem in line with the evidence base
- Ensure good governance and accountability by all partners involved in the delivery of the strategy
- Report to the National Oversight Committee on progress in the implementation of its work programme.

Members are expected to develop what is called a "liaison relationship" (Department of Health 2017) (p. 78) with DATFs to support effective coordination and communication between delivery bodies and stakeholders at all levels.

Subcommittees: The National Oversight Committee can establish subcommittees in order to address specific issues and draw on any expertise necessary to support the National Oversight Committee in delivering its functions.

Drugs Policy and Social Inclusion Unit, Department of Health: The unit is responsible for:

- Analysing the implications of research findings for policy and design of initiatives to tackle the drug problem
- Providing the National Oversight Committee with advice on the commissioning of new research and the development of new data sources, having regard to current information and research deficits, advice, changing patterns of drug use, and emerging trends

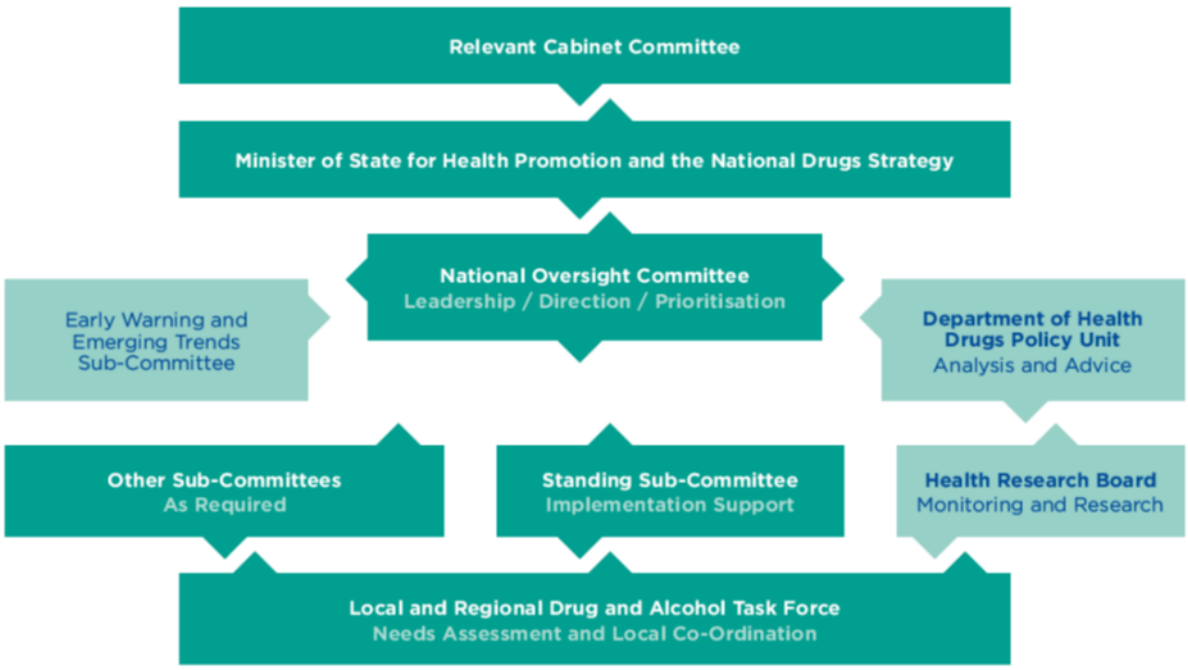
- Providing a secretariat to the National Oversight Committee and the Standing Subcommittee.

HRB: The HRB is the EMCDDA's national focal point. It manages the commissioning of any research that the National Oversight Committee decides needs to be undertaken in order to address the gaps in its knowledge.

Early Warning and Emerging Trends Committee: This committee receives, shares, and monitors information from national and EU sources on new psychoactive substances of concern and on any emerging trends and patterns in drug use and the associated risks.

DATFs: The terms of reference of the DATFs are referred to in the national drugs strategy. Based on these terms of reference, the role of the DATFs continues to focus on assessing the extent and nature of the drug and alcohol problem in their areas, and on coordinating action at local level so that there is a targeted response to the drug problem in local communities. The DATFs continue to implement the national drugs strategy in the context of the needs of their region or local area through action plans. They also provide an annual report on their activities to the Minister of State with responsibility for Health Promotion and the National Drugs Strategy. In the strategy, the Department of Health has responsibility for supporting the measurement of the DATFs' performance through the performance measurement system. DATFs are partners of the HSE in the oversight and implementation of the drugs strategy at local level, and they make recommendations to the HSE regarding funding of projects. While the DATFs assist the HSE in the management of the projects, the statutory provision states that it is the exclusive responsibility of the HSE to ensure that the funding is appropriately managed (personal communication, HSE, July 2018).

Figure T1.3.1.1 Structures supporting implementation of Reducing Harm, Supporting Recovery



Source: Figure 11, p. 79 (Department of Health 2017).

T1.4 Drug-related public expenditure

T1.4.1 Data on drug-related expenditure

Budget allocation process

As described in Section T1.3.1, the Minister for Health has overall responsibility for the national drugs strategy, while a wide range of Government Departments and State agencies, as well as the community and voluntary sector, have responsibility for delivering on its actions. There is no centrally held or ring-fenced budget allocated to the national drugs strategy. Instead, delivery of the strategy is funded by each Government Department securing the budget for the activities for which it is responsible and has committed to deliver. Government Departments negotiate their budgets as part of Ireland's annual national budgetary process.

In simplest terms, Government Departments engage in bilateral negotiations with the DPER about their budgets for the following year. The estimates process requires each Department to forecast its expenditure for the following year based on the range of activities it has committed to deliver in that year, including actions that relate to the national drugs strategy. It reflects the cost of providing an existing level of public service by the Government Department/agency and any plans for additional services and commitments. The previous year's budget is used as a baseline and Departments can amend this to reflect changes in their responsibilities and departmental priorities. After further detailed negotiations with Departments, the DPER agrees on proposed Estimates for Public Services for approval by Cabinet. These estimates are then voted on by Ireland's parliament. More information on this complex process can be found at https://webarchive.oireachtas.ie/parliament/media/housesoftheoireachtas/libraryresearch/lrsnotes/lrsnotebudget_process_and_documents_140422.pdf.

Labelled expenditure

Table 1.4.1 provides a summary of Ireland's labelled expenditure since 2014. As with the 2018 data, the data for 2019 and 2020 are subject to some reporting limitations. The drop in total expenditure in 2019 by approximately €21m since 2018 and €54m since 2017 reflects limitations in reporting of expenditure from AGS, the Department of Justice, and the Revenue's Customs Service, rather than a reduction in expenditure per se. While data from the Department of Justice and Revenue's Customs Service are available again in 2020, there continues to be a problem with accessing some data from AGS. Since 2018 AGS have only reported on the cost of expenditure at the Garda National Drugs and Organised Crime Bureau. Therefore, the figure reported for 2018, 2019 and 2020 does not reflect the drug enforcement activity off the organisation as a whole. In addition data has not been provided by the Irish Prison Service. The Department of Further and Higher Education, Research, innovation and Science features for the first time as responsibility for the Drug Court's education support now comes under its remit rather than the Department of Education's. The increase in spend by the DCEDIY in 2020 reflects the establishment of a new single funding scheme, UBU Your Place Your Space, which aims to prevent drug misuse through the development of youth facilities, including sport and recreational facilities (for more information see section T1.1.3 of the Prevention Workbook). Total labelled expenditure for 2020 was €233.203m (rounded up to three decimal places).

Table 1.4.1. Public expenditure directly attributable to drug programmes (labelled), 2014–2020

Department/ Agency [1]	2014 (€m)	2015 (€m)	2016 (€m)	2017 (€m)	2018 (€m)	2019 (€m)	2020

							(€m)
Health Research Board	€0.908	€1.013	€1.247	€0.756	€0.786	€0.786	€0.883
HSE Addiction Services	€86.122	€91.523	€93.43	€97.87	€99.828	€103.419	€105.653
HSE Drugs and Alcohol Task Force Projects	€21.570	€22.064	€22.78	€22.14	€22.63	€22.92	€22.436
An Garda Síochána[2]	€43.000	€43.000	€46.00	€47.00	€14.25	€13.17	€13.218
D/Children, Equality, Disability, Integration and Youth	€19.548	€19.548	€20.05	€20.04	€20.46	€20.46	€39.4
D/Justice	€18.762	€19.363	€20.56	€7.30	€6.95	-	€7.688
Revenue Customs Service	€16.235	€17.445	€17.36	€17.36	€19.60	-	€16.554
D/Social Protection (former FÁS area)	€14.063	€13.900	€16.41	€17.98	€17.22	€20.07	€20.789
D/Health	€7.266	€7.323	€6.08	€5.54	€6.015	€5.955	€5.974
Irish Prison Service	€4.200	€4.235	€4.40	€4.20	-	-	-
D/Education	€0.748	€0.748	€0.77	€0.76	€0.76	€0.72	€0.319
D/Further & Higher Education, Research, Innovation & Science	-	-	-	-	-	-	€0.289
Total	**€232.422**	**€240.162**	**€249.087**	**[3]€240.95**	**[3]€208.499**	**[3]€187.50**	**€233.203**

[1] The department or agency's name as at the time of writing (September 2021) is listed here.

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

[3] The €53 million decrease in expenditure between 2017 and 2019 reflects limitations in reporting of expenditure from An Garda Siochana, Department of Justice, Irish Prison Service, and Revenue's Customs Service, rather than a reduction in expenditure per se.

Unlabelled expenditure

A new estimate of unlabelled drug related expenditure in Ireland is available. The relevant report is discussed in section T3.1 of this workbook (Bruton*, et al.* 2021).

T1.4.2 Breakdown of estimates of drug-related public expenditure

Labelled expenditure is reported by each Government Department or agency to the Drugs Policy and Social Inclusion Unit at the Department of Health for the purpose of this workbook. Unit staff contact each Government Department and ask for labelled data in line with Table 1.4.2, and they coordinate its collection and make it available to the Irish Focal Point. The total labelled expenditure in Table 1.4.2 is €233,183,858. The slight variation in total with Table 1.4.1 above is due to a rounding up of figures to the decimal places in Table 1.4.1. Unlabelled expenditure is not included but there is a new estimate available for Ireland (see section T3.1 in this workbook).

Table 1.4.2 Breakdown of drug related public expenditure

Expenditure	Year	COFOG classification	National accounting classification	Trace (Labelled, Unlabelled)	Comments
€611,988	2020	gf07	s1311	Health	Research and reports in relation to drug services and drug-related deaths
€271,000	2020	gf07	s1311	Health	National Documentation Centre
€210,675	2020	gf07	s1311	Health	Research and monitoring for the national drugs strategy
€4,116,705	2020	gf07	s1311	Health	Treatment and rehabilitation services provided to drug users -LDATF
€1,164,371	2020	gf07	s1311	Health	Treatment and rehabilitation services provided to drug users – RDATF
€209,181	2020	gf07	s1311	Health	National network of community activists and community organisations - Citywide
€165,931	2020	gf07	s1311	Health	Supports the development of family support groups throughout the country - NFSN
€56,758	2020	gf07	s1311	Health	Residential treatment for adults
€50,000	2020	gf07	s1311	Health	Other miscellaneous
€39,400,000	2020	gf08	S1311	Children, Equality, Disability, Integration & Youth	Youth programme for disadvantaged, marginalised or vulnerable young people (est. 2020) - UBU
€318,774	2020	gfo9	s1311	Education and Skills	Drug education and prevention projects LDATF
€288,991	2020	gf09	s1311	Furth & Higher Education, Research, Innovation 7 Science	Drug Court - Education support
€75,310,509	2020	gf07	s1311	Health Service Executive	Drug related health services
€14,803,907	2020	gf07	s1311	Health Service Executive	Treatment and rehabilitation services provided to drug users –LDATF
€7,631,749	2020	gf07	s1311	Health Service Executive	Treatment and rehabilitation

					services provided to drug users -RDATF
€534,150	2020	gf07	s1311	Health Service Executive	Cross Task Force Funding
€7,783,165	2020	gf07	s1311	Health Service Executive	Drug related health services - NDTS
€22,025,048	2020	gf07	s1311	Health Service Executive	Drug related health services -PCRS
€20,260,507	2020	gf10	s1311	Social Protection	Training & rehabilitation places for drug referred clients on Community Employment
€529,313	2020	gf10	s1311	Social Protection	Support for community-based projects
€33,161	2020	?	s1311	Justice	Contribution to Maritime Operational and Analysis Centre Lisbon
€1,116	2020	gf03	s1311	Justice	Drug Treatment Court
€99,947	2020	gf07	s1311	Justice	Research on drug-related deaths - HRB
€1,427,500	2020	gf07	s1311	Justice	Community based rehabilitation services
€6,106,684	2020	gf09	s1311	Justice	Youth crime diversion programmes
-		gf03	s1311	Irish Prison Service	Drug treatment services in Prisons
€13,218,730	2020	gf03	s1311	An Garda Síochana	Policing/investigation costs of Garda National Drugs & Organised Crime only.
€16,554,000	2020	gf03	s1311	Revenue's Customs Service	Border policing (anti-smuggling)
€233,183,858					

Abbreviations: COFOG, Classification of the functions of government; LDATF, Local Drug and Alcohol Task Force; NDTS, National Drug Treatment Service; NACDA, National Advisory Committee on Drugs and Alcohol; NFSN, National Family Support Network; RDATF, Regional Drug and Alcohol Task Force

T2. Trends.

Not applicable for this workbook.

T3.1 Developments in drug policy

1. Focused policy assessment on Ireland's national drugs strategy
2. Drug policy changes in response to the COVID-19 pandemic
3. Legislation against the coercion and use of minors in the sale and supply of drugs
4. Updates on implementation of the Public Health (Alcohol) Act 2018
5. Health Diversion Approach to possession of drugs for personal use.

6. Establishment of a pilot supervised injecting facility

1. Focused policy assessment on Ireland's 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 (Bruton*, et al.* 2021). This focused policy assessment (FPA) of the national drugs strategy (Department of Health 2017) 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' (Bretteville-Jensen*, et al.* 2017) (p. 23). In Ireland, it includes budget allocations for the Health Service Executive (HSE) Addiction Services and treatment services in prisons, for example. Bruton *et al.* report the expenditure data as it appears in Ireland's 2020 National Report (Health Research Board. Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2021) (see Table 3.1.1).

Table 3.1.1: 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 (Health Research Board. Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2021)

* 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.

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' (Bretteville-Jensen*, et al.* 2017) (p. 24). 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, (Mongan and Long 2016), (Hope 2014), (Byrne 2010) 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' (Bruton*, et al.* 2021) (p. 20).

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 (National Drug Intelligence Center 2011). 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) (Bruton*, et al.* 2021) 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 3.1.2 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.

Table 3.1.2: 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) (Bruton*, et al.* 2021)

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' (Bruton*, et al.* 2021) (p. 27).

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' (Bruton*, et al.* 2021) (p. 27). 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 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 (Mongan*, et al.* 2021). 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 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' (Bruton*, et al.* 2021) (p. 69).

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.
- The trend for offences for importation of drugs has remained relatively stable over the period 2014–2019.
- Possession offences (possession for sale and supply and possession for personal use) have been increasing since 2015.
- 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.
- There has been an increase in the quantity (kg) of drugs seized in recent years, while the number of seizures has increased since 2017.

It should be noted that all but the last of these bullets of data come from the Central Statistics Office (CSO) which 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.

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 have constrained the conclusions that can be drawn on the progress made under each goal, and in turn the overall performance of RHSR' (Bruton*, et al.* 2021) (p. 70). 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' (Bruton*, et al.* 2021) (p. 6). 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 the 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 the 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.

2. Drug policy changes in response to the COVID-19 pandemic

Ireland made a number of policy changes aimed at preventing the spread of COVID-19 among people who use drugs. These were reported on in the 2020 National Report in the context of a publication entitled *Saving Lives in the time of COVID-19 – Case Study of Harm Reduction, Homelessness and Drug Use in Dublin, Ireland* (O'Carroll*, et al.* 2020). Those which have continued to be in play in September 2021 were related to opiate substitution therapy and Naloxone availability (based on personal communication with the HSE, September 2021).

Opioid substitution therapy (OST): National contingency guidelines were issued that allowed for reduced waiting times (Health Service Executive 2020). These new guidelines resulted in the waiting times for treatment at one service provider (GMQ Medical) being reduced from 12–14 weeks to 2–3 days.

***Naloxone*:** Access pathways to the opioid antagonist naloxone were relaxed in response to the COVID-19 crisis through the national contingency guidelines (Health Service Executive 2020). The new guidelines recommend that everyone in receipt of OST should be offered and encouraged to take a supply of naloxone. It was to be administered by a person trained in its use, and the injectable product was to be used instead of the intranasal product.

3. Legislation against the coercion and use of minors in the sale and supply of drugs

In January 2021, the General Scheme of the Criminal Justice (Exploitation of Children in the Commission of Offences) Bill was announced, thus marking the first stage of the process of introducing new legislation in Ireland. If enacted, the Bill will outlaw the grooming of children into crime by creating specific offences where an adult compels, coerces, induces, or invites a child to engage in criminal activity. Those found guilty of the new offences would face imprisonment of 12 months on summary conviction and up to five years on indictment. The child concerned does not have to be successful in carrying out the offence for the law to apply. Furthermore, the adult would still be prosecuted separately for any crime they commit using the child as their agent. The Bill aims to address the influence of criminal networks that draw children into criminality, with all the potential lifetime consequences that entails. This Bill addresses the commitments made in the Programme for Government to legislate against the coercion and use of minors in the sale and supply of drugs, and to criminalise adults who groom children to commit crimes.

- Criminal Justice (Exploitation of children in the commission of offences) Bill 2020: http://www.justice.ie/en/JELR/Criminal_Justice_(Exploitation_of_children_in_the_commission_of_offences)_Bill_2020%20%20General%20Scheme.pdf/Files/Criminal_Justice_(Exploitation_of_children_in_the_commission_of_offences)_Bill_2020%20%20General%20Scheme.pdf

Other new proposed legislation is detailed in section T3.4 of the Legal Framework workbook.

4. Updates on implementation of the Public Health (Alcohol) Act 2018

The Public Health (Alcohol) Act 2018 was signed into law in October 2018. It is the first piece of legislation to identify alcohol use as a public health issue. The aim of the Act is to reduce alcohol consumption in Ireland and the harms that it causes at a population level, and the Act provides for a suite of evidence-based measures to deliver on this aim. Since the 2020 National Report, progress has been made on implementing two more provisions of the Act. Details as follows:

- From 12 November 2020, the Act separated and reduced the visibility of alcohol products in mixed retail outlets.
- In May 2021 it was agreed by Government that minimum unit pricing (MUP) would be implemented from 1 January 2022.

Based on the findings of an overview of alcohol consumption, harm and policy in Ireland Table 3.1.1 summarises the provisions of the Act and their progress to commencement (O'Dwyer*, et al.* 2021).

Table 3.1.3 Summary of the provisions of the Public (Health) Act 2018

Measure	Rationale	Commenced

Minimum unit pricing (MUP)		
An MUP for all products containing alcohol will be introduced and set at 10 cent per gram of alcohol in the product. Unlike a tax increase where a retailer can choose to absorb the increase in price, the MUP will be compulsory across all alcohol products. Under the new legislation: • A 750 ml bottle of wine with an ABV of 12% will cost a minimum of €7.10. • A 700 ml bottle of vodka with an ABV of a strength of 35% will cost a minimum of €20.71. • A 500 ml can of beer with an ABV of a strength of 5% will cost a minimum of €1.97.	Research conducted by the HRB and the Royal College of Surgeons in Ireland (RCSI) prior to the introduction of the MUP indicated that the heaviest drinkers and those with lower incomes, such as students, buy the cheapest alcohol and are likely to be most affected by an MUP (Cousins*, et al.* 2016). Currently, it is possible for a man to consume his weekly low-risk guideline limit for €7.48, while a woman can consume hers for just €4.84 (Alcohol Action Ireland 2018). Increasing the price of alcohol products reduces their affordability and is one of the most effective ways of reducing alcohol consumption and related harm (Anderson*, et al.* 2009).	In May 2021, the Government agreed to measures to introduce MUP from 1 January 2022.
Health warning labels		
Section 12 of the Act stipulates that all alcohol products to be sold in Ireland will be required to display: • A warning informing the public of the danger of alcohol consumption • A warning outlining the danger of alcohol consumption when pregnant • A warning informing the public of the direct link between alcohol and fatal cancers • The quantity in grams of alcohol contained in the container concerned • The calorie content in the container concerned, and • Details of a website to be established and maintained by the HSE, providing public health information in relation to alcohol consumption.	Health warning labels ensure that the public has accurate information regarding the calorie content and the strength of alcohol products and that individuals are informed of the health risks associated with alcohol consumption. Findings from the Healthy Ireland Survey demonstrate that current public knowledge of the link between cancer and alcohol in Ireland is low. Just one-quarter of Irish women are aware of the direct link between alcohol and breast cancer, despite this being the most common type of cancer among women in Ireland.	This provision has yet to be commenced. Health warning labels on alcohol products are subject to approval at the EU level.
Structural separation		
Section 22 of the Act provides for the structural separation of alcohol products in mixed retail outlets (e.g. supermarkets and	Limiting the physical availability of alcohol is an important population-based measure to	Structural separation was commenced on 12

grocery stores). Retailers must choose from one of three options: • Storing alcohol products in an area of the store that is separated by a physical barrier • Storing alcohol products in one or more closed storage units or cabinets, or • Storing alcohol products in no more than three open storage units in the premises.	reduce alcohol consumption. Interventions targeting the availability of alcohol at a population level are effective in reducing alcohol-related harm and consumption (Babor, Thomas*, et al.* 2010b). (Babor, T*, et al.* 2010a)	November 2018. By 12 November 2020, all mixed-trade retailers are obliged by law to physically separate alcohol products from other grocery items.
Advertising		
A range of restrictions will apply to the advertisement of alcohol products, with a particular emphasis on protecting children and young people. The main restrictions include the following: • The content of advertisements will be restricted to specific information about the nature of the product. • Advertisements must contain health warnings regarding alcohol consumption, including during pregnancy, and a link to a public health website. • Advertisements in cinemas will be limited to films classified as over 18s. • There will be a 9.00 pm broadcast watershed for advertisements on television and radio. • The marketing and advertising of alcohol in print media will be restricted in relation to volume and type of publication. There will be a ban on advertising alcohol products: • In or near a school • In or near an early years service (e.g. crèche) • In a park, open space, or playground owned or maintained by a local authority • On public transport, and • In a train or bus station, and at a bus or Luas stop. The Act will also restrict the sale of children's clothing which promotes alcohol consumption or bears the brand name or emblem, the	Advertising is related to initiation of alcohol consumption, especially among children and adolescents, who are particularly vulnerable to advertising and marketing campaigns (Jernigan*, et al.* 2017). Reducing children's and young people's exposure to alcohol advertising may delay initiation and reduce alcohol consumption among young people. Early initiation of alcohol use has been associated with a number of negative consequences later in life (Hall*, et al.* 2016).	Some of these measures have recently become law, including measures around advertising in the vicinity of children (Sections 14, 17, and 20). Important measures yet to be commenced are: Section 13 on the restriction of the content of alcohol advertisements; Section 18 regarding limitations of advertising in print media; and Section 19 regarding the broadcast watershed on alcohol advertising.

corporate name or emblem, or the trademark or logo, of an alcohol brand or product.		
Sports sponsorship and sponsorship of other events aimed at children		
With the exception of motorsports, the Act does not ban alcohol sponsorship of sports. However, Section 15 of the Act prohibits advertising in sports grounds for events where the majority of competitors or participants are children, or directly in a sports area for all events (e.g. on the actual pitch, the racetrack, tennis court, etc.). Alcohol sponsorship of other events aimed at children, or where most of the participants are children, will also be prohibited under Section 16 of the Act.	As noted above, exposure to alcohol advertising and media has been associated with earlier initiation of drinking among adolescents and an increase in the volume of consumption among adolescents who already drink (Jernigan*, et al.* 2017). Prohibiting advertising at events aimed at children will further limit young people's exposure to alcohol advertising.	Sections 15 and 16 were both commenced in November 2018 with a three-year transition period.
Restrictions on the sale and supply of alcohol products		
Section 23 outlines a number of restrictions regarding the sale and availability of alcohol products. Several measures regarding limiting the sale and availability of alcohol products are outlined in the Act. One of the most important of these is the restriction of price-based promotions, to which young people may be particularly sensitive. Under Section 23, the Minister for Health will have the power to make regulations around: • The sale or supply of alcohol at a reduced price or free of charge to a certain target group • The sale or supply of alcohol at a reduced price to someone because they have already purchased a certain quantity of alcohol or another service • The sale or supply of alcohol during a limited time period (three days or fewer) that was less than the price charged for the same product the day before the offer was introduced, and • The promotion of a business or event in a way that is likely to encourage people to drink alcohol in a harmful manner.	Restricting the sale and supply of alcohol products, particularly restricting price-based promotions, will reduce the affordability and availability of alcohol. Reducing the affordability and availability of alcohol products is the most effective way of reducing alcohol consumption at a population level (World Health Organization 2014).	Section 23 was commenced in November 2018.

Source: Updated from (O'Dwyer*, et al.* 2021)

Abbreviations: ABV, alcohol by volume; MUP, minimum unit pricing

More detail on this legislation is available in Section T4.2 of the *Legal framework workbook*.

5. Health Diversion Approach to possession of drugs for personal use

On 2 August 2019, the Irish Government announced the launch of a Health Diversion Approach to the possession of drugs for personal use. The final *Report of the Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use* and supporting documents were also published that day (Working group to consider alternative approaches to the possession of drugs for personal use 2019), (Hughes*, et al.* 2019), (Irish government economic and evaluation service 2019). Taking into consideration the findings of this report and the range of stakeholder views, the Department of Health and the Department of Justice and Equality agreed to adopt a more health-led approach to possession of drugs for personal use.

The approach

The Health Diversion Approach offers alternatives to criminal prosecution for the first **two** instances in which people are found in possession of drugs for their personal use. Essentially, the action taken by AGS will depend on the number of times an individual has been caught in possession of drugs:

- On the first occasion, AGS will refer them, on a mandatory basis, to the HSE for a health screening and brief intervention.
- On the second occasion, AGS will have the discretion to issue an Adult Caution (see Section T2.2 of the *Legal framework workbook* for a description of the Adult Caution Scheme).
- On the third or any subsequent occasion, AGS will revert to dealing with the person in line with Section 3 of the Misuse of Drugs Act, 1977, under which the individual could receive a criminal conviction and custodial sentence.

The health screening and brief intervention will be carried out by trained HSE staff using SAOR: Screening and Brief Intervention for Problem Alcohol and Substance Use. New posts will be created across the HSE's Community Healthcare Organisation Areas for staff trained in SAOR to carry out the brief intervention.

Implementation progress to date

An implementation, monitoring, and evaluation group was established in late 2019 to examine the need for legislative change, the operational details, and the phasing of implementation of the Health Diversion Approach. The group is chaired by the Department of Health and its membership includes, but is not limited to, the HSE, AGS, and the Department of Justice. The group has met monthly since it was established. In July 2021, the group was finalising proposals to commence implementation of the programme on an administrative basis. Section 3 of the Misuse of Drugs Act, 1977 and the Misuse of Drugs Act, 1984 will remain in force; under this Section, the use and possession of illicit drugs will continue to be illegal. The Adult Caution Scheme has been expanded to include offences under Section 3 of the Misuse of Drugs Act, 1977 and the Misuse of Drugs Act, 1984 for the possession of cannabis and cannabis resin only. It gives AGS the option of diverting appropriate cases away from the criminal justice system. The Adult Caution Scheme will need further amendments to cover all drugs before it is compatible with the intended implementation of the Health Diversion Programme.

It is planned that the Health Diversion Programme will initially commence in five locations in mid-late 2021. The locations will include both Dublin and provincial areas and will coincide with AGS and HSE

administrative boundaries as far as is possible. People arrested for personal possession of illicit drugs in these locations will be automatically referred to the Health Diversion Programme. Further referral to HSE addiction services will be provided where this is required.

Detailed discussions have taken place between the Department of Health, the HSE, and AGS to explore solutions for an information communication technology (ICT) pathway to enable AGS to make SAOR appointments for programme participants through the Pulse system. Issues regarding General Data Protection Regulation (GDPR) are under consideration, as any data which are to be shared will have to be done so in a compliant manner (personal communication, Drug Policy and Social Inclusion Unit, Department of Health, July 2021).

Monitoring and evaluation

Specifications are being developed for detailed monitoring and evaluation of the Health Diversion Programme to enable assessment of its effectiveness and impact. This monitoring and evaluation will be carried out by an independent third party. It will include a monitoring framework for the programme as well as an interim and final evaluation following the first full year of implementation. The evaluation report will be published and will inform a review of the programme to determine if it is meeting its aims. (Personal communication, Drug Policy and Social Inclusion Unit, Department of Health, July 2021).

6. Establishment of a pilot supervised injecting facility

The establishment of a pilot supervised injecting facility is a commitment of the Irish Government and is supported in its Programme for Government (Fianna Fail*, et al.* 2020), as well as being an action in the national drugs strategy, *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* (Department of Health 2017). As reported on in previous National Reports, the Misuse of Drugs (Supervised Injecting Facilities) Act 2017 was signed into Irish law on 16 May 2017 (http://www.oireachtas.ie/documents/bills28/acts/2017/a0717.pdf). In the Introduction, the Act is summarised as:

"An Act to provide for the establishment, licensing, operation and regulations of supervised injecting facilities for the purposes of reducing harm to people who inject drugs; to enhance the dignity, health and well-being of people who inject drugs in public places; to reduce the incidence of drug injection and drug-related litter in public places and thereby to enhance the public amenity for the wider community; and to provide for matters related thereto."(http://www.oireachtas.ie/documents/bills28/acts/2017/a0717.pdf).

At the time of writing (September 2021), the facility has yet to open. The purpose of the facility will be to provide a clean, safe healthcare environment where people who inject drugs can access medical and social services from healthcare professionals. Despite the relevant legislation having been enacted, there was a lengthy process involved in initially securing planning permission (on a temporary basis of three years) in December 2019. However, this granting of permission was appealed to Ireland's High Court where, in July 2021, it was revoked. It is understood that the reason planning permission was revoked was not because it was for a supervised injecting centre, rather because of technical and legal issues with the planning process. The High Court's decision was also influenced by the failure to address adequately strongly held opposition lodged by a school near to the site.

T4. Additional information

T4.1 Additional important sources of information

1. New priorities for the British–Irish Council
2. Coordination, framing, and innovation: the political sophistication of public health advocates in Ireland
3. Irish drug policy alternatives: a qualitative study
4. Systematic review of media coverage on new psychoactive substances in Ireland 2000–2010.

1. New priorities for the British–Irish Council

On 11 March 2021, a ministerial meeting of the Misuse of Substances work sector of the British–Irish Council (BIC) was held online. The Irish Government is the lead administration for this strand of work. The meeting was chaired by the Minister of State for Public Health, Wellbeing and the National Drugs Strategy. The meeting was also attended by ministers from the Northern Ireland Executive, Scotland, Wales, the Isle of Man, Jersey, Guernsey, and the British Government (British Irish Council 2021).

British–Irish Council

The BIC was established in 1999 as part of the Good Friday Agreement in order to further promote positive, practical relationships among the people of the islands as well as to provide a forum for consultation and cooperation. The formal purpose of the BIC, as outlined in Strand 3 of the Agreement, is as follows:

"To promote the harmonious and mutually beneficial development of the totality of relationships among the peoples of these islands.... The BIC will exchange information, discuss, consult and use best endeavours to reach agreement on co-operation on matters of mutual interest within the competence of the relevant Administrations."

More details on the work of BIC are available from its website: https://www.britishirishcouncil.org/ and a copy of the Good Friday Agreement is available at: https://www.dfa.ie/media/dfa/alldfawebsitemedia/ourrolesandpolicies/northernireland/good-friday-agreement.pdf

Items covered and actions agreed

The communiqué published following the meeting on 11 March 2021 lacked detail on the content of the discussions but noted that the ministers discussed two key topics:

- **Financial mechanisms to reduce the consumption of alcohol:** Ministers described the efforts of member administrations to decrease alcohol consumption and agreed that there was value in comparing approaches and sharing learnings from the emerging evidence base.
- **Measurement of the effectiveness of addiction services and harm-reduction strategies:** The importance of effective monitoring and evaluation to ensure evidence-based policy-making and practice was recognised. It was agreed that sharing this diversity of knowledge, understanding, experiences, and learning across member administrations affords a unique resource for enhancing monitoring and evaluation.

Five topics were agreed as priorities for the group's work moving forward:

- Consider the lessons of the COVID-19 pandemic and the delivery of drug and alcohol services.
- Reduce the risk of drug-related deaths.
- Reduce alcohol-related harms through the use of financial mechanisms.
- Consider joined-up approaches to meeting the health and social needs of people who are homeless and use drugs and alcohol (in conjunction with the BIC Housing work sector).
- Engage with the voluntary and community sectors to consider their role in the provision of drug and alcohol services, and in the development and monitoring of policy.

No further details were available on what this work would entail.

2. Coordination, framing and innovation: the political sophistication of public health advocates in Ireland

The text that follows is taken from an article written for *Drugnet Ireland* (Doyle 2021). Policy researchers have long been interested in the processes that facilitate major policy change. A recent study by Lesch *et al.* (Lesch and McCambridge 2021) has explored the role of the public health advocacy coalition in promoting the passage of the Public Health (Alcohol) Bill in Ireland. Following a five-year campaign, the Public Health (Alcohol) Bill was approved by the Government in December 2015 and after a protracted and contested process the legislation was signed into law in October 2018.

The alcohol industry and the public health community formed two opposing coalitions during the policy debate. The alcohol industry's success in resisting population-level approaches to alcohol policy has been identified in Ireland and elsewhere. In contrast, public health advocates have typically had limited success. In this present case, however, public health advocates in Ireland were able to develop sophisticated political strategies and thereby bring about a major change in alcohol policy.

Methodology

The study by Lesch *et al.* was based on a review of records from public health advocacy coalition and its campaign to promote the Public Health (Alcohol) Act 2018 in Ireland. The authors' goal was to identify the key actors in the campaign and the key approaches taken in framing the issues. Towards this goal, they undertook a thematic analysis using primary documents produced by the advocates, newspaper articles, and semi-structured interviews with key advocates, public health experts, and elected officials.

Their analysis documented the growing political sophistication and effectiveness of public health advocates in Ireland. First, a broad-based coalition enabled advocates to pool resources and coordinate their strategy and messaging. Second, issue-framing was critical in shifting the focus of the debate to alcohol-related harm. This placed pressure on politicians by making available evidence on the extent of the problem. Finally, evidence of political learning was presented, where advocates' knowledge of the political system spurred innovations in campaigning. These three strategies – coalition-building, issue-framing, and political learning – are discussed in greater detail below.

Coalition-building

The public health alcohol advocacy community in Ireland had traditionally comprised a relatively small group of non-governmental organisations (NGOs), public health experts, and public health officials. Starting from the year 2000, however, there began to be a concerted push to professionalise advocacy work in this community. The national advocacy organisation Alcohol Action Ireland (AAI) began to participate in numerous policy deliberations, including those of the National Substance Misuse Strategy (NSMS) Steering Group. When the Government announced that it would be acting on the policy recommendations of the NSMS report, AAI mobilised a cross-party group of senators and members of the Irish Parliament (TDs).

Interest in alcohol policy also extended to the Irish medical establishment, leading to the formation of an alcohol policy group in 2012. Key figures in the Royal College of Physicians of Ireland (RCPI) and in AAI decided to collaborate with other advocacy organisations that supported the key principles of the Bill. Together, these organisations formed the Alcohol Health Alliance Ireland that brought together 62 organisations in all.

The establishment of this broad coalition allowed members to effectively pool their limited resources. The authors (Lesch and McCambridge 2021) argued that drawing "on the strength, and the reputations"' of its membership helped to strengthen the advocates" credibility giving them "more clout with the public, with politicians, and with the media" (Lesch and McCambridge 2021) (p.4). As one advocate explained, AAI had been "a small charity, a small voice, [and] a lone voice, with a limited budget". However, its inclusion as a partner in collaboration with organised medicine enabled it to "speak with more authority" on alcohol harms (Lesch and McCambridge 2021) (p.4).

The coalition coordinated their strategy and maintained message discipline by advising experts ahead of their media appearances. As one member remarked, traditionally there were "lots of disparate voices shouting out in an uncoordinated way" (Lesch and McCambridge 2021) (p.4). The alliance ensured that when an issue was raised in the media, the most effective voices were the ones that articulated the public health position.

The alliance also recruited individuals from member organisations who had backgrounds in public affairs. Among these were individuals who had previously worked as journalists and political advisers – and had therefore acquired an intimate knowledge of the political system. The close working relationships with politicians and key officials within the Department of Health allowed the alliance to keep "on top of what was happening in government … and what … might have been said in the media" (Lesch and McCambridge 2021) (p.4).

Issue-framing

A key strategy in issue-framing was that of focusing on the content of the problem – the health harms – rather than particular measures within the Bill itself. Advocates made extensive use of social media and developed multimedia strategies to establish their preferred framing. The alliance used its website and other communication materials, including infographics, to highlight the harms caused by high levels of alcohol consumption. Advocates released hundreds of documents, including reports and press releases, to generate media coverage. Advocates also used social media, press interviews, and editorials at key stages of the Bill's progression to underline the principal harms frame.

Although these advocates faced entrenched alcohol industry positioning, they found ways to pivot when confronted by arguments that framed the issues in less advantageous frames. For example, when industry advocates emphasised the economic costs of the Bill, advocates responded by

highlighting the healthcare costs associated with the status quo. According to one citation, the alliance's "expert stakeholder alliances and evidence-based communications" (Lesch and McCambridge 2021) (p.5) succeeded in keeping alcohol on the agenda for more than three years, despite facing a well-resourced and culturally embedded opposition.

Political learning

There is evidence of political learning where advocates' prior experiences and knowledge of the political system in Ireland spurred innovations in campaigning. Key lessons had been drawn from other successful public health campaigns, including the campaign to ban smoking in public places.

The specific expertise of the advocates was critical to the Bill's passage; this included experience in politics, journalism, and in campaigning organisations. Politicians were targeted and close relationships were formed with those who were sympathetic, broadening the coalition and leveraging these interactions to shape the legislative process. Local grassroots organisations also played a key role in reinforcing this tactic at a local level. These strategies were interdependent and mutually reinforcing, and they succeeded in building support for public health advocates' preferred policies among politicians and among the general public.

Advocates exhibited sophistication throughout the debates over the Bill. One expert, who was not formally involved in the coalition, had this to say about its influence:

"[The alliance] was pivotal because they made it a campaign and they ran it like a campaign … Campaigns are not accidental things … they have to have many arms … they have to have a communications arm, a political arm, a policy arm, [and] a civil service arm … I think they covered all the bases … I think the public health side [was] strong and … more savvy than before." (Lesch and McCambridge 2021) (p.6).

Discussion

The findings of Lesch *et al.* provide insights into the developing capacity of advocates to drive major policy change. The success of the alcohol advocacy coalition in its campaign to pass the Public Health (Alcohol) Bill was a hard-fought campaign, but other equally hard-fought advocacy campaigns preceded it, including the ban on smoking in public places as well as the national referenda on divorce, abortion, and same-sex marriage. Such successes generate momentum and are relevant to appreciating how the broader advocacy community has professionalised over time.

Several Irish experts have been instrumental in generating high-level awareness of the existence of an alcohol problem in Ireland, gradually reframing the problem away from an issue affecting a subgroup of 'alcoholics' towards a fuller population-level understanding of alcohol harms. Politicians were receptive to major policy change due in part to sustained public attention to alcohol as a problem.

The recent study by Lesch *et al.* is the latest in a broader research programme involving the alcohol industry and the role of evidence in alcohol policy-making. In studies of the alcohol industry, a recurring finding is that it holds advantages with respect to resources and lobbying efforts. This new study by Lesch *et al.* has shown, however, that experts may possess unique capabilities or attributes – such as public trust – which can help to mitigate the industry's resource advantage.

Finally, the prolonged development of alcohol policy innovation in Ireland underscores the perennial role of conflict. The Irish advocacy coalition saw itself as fighting a war with industry in pursuit of

rational policy-making, based on using high-quality scientific evidence to reduce avoidable harms caused by alcohol. In such terms, an important series of battles have been won, culminating in the passage of what has become the Public Health (Alcohol) Act 2018. However, the political war will not end with legislative enactment. Researchers will need to focus on policy implementation, examining how each coalition seeks to advance its interests and ideas in this next stage of the policy process.

3. Irish drug policy alternatives: a qualitative study

The voice of people who use drugs (PWUD) is often missing from the debate on drug policy. In an effort to address this gap, Leonard and Windle recently published their findings from a qualitative study carried out in Cork, a study entitled *'I could have went down a different path': Talking to people who used drugs problematically and service providers about Irish drug policy alternatives* (Leonard and Windle 2020). The findings are placed within the broader context of international literature on the topic.

Gap in debate

Leonard and Windle acknowledge that some effort has been made by policymakers internationally to include the voices of PWUD in discussions on the development of drug policy. The Irish Government's Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use is identified as an example of where this has been attempted, albeit with limitations (Working group to consider alternative approaches to the possession of drugs for personal use 2019). Leonard and Windle set this view within the broader context of a global movement towards including those most affected by policies and practices in their planning, implementation, and evaluation (Leonard and Windle 2020) (p. 2).

Methods

Semi-structured interviews were carried out with eight people who had used drugs problematically. At the time of interview, they had all had at least one year of abstinence. In addition, all of these people had been criminalised for their drug use and seven of the eight had served at least one custodial sentence. Six practitioners who work with PWUD were also interviewed. The interviews set out to explore the relationship between relative deprivation and problematic drug use; decriminalisation of drugs for personal use; depenalisation of cannabis; safe injecting facilities; and heroin-assisted treatment. The authors acknowledge the limitations of their study, including the small sample size and that all participants had undertaken therapy and were therefore not representative of the PWUD population more broadly.

Problematic drug use, economic deprivation, and criminalisation

A recurring theme throughout the paper is the link between problematic drug use and economic deprivation. The authors use a subterranean structuration framework to understand this link, which is a focus for study participants. This approach argues that a lack of meaningful employment opportunities for young people results in a situation where drug use and the surrounding activities (including buying and dealing) are perceived to offer an alternative and viable social and economic activity. It allows those living in economically deprived areas to find purpose and company, a sense of identity, excitement, and adventure, while also dulling "the pains of existence and exclusion" (Stevens 2011) (p. 45).

"[Subterranean structuration draws attention to] the constraints placed on the choices made by people who have been most affected by the withdrawal of employment in deprived areas. These

people are forced to make choices in situations which offer them little hope for pleasure, purpose or respect, no matter how hard they struggle" (Stevens 2011) (p. 10).

The experiences of those interviewed for this study illustrate the reality of this inextricable link between problematic drug use and economic deprivation.

Penalisation and criminalisation

Study participants argued that criminalising PWUD from economically deprived areas has little deterrent effect. Instead, it serves to exacerbate the problems that made drugs attractive in the first place. These findings are consistent with international literature. Some participants perceived arrest and incarceration as an 'occupational hazard' of problematic drug use. Unintended consequences of this included moving on to heroin use while in prison; the impact on children and partners of their being in prison; and the negative impact of a criminal record on their employment opportunities.

Perceptions on alternative drug policies

Four alternative drug policies were explored: decriminalisation, depenalisation, supervised injecting facilities, and heroin-assisted treatment.

Decriminalisation and depenalisation: The authors used the Dutch and Portuguese models as examples of depenalisation and decriminalisation, respectively. Decriminalisation was defined to participants as "the removal of sanctions under the criminal law, with optional use of administrative sanctions (e.g. provision of civil fines or court ordered therapeutic responses)". Depenalisation was defined as "the decision in practice not to criminally penalise offenders, such as non-prosecution or non-arrest" (Hughes and Stevens 2010) (p. 999). Participants' views were mixed about the Dutch model. While it was seen as a way to encourage safer cannabis use, some were concerned that it would lead to increased drug use. On the other hand, all of the participants were supportive of the Portuguese model. Much of this support revolved around drug treatment – Irish drug treatment services were perceived to be insufficient and "criminalisation without supports leads to a revolving door process for drug offenders" (Leonard and Windle 2020) (p. 20). Overall, a model that combines decriminalisation with expansions in drug treatments and the welfare state was deemed to offer the greatest chance of success.

Supervised injecting facilities (SIFs): There was overwhelming support for SIFs among study participants. Among the benefits identified were a reduction in street litter (drug paraphernalia), safer injecting practices, and an opportunity to offer PWUD additional supports.

Heroin-assisted treatment (HAT): HAT is described as "a harm reduction measure for people who have used heroin long term and have not responded well to other forms of treatment whereby pharmaceutical-grade grade heroin is usually taken under medical supervision" (Leonard and Windle 2020) (p. 24). The aim is not abstinence but stabilisation. None of the PWUD in this study had heard of HAT and were surprised that it existed as a policy. While there was some tentative support for its inclusion as part of wider changes, concerns about it were also expressed. Overall, these stemmed from a concern that it might mean people would remain in long-term drug use for longer than necessary and that they might not be offered the opportunity to become abstinent. The possible benefits identified were a reduction in the harms associated with street heroin use – a safer product, a reduction in acquisitive crime, and a reduction in business for street dealers.

Conclusions

Leonard and Windle's paper provides valuable insights on a variety of topics from the perspective of PWUD and those working with them. It illustrates the complexity of problematic drug use and the policy responses required. No single policy is perceived as offering a silver bullet to address the situation. Rather, participants repeatedly emphasised the need for wider structural reforms to address economic inequality and deprivation, alongside improvements in drug treatment services.

4. Systematic review of media coverage on new psychoactive substances in Ireland 2000–2010

In 2010, new psychoactive substances (NPS) were the subject of two pieces of legislation in Ireland. The first (enacted in May 2010) expanded the list of substances controlled under the Misuse of Drugs Acts 1977 and 1984 to include over 100 NPS (Misuse of Drugs (Amendment) Regulations 2010 (S.I. No. 200/2010). http://www.irishstatutebook.ie/eli/2010/si/200/made/en/print). The second, the Criminal Justice (Psychoactive Substances) Act 2010 (enacted in August 2010), covered the sale of substances by virtue of their psychoactive properties. It was aimed at vendors of NPS and effectively made it an offence to sell a psychoactive substance (2010). A new paper by Windle and Murphy reports on a systematic review of Irish media articles, entitled *How a moral panic influenced the world's first blanket ban on new psychoactive substances* (Windle and Murphy 2021).

Methods

Studies reported on in previous National Reports have found positive impacts of the legislation for public health (Smyth*, et al.* 2017), (Smyth*, et al.* 2020). Windle and Murphy's study was not designed to evaluate the Acts or their impact on the NPS market; rather, it set out to trace the "historical processes whereby attitudes towards headshops shifted from one of toleration to the passing of this tough new law" (Windle and Murphy 2021) (p. 1). The authors carried out a qualitative and quantitative review of media coverage of headshops in Ireland published between 2000 and 2010 (N=338).

Findings

The authors argued that analysis of the media coverage of headshops over the period demonstrates that Ireland experienced a 'moral panic' about headshops, which at least in part led to the 2010 Act. Based on previous national and international research, they framed their findings around a moral panic theory. Four timeframes were identified:

- **2000–2007 (6 articles):** Headshops first opened in Ireland in the early 2000s, selling cannabis paraphernalia. They were only mentioned in the media sporadically and most of the articles published between 2004 and 2007 viewed them as 'harmless'. However, once they started to sell NPS in 2007, a "trickle of condemnation began" (Windle and Murphy 2021) (p. 3).
- **2008 (19 articles):** Coverage of headshops was again sporadic in 2008 and tended to focus on the NPS benzylpiperazine (BZP) and its scheduling as a controlled substance in early 2009. Discussion of the negative impact of NPS on young people's health and well-being also began to be discussed.
- **2009 (27 articles):** Media interest increased in 2009 but continued to be at a relatively low level. The language used to describe headshops was 'relatively timid', although isolated incidents of them being described as a threat. This is what the authors describe as a "core feature of moral panic language" (Windle and Murphy 2021) (p. 4).

- **2010 (286 articles):** 2010 was when the authors argue the moral panic ensued. Articles on headshops and their supply of NPS were numerous and appeared regularly across local and national newspapers. They attracted high-level political attention as well as that from other stakeholders, including medical experts. The authors observed that the language used in these articles became gradually more stringent and sensationalist during the year and were characterised by methods such as 'panic messages' that fed into a moral panic. Articles linked NPS to violent crime and reported that headshops were selling to vulnerable people, especially young people. The narrative identified NPS and the headshops as the 'folk devils', where young people were depicted as victims. The year 2010 also saw peaceful and more violent protests organised by a variety of people, including drug dealers. All of this culminated in the implementation of the Criminal Justice (Psychoactive Substances) Act 2010.

Conclusion

The authors were keen to note that while they make the case that analysis of media coverage provides evidence of a moral panic in Ireland over the headshops, they were not arguing that the State's response was disproportionate. Indeed, they perceive the closure of the headshops as having been inevitable, given the nature of drug policy in Ireland. However, they consider that the moral panic may have resulted in more stringent legislation being passed more quickly than may otherwise have been the case.

T4.2 Any other important aspect of drug policy or public expenditure that has not been covered in the specific questions above.

There is no more information to add.

T4.3 National estimate of the contribution of illicit drug market activity to the National Accounts

There are national estimates of the contribution of illicit drug market activity to the National Accounts. In order to comply with the Eurostat requirements, the revised and additional estimates for illegal activities, including illicit drugs, for Ireland were first included in the Central Statistics Office's Quarterly National Accounts Quarter 1 2014 (https://www.cso.ie/en/statistics/nationalaccounts/archive/releasearchive2014/). These estimates have been included in the Quarterly National Accounts in all subsequent quarters and also in the annual National Income and Expenditure (NIE) accounts, the most recent being NIE 2020, published in July 2021 (see https://www.cso.ie/en/releasesandpublications/ep/p-nie/nie2020/). Ireland estimates the production and trafficking of illegal drugs from the supply side based on data on annual drug seizures by individual drug type (in terms of volume and street value), which are provided by AGS. Due to the volatile nature of seized quantities, the estimate is based on the average of a longer time series. In order to derive import/wholesale prices, Ireland bases its estimates on information from the United Nations Office on Drugs and Crime's *World Drug Report*.

T5. Sources, methodology and references

T5.1 Sources

- Health Research Board's National Drugs Library: https://www.drugsandalcohol.ie/

- Houses of the Oireachtas (Parliament): www.oireachtas.ie
    - For more information on Ireland's budgetary process, please see: https://www.oireachtas.ie/en/visit-and-learn/how-parliament-works/the-budget/
- Central Statistics Office: www.cso.ie
    - Central Statistics Office for National Accounts data: https://www.cso.ie/en/statistics/nationalaccounts/
- Department of Health: https://www.gov.ie/en/organisation/department-of-health/

T5.2 Studies used in this report

Where appropriate, this information is outlined in Sections T3.1 and T4.1, under each study.

T5.3 References

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European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised European Union (EU) agency based in Lisbon. The EMCDDA provides the EU and its member states with information on the nature, extent, and consequences of, and responses to, illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the EU and member states. There are 30 national focal points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the EMCDDA for analysis, from which it produces the annual *European Drug Report* and other outputs.

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

Acknowledgements

Completion of the national focal point's reports to the EMCDDA depends on the support and cooperation of a number of Government Departments and statutory bodies. Among those to whom we would like to express our thanks are the staff of the following:

Customs Drugs Law Enforcement, Revenue

Department of Children, Equality, Disability, Integration and Youth.

Department of Education

National Drugs and Organised Crime Bureau, An Garda Síochána

Drugs Policy Division, Department of Justice

Drugs Policy and Social Inclusion Unit, Department of Health

Forensic Science Ireland

Health Protection Surveillance Centre, Health Service Executive

Hospital In-Patient Enquiry Scheme, Health Service Executive

Irish Prison Service

National Advisory Committee on Drugs and Alcohol, Department of Health

National Social Inclusion Office, Primary Care Division, Health Service Executive

We also wish to acknowledge the assistance of the coordinators and staff of local and regional Drug and Alcohol Task Forces, and of voluntary, community-based, and other non-governmental organisations.

We wish to thank our HRB colleagues in the Evidence Centre, the National Drug Treatment Reporting System, the National Drug-Related Deaths Index, and the HRB National Drugs Library, all of whom make significant contributions to the preparation of the National Report.