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In this issue

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Launch of the ESHEILD project at UCC

The ESHEILD project was launched in University College Cork (UCC) on 29 February 2025 at an event attended by harm reduction experts, policy-makers, and student representatives. With further higher education institutions (HEIs) expected to adopt the initiative, ESHEILD marks the beginning of a coordinated national effort to reduce drug-related harms and risks among students across Ireland.

The ESHEILD project, which is based in UCC and is funded by the Department of Health, is a multi-strand initiative that aims to support HEIs in tackling student drug use by providing students with the MyUSE app and guiding HEIs to implement the Framework for Response to the Use of Illicit Substances within Higher Education.

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(continued on page 3)

Contents

The policy, research, and other documents covered in this issue of *Drugnet Ireland* have all been retrieved by the HRB National Drugs Library and may be accessed on its website **www.drugsandalcohol.ie**

Launch of ESHEILD

continued

ESHEILD
Enabling Students and Higher Education Institutions to Lead the Response on Drugs

ESHEILD was developed in response to findings from the Drug Use in Higher Education in Ireland (DUHEI) survey, which gathered responses from over 11,500 students across 21 HEIs.[1] The findings demonstrated the high prevalence of drug use in the Irish student population, with more than one-half of participants reporting use of illicit substances. Importantly, more than one-half of students surveyed felt that drug use has a negative impact on student life, and more than one-half of current drug users were found to be at moderate or substantial risk of harms arising from their drug use. These results highlighted the need for evidence-based and student-centred interventions, an approach ESHEILD takes by combining digital innovation, behavioural science, and institutional policy reform.

The ESHEILD Implementation Team includes Dr Michael Byrne, Head of UCC Student Health; Professor Samantha Dockray and Dr Conor Linehan, School of Applied Psychology; Professor Ciara Heavin, Business Information Systems; Dr Seán Millar, School of Public Health and European Union Drugs Agency (EUDA) Irish national focal point; Dr Sheena McHugh, School of Public Health; Piotr Janus, Business Information Systems; and Siobhán Thomas, School of Applied Psychology. The programme will support students and HEIs to reduce harms experienced through drug use. It also aims to reduce the overall number of students choosing to take drugs. Each participating Irish HEI will be provided with MyUSE, a prevention, education, and behavioural change intervention digital tool that aims to increase mindful decision-making with respect to drug use, cultivate harm reduction practices in the HEI context, and promote alternatives to drug use activities.

ESHEILD Principal Investigator Dr Michael Byrne speaking at the launch of the project at UCC.

Professor Samantha Dockray led the development of the MyUSE algorithm, which draws on evidence-based science to deliver 29 behavioural change techniques to students in HEIs. The MyUSE app was developed for all students, whether they use drugs or not, and provides individualised information and supports in order to reduce harms associated with drug use and enhance students' psychosocial well-being.

The second strand of the ESHEILD project will see the implementation of a framework in conjunction with local and regional Drug and Alcohol Task Forces. This second strand provides an action plan to address the use of illicit substances and related harms in Irish HEIs, and it includes four core recommendations for HEIs: (1) developing institution-specific policies; (2) implementation of an action plan; (3) assigning a senior officer to develop and implement these; and (4) facilitating student engagement with the collection of data related to drug use.

Launch of ESHEILD

continued

ESHEILD Principal Investigator Dr Michael Byrne was lead member of the Rapid Response Group convened to develop the Framework for Response to the Use of Illicit Substances within Higher Education. Speaking about the project, Dr Michael Byrne said:

> *The Framework contains a series of 16 actions that higher education institutions in Ireland can implement to reduce harms experienced through drug use. From core actions such as developing a drugs and alcohol policy for their institution right through to ensuring that there is access to addiction and recovery services on campus, implementing this Framework ensures that there is an effective multicomponent approach to harm reduction in the HEI sector in Ireland.*

Seán Millar

1 Byrne M, Dick S, Ryan L, *et al.* (2022) *The Drug Use in Higher Education in Ireland (DUHEI) Survey 2021: main findings.* Cork: University College Cork. Available from: https://www.drugsandalcohol.ie/35515/

Policy and legislation

New national drugs strategy

The Department of Health has begun the process of developing the successor to the national drugs strategy *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025*.[1] The strands of work informing this process include:

- The findings and recommendations of the Citizens' Assembly on Drugs Use and the views of the Oireachtas Joint Committee on Drugs Use[2,3]
- An independent evaluation of *Reducing Harm, Supporting Recovery* and its action plans
- Consultations with stakeholders on key themes relating to the new strategy
- The commitments made in the 2025 Programme for Government[4]
- Developments in the European Union's (EU's) Drugs Strategy and Action Plan (which also expire in 2025).[5]

Most of these strands have been covered in previous issues of *Drugnet Ireland*.[6–10] Brief descriptions of the two elements that have not yet been covered in this publication are outlined below.

Evaluation of the national drugs strategy 2017–2025

An independent evaluation of the national drugs strategy and its action plan is being carried out by Grant Thornton. The evaluation will explore the impact of the strategy; the effectiveness of the governance and coordination structures that underpin the strategy; the performance of the

National drugs strategy
continued

strategy in relation to key outcome indicators; and the coherence and synergies between the national strategy and relevant international responses. It is expected to be completed by the end of Q2 2025.

Consultations with stakeholders

The Department of Health convened in-person consultations with over 250 stakeholders. Independent consultants were responsible for facilitating and reporting on each session. The themes examined during these consultations were the priorities for the new strategy; the planning and delivery of drugs services in the Health Service Executive (HSE) health regions; the lived and living experience of people who use drugs and their families; the development of the drugs workforce; and drug prevention.

Minister's comment on the process

In concluding her response to a question on the development of the new drugs strategy in the Seanad on 4 March 2025, the Minister of State with responsibility for Public Health, Wellbeing and the National Drugs Strategy, Jennifer Murnane-O'Connor, said:

> *The new strategy will set out an ambitious vision for preventing drug use, improving access to evidence-based treatment services and supporting people's recovery from drug use. It will also strengthen co-operation with EU member states, the British-Irish Council and the Council of Europe in addressing the challenges of illicit drug use. It is my intention to engage with the Oireachtas in implementing this new strategy because I am conscious that we need to have cross-party support for it. We all need to work together on this.*[11]

Lucy Dillon

1 Department of Health (2017) *Reducing harm, supporting recovery: A health-led response to drug and alcohol use in Ireland 2017-2025*. Dublin: Department of Health. Available from: https://www.drugsandalcohol.ie/27603/

2 The Citizens' Assembly (2024) *Report of the Citizens' Assembly on Drugs Use*. Volume 1. Dublin: The Citizens' Assembly. Available from: https://www.drugsandalcohol.ie/40393/

3 Joint Committee on Drugs Use (2024) *Joint Committee on Drugs Use Interim Report*. Dublin: Houses of the Oireachtas. Available from: https://www.drugsandalcohol.ie/42080/

4 Fianna Fáil, Fine Gael, Independent TDs (2025) *Draft programme for Government 2025: securing Ireland's future*. Dublin. Available from: https://www.drugsandalcohol.ie/42537/

5 Council of the European Union (2020) *EU drugs strategy 2021-2025*. Brussels: Council of the European Union. Available from: https://www.drugsandalcohol.ie/33750/

6 Dillon L (2024) *Final report of the Citizens' Assembly on Drugs Use*. *Drugnet Ireland*, 87 (Winter Supplement): 2–12. Available from: https://www.drugsandalcohol.ie/40651/

7 Dillon L (2024) Oireachtas Joint Committee on Drugs Use. *Drugnet Ireland*, 89 (Autumn): 13–14. Available from: https://www.drugsandalcohol.ie/42091/

8 Dillon L (2025) New Programme for Government and Minister for the National Drugs Strategy. *Drugnet Ireland*, 90 (Winter): 8. Available from: https://www.drugsandalcohol.ie/42796/

9 Dillon L (2021) Publication of EU Drugs Strategy 2021–2025. *Drugnet Ireland*, 77 (Spring): 7–11. Available from: https://www.drugsandalcohol.ie/34279/

10 Dillon L (2021) EU Drugs Strategy 2021-2025: policy areas, themes, and strategic priorities. *Drugnet Ireland*, 77 (Spring): 1–6. Available from: https://www.drugsandalcohol.ie/34280/

11 Seanad Éireann debate: Tuesday, 4 Mar 2025, Health Strategies. Available from: https://www.oireachtas.ie/en/debates/debate/seanad/2025-03-04/3/#s9

Guidance on human rights and drugs policy

The Pompidou Group (Council of Europe International Cooperation Group on Drugs and Addictions) is the Council of Europe's drug policy cooperation platform. In March 2025 it published a new report titled *Bringing human rights to the heart of drug and addiction policies: Guidance for aligning drug and addiction policies with human rights*.[1] The report provides a succinct but comprehensive overview of the issues related to human rights to be considered by all stakeholders involved in the drug policy-making process.

Background

The Pompidou Group has 41 member states which include those from outside Europe. Upholding the core values of the Council of Europe – human rights, democracy, and the rule of law – is central to the Group's mission. It seeks to 'balance the interests of the community at large with protection of the individual's fundamental rights in responding to drug use and illicit trafficking in drugs'.[2] Since the United Nations' General Assembly Special Session in 2016, there has been an increased focus internationally on human rights and how they relate to drug policies. The Pompidou Group has been proactive in this area by focusing on promoting compliance of drug policy with human rights; for example, through its publication of a human rights in drug policy self-assessment tool in 2022[3,4] and the publication of the new guidance document that is the subject of this article.[1]

Human rights

The human rights referred to in the report are those 'enshrined in the Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No. 5, the Convention) and other international legal instruments' (p. 7).[1] In the second section of the report, the authors identify a set of nine key human rights that need to be safeguarded when developing policies to address all aspects of the drugs issue. Those human rights selected are the right to life; the right to healthcare; the prohibition of torture or inhuman or degrading treatment or punishment; the right to respect for private and family life; the right to a fair trial; the right to freedom from discrimination and stigmatisation; the right to freedom of expression and assembly; the right to prevention, as well as to treatment and harm reduction; and the prohibition of slavery and forced labour.

Human rights policy objectives

The third section of the report discusses policy objectives, with an emphasis on how these should be aligned with human rights – 'all stakeholders should take full account of human and social rights when developing, implementing, monitoring and evaluating drug and addictions policies' (p. 11).[1] The authors identify a set of 16 policy objectives to be pursued. It is beyond the scope of this article to provide a full list, but some of those that are pertinent to the Irish context include:

- Ensuring the availability of evidence-based early universal, selective, indicated, and environmental prevention programmes at all levels and accessible to relevant target groups

Human rights and drugs policy
continued

- Ensuring recovery paths and providing social and professional reintegration programmes
- Creating opportunities to ensure human dignity and overcome stigma and discrimination of people who use drugs and those with substance use disorder or addictive behaviours
- Heeding the notion of human dignity by applying a person-first approach to ensure equal opportunities for all those concerned based on their individual needs with the aim of leaving no one behind
- Avoiding coercive sanctioning and promoting alternatives to criminal justice sanctions encouraging proportionate sentencing in court and other legal processes involving people who use drugs and those with substance use disorder or addictive behaviours
- Raising awareness of human rights and relevant standards
- Providing adequate funding for prevention, treatment and care, risk and harm reduction, and recovery
- Making the best possible use, in accordance with human rights law, of e-medicine and online counselling, and supporting other emerging online technologies, including artificial intelligence, to increase access and coverage of services, particularly for those who are difficult to reach.[1]

Assessment and evaluation

The Pompidou Group advocates for member states to have processes in place for the ongoing assessment and evaluation of drug policies to ensure that human rights remain safeguarded. This supports a process through which the learning from these assessments can feed back into the policy-making process. Member states are directed to the Pompidou Group's self-assessment tool for drug policy compliance with human rights standards for guidance in this matter.[3,4] Central to this process is the importance of maintaining good working relationships between all those involved in the policy-making process, with a special emphasis on the government sector and civil society stakeholders.

Democratic governance

The final section of the report looks briefly at the issue of democratic governance. The Group emphasises the importance of the democratic governance principles of 'relying on science and evidence, inclusive dialogue and participation, transparency and accountability' (p. 19)[1] and how they should be incorporated into all stages of the policy-making cycle (development, implementation, monitoring, and evaluation). All stakeholders are seen as having a role in the governance process, and those listed by the Group are 'government, non-governmental organisations, scientific, professional and academic communities, international or regional organisations or agencies, as well as organisations representing people who use drugs and those with substance use disorder or addictive behaviours, their families and other service users' (p. 19).[1]

Lucy Dillon

1 Pompidou Group (Council of Europe International Cooperation Group on Drugs and Addictions) (2025) *Bringing human rights to the heart of drug and addiction policies: Guidance for aligning drug and addiction policies with human rights*. Strasbourg: Council of Europe. Available from: https://www.drugsandalcohol.ie/42239/

2 More information on the activities of the Pompidou Group is available from: https://www.coe.int/en/web/pompidou/about

Human rights and drugs policy
continued

3 Pompidou Group (2022) *Human rights in drug policy: a self-assessment tool*. Strasbourg: Pompidou Group of the Council of Europe. Available from: https://www.drugsandalcohol.ie/36575/

4 Dillon L (2022) Assessment tool for human rights. *Drugnet Ireland*, 83 (Winter): 7. Available from: https://www.drugsandalcohol.ie/37382/

Recent research

Early and risky adolescent alcohol use independently predict alcohol, tobacco, cannabis, and other drug use in early adulthood in Ireland

Background

In 2023, the Health Research Board (HRB) partnered with Trinity College Dublin to examine the alcohol- and drug-related data collected in the nationally representative, longitudinal Growing Up in Ireland (GUI) study. A series of publications have ensued as a result of this collaboration.[1-4] The most recent of these examined the association between age of alcohol initiation and hazardous alcohol use during adolescence with alcohol, tobacco, cannabis, and other drug use during early adulthood.[5]

Methods

Using logistic regression methodology (bivariable and multivariable logistic regression models), the study used GUI data from Wave 1 (when participants were aged 9 years), Wave 2 (when participants were aged 13 years), and Wave 3 (when participants were aged 17 years) and examined the association between age of alcohol initiation and reports of hazardous drinking patterns (using the Alcohol Use Disorders Identification Test (AUDIT) scores) at Wave 3 with high-risk alcohol (AUDIT score >15), tobacco, cannabis, and other drug[6] use at Wave 4 (when participants were aged 20 years).

Results

Of the 4,554 participants who completed all 4 waves of the survey, over one-quarter (27%) had their first alcoholic drink at age 14 years or younger and by age 17 years, 6% had an AUDIT score of 15 or higher, indicating high-risk drinking patterns; by age 20 years (Wave 4), this had increased to 14% of participants. Over one-third were smokers at age 20 years (38%), almost one-quarter were cannabis users (24%), and 28% had used other drugs in the past year.

Adolescent alcohol use
continued

Bivariable regression analysis

Age of alcohol initiation

An examination of age of alcohol initiation revealed that delaying alcohol use was associated with lower rates of high-risk alcohol, tobacco, cannabis, or other drug use at age 20 years, relative to those who had their first alcoholic drink at age 14 years or younger. Conversely, early alcohol initiation was positively associated with substance use at age 20 years.

AUDIT scores at age 17 years

Those with 'increasing risk' alcohol use (an AUDIT score of between 8 and 15) at age 17 years had a fourfold increase in the odds of high-risk alcohol use at age 20 years, while those whose alcohol use was high risk (AUDIT score >15) at age 17 years had a 14-fold increase in the odds of continued high-risk alcohol use at age 20 years relative to adolescents who had been classified as low risk. In addition, high AUDIT scores at age 17 years doubled the odds of other drug use at age 20 years.

Multivariable regression analyses

Age of alcohol initiation

Following the addition of exposures and covariates, multivariable analyses continued to show the association between delayed alcohol use and reduced odds of high-risk alcohol use at age 20 years, although effect sizes were reduced. Delayed alcohol initiation also remained associated with reduced odds of cannabis and tobacco use at age 20 years.

AUDIT scores at age 17 years

High-risk alcohol use at age 17 years remained strongly associated with cannabis use at age 20 years, although it was not statistically significant. It also doubled the odds of tobacco use at age 20 years and was associated with an 11-fold increase in the odds of continued high-risk alcohol use at age 20 years.

Additional analyses

Additional analyses examining factors associated with substance use at age 20 years using survey-weighted multivariable generalised estimating equations regression models indicated that male sex doubled the odds of cannabis use and was associated with a 40% increase in the odds of other drug use.

Higher externalising scores (indicating a higher likelihood of hyperactivity, impulsivity, and aggression) were associated with a 50% increase in the odds of both tobacco use and high-risk alcohol use. Lower parental monitoring was associated with a 30% increase in the odds of cannabis use and a 40% increase in the odds of tobacco use. Those with friends who used cannabis at age 17 years had a fourfold increase in the odds of cannabis use and a threefold increase in the odds of other drug use.

Conclusions

Adjusted modelling analysis consistently showed that age of alcohol initiation and risky alcohol use during adolescence independently predict high-risk alcohol use, tobacco use, cannabis use, and other drug use in early adulthood. These findings add to the mounting conclusive evidence of the risks associated with alcohol use in children, especially early and risky alcohol use. Urgent public health measures to address this are required in order to prevent the escalation to more serious substance use in adulthood.

Anne Doyle

1 Mongan D, Millar S, Brennan MM, *et al.* (2025) Longitudinal associations between childhood adversity and alcohol use behaviours in early adulthood: examining the mediating roles of parental and peer relationships. *Child Abuse Negl,* 161: 107302. Available from: https://www.drugsandalcohol.ie/42645/

Adolescent alcohol use
continued

2 Mongan D, Millar S, Brennan M, *et al.* (2025) Associations and mediating factors between adverse childhood experiences and substance use behaviours in early adulthood: a population-based longitudinal study. *Addict Behav,* 161: 108194. Available from: https://www.drugsandalcohol.ie/42204/

3 Brennan M, Cavallaro M, Mongan D, *et al.* (2025) Factors associated with cocaine use at 17 and 20 years old: a longitudinal analysis of a nationally representative cohort. *J Adolesc Health,* 76: 488–498. Available from: https://www.drugsandalcohol.ie/42555/

4 Brennan M, Corrigan C, Mongan D, *et al.* (2024) Predictors and outcomes of adolescent alcohol and drug use: a scoping review. *Eur J Public Health,* 34. Available from: https://www.drugsandalcohol.ie/42212/

5 Brennan MM, Mongan D, Doyle A, *et al.* (2025) Early and risky adolescent alcohol use independently predict alcohol, tobacco, cannabis and other drug use in early adulthood in Ireland: a longitudinal analysis of a nationally representative cohort. *BMC Public Health* , 25: 1129. Available from: https://www.drugsandalcohol.ie/42914/

6 Cocaine, ecstasy, ketamine, amphetamines, poppers, lysergic acid diethylamide (LSD), magic mushrooms, crack, or the misuse of prescription drugs.

Adverse childhood experiences and drug use among young adults in Ireland

Adverse childhood experiences (ACEs) describe different types of stressful or traumatic experiences during childhood, and exposure to extreme stress during critical periods of early life may increase the likelihood of exposure to a range of adverse factors.[1] Importantly, studies have demonstrated positive associations between ACEs and substance use behaviours in young adults.[2] However, many of these are based on cross-sectional data, which cannot provide evidence on the hypothesised direction of association between ACEs and substance use. In addition, the pathway between ACEs and substance misuse among emerging adults is not fully understood and few studies have investigated potential mediating factors.

Recent research conducted in Ireland examined ACE exposure associations with substance use behaviours using data from the Growing Up in Ireland study.[3] Utilising a population-based longitudinal sample of 4,729 young people in Ireland recruited at age 9 years, the research had three aims. First, to describe the extent of ACE exposures among the sample population and the proportion who engaged in illicit substance use (current cannabis use, other illicit drug use, and problematic drug use) at age 20 years. Second, to examine individual and cumulative ACE exposure relationships with substance use behaviours. Third, to explore whether these associations are mediated by parent and peer relationships and liking school.

Notable findings from the study, which has been published in the journal *Addictive Behaviors,* include the following:

- Just over 30% of young adults had experienced two or more ACEs during the study period. With respect to drug use,

Adverse childhood experiences and drug use among young adults

continued

23.7% of participants indicated current cannabis use at age 20 years, while 27.9% used other illicit drugs. Just under 15% of young adults had a Cutting down, Annoyance by criticism, Guilty feeling and Easing of withdrawal symptoms (CAGE) score of 2 or more, suggesting problematic drug use.

- Regarding individual ACEs, significant associations with substance use behaviours were noted for young adults who had experienced conflict between parents and for those who had endured mental health disorders and drug taking/alcoholism in their immediate family.
- Significant dose–response relationships were also observed between the number of ACEs and substance use, with study participants who had experienced two ACEs or three or more ACEs having an approximate twofold and approximate threefold increased odds of problematic drug use, respectively, when compared with participants who had experienced no ACEs during the study period.
- Mediation analyses suggested that parent and peer attachment and liking school partially mediate relationships between ACEs and substance use behaviours in young adults.

The authors suggest that prevention programmes which aim to reduce illicit substance use among young adults with traumatic childhood experiences should target children who have experienced parental conflict, mental illness, and substance use disorders in their families, as well as multiple ACEs, as these children are at a high risk of future substance use and problematic drug use. In supporting these children, identified mediators such as interpersonal relationships and school engagement may help guide selection of prevention interventions.

Seán Millar

1 Pitts C, Millar SR, Perry IJ and Phillips CM (2024) Relationships between childhood adversity and inflammatory biomarkers in adulthood: A cross-sectional analysis of a middle-to older-aged population. *SSM Popul Health,* 25: 101608. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC10797532/

2 Grummitt L, Barrett E, Kelly E and Newton N (2022) An umbrella review of the links between adverse childhood experiences and substance misuse: what, why, and where do we go from here? *Subst Abuse Rehabil,* 13: 83–100. Available from: https://www.drugsandalcohol.ie/37495/

3 Mongan D, Millar SR, Brennan MM, Doyle A, Galvin B and McCarthy N (2025) Associations and mediating factors between adverse childhood experiences and substance use behaviours in early adulthood: a population-based longitudinal study. *Addict Behav,* 161: 108194. Available from: https://www.drugsandalcohol.ie/42204/

Factors associated with cocaine use among young adults in Ireland

The Republic of Ireland ranks fourth globally for past-year cocaine use, with 2.4% of the general adult population reporting such use in 2019.[1] It ranks second in Europe for lifetime cocaine use among 15–24-year-olds, with such use estimated at 6.8% in 2021.[2] National drug treatment surveillance data revealed a 259% increase in cases where cocaine was the main problem drug between 2016 and 2022; in 2022, cocaine surpassed opioids as the leading problem drug, accounting for 34% of all drug treatment cases.[3] In addition, among individuals aged 15–24 years, cocaine-related hospital discharges rose by 83% between 2015 and 2019, while cocaine-related deaths increased by 41% between 2007 and 2017.[2] However, despite growing concerns about trends in cocaine use in Ireland, there is a lack of longitudinal studies that prospectively examine factors associated with cocaine initiation and use in general youth populations.

Recent research examined individual, family, and socio-environmental exposures associated with incident past-year cocaine use at ages 17 years (n=5965) and 20 years (n=4679) using data from the Growing Up in Ireland study.[4] Notable findings from this research, which have been published in the *Journal of Adolescent Health,* include the following:

- Almost 4% of 17-year-olds and 22.9% of 20-year-olds reported past-year cocaine use.
- Cocaine use increased by 475% between ages 17 and 20 years, and over 75% of those who used cocaine at age 17 years continued to use it at age 20 years.
- Alcohol use at age 14 years or younger was associated with 8 times the odds of cocaine use at age 17 years (odds ratio (OR): 8.0;, 95% confidence interval (CI): 1.7–7.3) and 19 times the odds of cocaine use at age 20 years (OR: 19.2; 95% CI: 8.6–43.2).
- Peer cannabis use was associated with seven times the odds of cocaine use at age 17 years (OR: 7.3;, 95% CI: 2.9–18.3) and double the odds of cocaine use at age 20 years (OR: 2.4; 95% CI: 1.8–3.2).
- Growing up in a neighbourhood where substance use was common doubled the odds of cocaine use at age 17 years (OR: 2.4; 95% CI: 1.3–4.4).

The authors note that the sharp increase in cocaine use between age 17 years and age 20 years suggests that this period is crucial for intervention, and that delaying alcohol initiation and reducing cannabis exposure may help prevent cocaine use later in adolescence and young adulthood. In addition, targeted public health interventions, especially in high-risk environments, may be necessary to curb rising cocaine use.

Seán Millar

1 UNODC (2023) *Global Report on Cocaine 2023 – Local Dynamics, Global challenges*. Geneva: United Nations publications. Available from: https://www.unodc.org/documents/data-and-analysis/cocaine/Global_cocaine_report_2023.pdf

Factors associated with cocaine use among young adults

continued

2 Doyle A, Sunday S, Galvin B and Mongan D (2022) *Alcohol and other drug use among children and young people in Ireland: Prevalence, risk and protective factors, consequences, responses, and policies*. HRB Overview Series 12. Dublin: Health Research Board. Available from: https://www.hrb.ie/wp-content/uploads/2024/06/HRB_Overview_Series_12.pdf

3 O'Neill D, Lyons S and Carew AM (2022) *National Drug Treatment Reporting System: 2022 drug treatment demand*. HRB StatLink Series 12. Dublin: Health Research Board. Available from: https://www.hrb.ie/wp-content/uploads/2024/06/NDTRS_Drug_treatment_demand_2022_bulletin.pdf

4 Brennan MM, Cavallaro M, Mongan D, *et al.* (2025) Factors associated with cocaine use at 17 and 20 years old: a longitudinal analysis of a nationally representative cohort. *J Adolesc Health*, 76(3): 488–498

New report on problem drug use in Cork city published

Problem drug use (PDU) is defined as recurrent drug use that is causing harm to an individual, or is placing them at a high probability or risk of suffering harm.[1] Substances associated with PDU include opioids, cocaine (powder and crack), amphetamines, benzodiazepines, Z-drugs, and gabapentinoids. PDU can lead to many harms for populations and individuals. Such harms include increased criminal activity, drug-related litter, increased risk of infectious diseases passed on from shared syringes and needles, substance use disorders, overdoses, and death.

To date, studies on PDU in Ireland have largely been conducted at a national level or have concentrated on Dublin city, as a majority of PDU has historically taken place within inner city Dublin. However, research suggests that PDU is also occurring in Cork city.[2] In 2024, the Health Service Executive (HSE) Cork and Kerry, as well as Cork City Council, contracted the School of Public Health, University College Cork (UCC) to conduct a study on PDU in Cork city. Specifically, the objectives of this research were to provide estimates on the prevalence of PDU; number of syringes exchanged; numbers in treatment; non-fatal overdose cases; and self-harm related to PDU and drug-related deaths in Cork city using the most recent available data and to compare trends over time. The main findings from the published report[3] are discussed below.

A four-source capture-recapture analysis estimated that there were 859 (95% confidence interval (CI): 774–1,079) problematic opioid users in Cork city in 2022, which equates to a prevalence rate of 5.59 (95% CI: 5.04–7.02) opioid users per 1,000 population. In 2022, almost one-third of opioid users in Cork city were unknown to services. Between 2019 and 2022 the prevalence of opioid use remained relatively stable, with a majority of users being male and aged between 35 and 64 years. However, the needle exchange programme in Cork city has shown a general increase in the number of syringes exchanged since 2019, with

Problem drug use in Cork city

continued

an average of 6,685 syringes being provided each month from pharmacy-based sites in 2023. Data from household surveys demonstrate an increase in the use of cocaine (including crack) and amphetamines, with these increases being noticeably pronounced among young adults. The main problem drug for cases entering treatment in Cork city for PDU has shifted; since 2019, trends indicate a gradual reduction in the number of cases entering treatment for opioids, with an increase in the number of cases accessing treatment services for cocaine use.

For the years 2019–2023, benzodiazepines were the main drug implicated in non-fatal overdose cases in Cork city, followed by opioids, with an average of one opioid overdose occurring each week. Between 2018 and 2021 there was a total of 487 self-harm presentations related to PDU by Cork city residents; benzodiazepines were the main drug implicated in self-harm presentations (63.2%), followed by opioids (30.6%), gabapentinoids (11.9%) and cocaine (9.0%). During this period, there was a total of 140 poisoning deaths due to PDU recorded, with an average of 35 deaths each year. Opioids were the main drug implicated in poisoning deaths (75.7%), followed by benzodiazepines (59.3%), gabapentinoids (27.9%) and cocaine (14.3%).

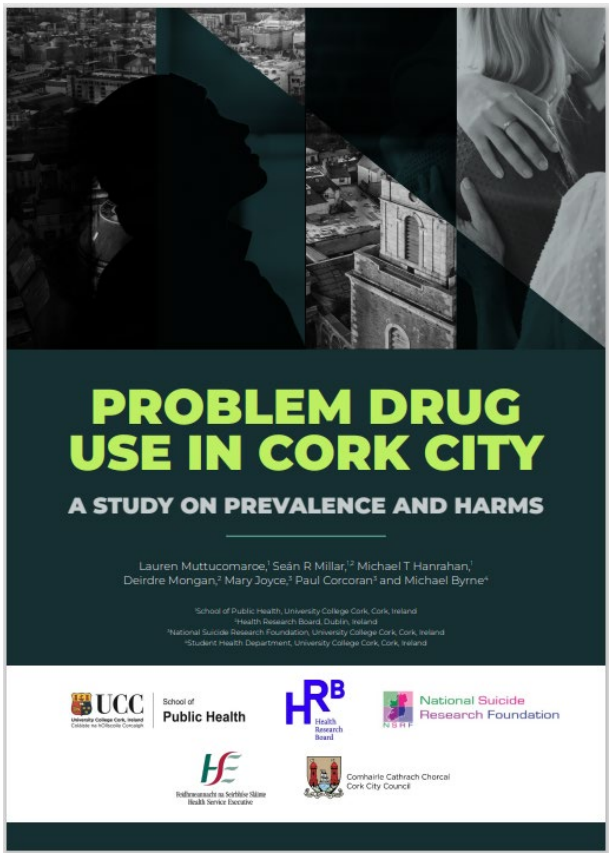
The authors note that the study shows that PDU is taking place in Cork city, with a number of associated harms. Although Cork city has a variety of harm reduction services that deal with education, assessment, treatment and post-treatment support, the authors suggest that the disconnect between problem drug users and these programmes may benefit from additional services. The authors also recommend ongoing research on PDU in Cork city for effective service planning and to allow policy-makers to evaluate the impact of strategies aimed at reducing drug-related harms.

Seán Millar

1 European Monitoring Centre for Drugs and Drug Addiction (2013) *PDU (problem drug use) revision summary*. Luxembourg: Publications Office of the European Union. Available from: https://www.drugsandalcohol.ie/27693/1/att_218205_EN_PDU%20revision.pdf

2 Hanrahan MT, Millar SR, Phillips KP, Reed TE, Mongan D and Perry IJ (2022) *Problematic opioid use in Ireland, 2015–2019*. Dublin: Health Research Board. Available from: https://www.hrb.ie/fileadmin/user_upload/HRB_CRC_Report.pdf

3 Muttucomaroe L, Millar SR, Hanrahan MT, *et al.* (2025) *Problem Drug Use in Cork City: A study on prevalence and harms.* Cork: University College Cork. Available from: https://www.drugsandalcohol.ie/42736



An electronic copy of the report is available from the National Drugs Library at: https://www.drugsandalcohol.ie/42736

Prevalence and current situation

Death by suicide and gambling

A paper titled 'A qualitative analysis of people who died by suicide and had gambling documented in their coronial file',[1] which explores the relationship between death by suicide and gambling in Ireland, was published in April 2025. It is the first study to explore this topic using coronial records in Ireland.

Context

Since the mid-1990s, the availability of gambling and gambling products (including online products) has increased dramatically. In turn, rates of gambling and problematic gambling have also increased. In Ireland, the estimate of adults with problematic gambling behaviours is 3.3%, with a further 7.1% having 'multiple problematic gambling experiences' (p. 2).[2]

The Reynolds *et al.* paper is grounded in the context of a growing body of international evidence of the harms associated with gambling, including an association with an increased risk of suicidal ideation and suicide attempts. Among the other harms associated with gambling found in the literature are financial difficulties, mental health issues, relationship problems, addiction, and crime.

Research aim

The aim of the research carried out by Reynolds *et al.* is to identify and profile individuals who died by suicide in Ireland between 2015 and 2020 and had gambling documented in their coronial file. A qualitative approach was taken to analysing the data to describe any other proximal (or acute) and distal (or chronic) risk factors documented in the file.

The Irish Probable Suicide Death Study

The Irish Probable Suicide Death Study (IPSDS) for 2015–2020 collected its data through an annual census of closed coronial files. Researchers working on the IPSDS have access to all relevant coronial documents. They classify a death as a suicide 'on the balance of probabilities (i.e. civil standard of proof)' (p. 2),[1] and therefore the IPSDS includes 'all coroner-determined and research-determined suicides, meaning deaths that were more likely than not, based on the weight of evidence, to have been a suicide' (p. 2).[1] The IPSDS is a valuable resource for those working in the field of suicide prevention, and is at the core of this study.

Methodology

Information on an individual's gambling history is not routinely collected as part of Irish coroners' investigations. The authors screened the files of the 3,625 deaths from the IPSDS (2015–2020) for any mention of gambling. They found 23 deaths where gambling was mentioned in the notes for these cases. Further analysis was carried out on these cases using a database into which demographic and clinical variables, as well as adverse events experienced by the person, were logged. Thematic analysis was used to identify the long-term distal and the short-term proximal risk factors reported in the context of these deaths.

Death by suicide and gambling

continued

Findings

The mean age of the sample was 38.7 years (standard deviation (SD): 9.82), 21 were male, and 21 were parents. More than one-half (57%) of cases had been in contact with health services prior to their death, including with a general practitioner (GP) (in 46% of cases) and with a counselling-related service or inpatient/outpatient psychiatric service (in 38% of cases).

The findings on risk factors echoed those in the international literature.

Distal risk factors

Mental health conditions (including a history of substance use) featured heavily in these cases. A history of a mental health condition was noted for more than two in every three cases; these included a recurrent depressive disorder, bipolar disorder, schizophrenia, and borderline personality disorder. A history of substance use was recorded in over one-half of the deaths, 'most notably' (p. 3)[1] cocaine use, followed by alcohol dependency. Past suicidal intent and/or behaviour was also a feature for one-half of these cases. Other social and environmental distal risk factors identified included adverse childhood experiences (ACEs), chronic illness, reclusiveness, and social isolation.

Proximal risk factors

Acute distress and mental health symptoms were reported around the time of death for more than one-half of cases. Some people had recently been discharged from inpatient hospitals or had changed psychiatric medications prescribed. Financial problems also featured, including those related specifically to gambling. Other factors included interpersonal problems, such as relationship difficulties with a spouse, alcohol and drug use/intoxication at the time of death, work stress, employment issues, and legal/criminal issues.

Discussion

The authors' exploration of the risk factors experienced by these people leading up to and at the time of their deaths presents a complex picture. In discussing their work, Reynolds *et al.* outline the findings of four international studies that use coronial data to investigate gambling and suicide, as well as a systematic review and meta-analysis of 40 risk factors for suicide. The meta-analysis found that 'the presence of any mental, drug or alcohol disorder, suicide attempt history and adverse life events, including relationship conflict and legal problems, were associated with an increased suicide risk' (p. 4).[1] Based on their own analysis, Reynolds *et al.* suggest that those with reported gambling issues have a similar pattern of risk factors. 'It indicates that those with gambling-related behaviours already have a vulnerable profile with an increased suicide risk, in addition to their gambling' (p. 4).[1]

Limitations

This study, which is based on a comprehensive national database, provides the first estimates of the numbers of those who died by suicide in Ireland and for whom gambling was documented in their coronial records. However, the authors identify some limitations to their work. For example, it does not involve analysis of association and so cannot be taken to infer causality between suicide and gambling. Coroners across Ireland vary in the way they conduct their investigations and there is no routine collection of information on gambling. This will impact on data recording, and Reynolds *et al.* argue that it may contribute to the underreporting of gambling in these cases. Underreporting may be further accentuated given the stigma and hidden nature of gambling.

Conclusions

The authors argue that further research is needed to 'understand and visualise the complex interplay between gambling

Death by suicide and gambling
continued

and other factors for suicide based on coronial information' (p. 4).[1] To facilitate this, improvements need to be made to the collection of data on gambling and its harms, especially as it relates to cases of suicide. They suggest support for interventions and policies that reduce all risk factors associated with suicide, including gambling and its associated harms. A new suicide reduction strategy for Ireland is to be developed and this offers 'an opportunity to include gambling as an area for action' (p. 2).[1] Based on their findings, Reynolds *et al.* conclude that 'a public health approach to reducing gambling harm should be embedded in a wide range of policies, including mental health, men's health, substance use, online safety, and suicide prevention' (p. 4).[1]

Lucy Dillon

1 Reynolds CME, Cox G, Lyons S, McAvoy H, O'Connor L and Kavalidou K (2025) A qualitative analysis of people who died by suicide and had gambling documented in their coronial file. *Addict Behav,* 163: 108267. Available from: https://doi.org/10.1016/j.addbeh.2025.108267. https://www.drugsandalcohol.ie/42583/

2 O'Ceallaigh D, Timmons S, Robertson D and Lunn P (2023) *Measures of problem gambling, gambling behaviours and perceptions of gambling in Ireland*. ESRI Research Series 169. Available from: https://esri.ie/publications/measures-of-problem-gambling-gambling-behaviours-and-perceptions-of-gambling-in

Overprescribing of benzodiazepines, Z-drugs and gabapentinoids in Ireland

The *Examining the overprescribing of Benzodiazepines, z-drugs and Gabapentinoids in Ireland* report was published by the Medical Council on 25 February 2025.[1] The aim of the report was to outline key issues along with recommendations identified by the Overprescribing Working Group.

Working Group

The Overprescribing Working Group ('the Working Group') was established in 2019 by then President of the Medical Council, Dr Rita Doyle. Initially, the remit was to review concerns about overprescribing benzodiazepines and associated complaints received by the Medical Council. Z-drugs and gabapentinoids were added later. The Working Group consisted of representatives from a range of stakeholders, including the Health Service Executive (HSE); Department of Health; Pharmaceutical Society of Ireland (PSI); Irish College of General Practitioners (ICGP); Nursing and Midwifery Board of Ireland (NMBI); Health Products Regulatory Authority (HPRA); Irish College of Psychiatry; and Faculty of Pain Medicine, College of Anesthesiologists of Ireland.[1]

Overprescribing of benzodiazepines

continued

Medications

Benzodiazepines, Z-drugs, and gabapentinoids are mainly prescribed to reduce symptoms related to a range of psychological and neurological issues. They aim to enhance quality of life.[1] The typical uses for each class of drug are as follows:

- Benzodiazepines (for example, diazepam and alprazolam) are sedatives that are used short term to manage anxiety, panic, addiction, alcohol detoxification, and insomnia.
- Z-drugs (for example, zopiclone and zolpidem) are used to treat insomnia.
- Gabapentinoids (for example, gabapentin and pregabalin) are used to treat pain.

The Misuse of Drugs Regulations 2017 provide controls for the prescribing of benzodiazepines and Z-drugs. Under this legislation, benzodiazepines are listed in Schedule 3 or Schedule 4 Part 1, whereas zolpidem and zopiclone are listed in Schedule 4 Part 1. Under Schedule 4 Part 1, the maximum length of a benzodiazepine or Z-drug prescription is 9 months.[1] In Ireland, gabapentinoids are not classified as a controlled drug in the Misuse of Drugs Regulations 2017.[1]

Prescribing

Doctors are responsible for the safe prescribing of benzodiazepines, Z-drugs, and gabapentinoids. They adhere to drugs prescribing guidelines issued by the Medical Council.[2] The *Guide to Professional Conduct & Ethics for Registered Medical Practitioners* guidelines document outlines the principles of professional practice that all doctors are required to follow.[2] Registered nurses and midwife prescribers who have undertaken approved training must also adhere to legislation; professional regulation; and policies, procedures, and guidelines.[1]

Tracking use

Public health system

Benzodiazepine, Z-drug, and gabapentinoid usage is tracked using the Primary Care Reimbursement Service (PCRS). The PCRS processes payments to practitioners providing free or reduced cost services, using the General Medical Service (GMS) scheme.[1] Pharmacies submit reimbursement claim data to the PCRS. This provides GMS-contracted doctors with an outline of their prescribing habits and how these habits relate to their peers. In addition, the PCRS operates a suite of Community Drug Schemes (CDSs); the GMS; the Drugs Payment Scheme (DPS); and the Long-Term Illness (LTI) Scheme. Drugs prescribed under these schemes are reported monthly and annually. Open data for all GMS drug claims (benzodiazepines and Z-drugs) can be found on the PCRS website.[3]

Only GMS data are used in Irish prescribing data analysis, which has been shown to represent only one-third of the population.[4] However, 2018 figures captured under the PCRS Community Drug Scheme indicated that over 65% of the population had either a medical card, DPS eligibility, or LTI Scheme eligibility.[1] The report further acknowledges that clinically active doctors (43%) in Ireland provide services publicly and privately; of this cohort, 6.8% only provide privately funded services.[1] GMS data only account for doctors with a GMS contract who are providing publicly funded services.[1]

Open data are published for GMS benzodiazepine and Z-drug claims by community pharmacists monthly. Figure 1 shows that since 2018, public prescribing of benzodiazepines and Z-drugs has decreased each year. Figure 2 provides a breakdown of total monthly prescriptions between September 2021 and September 2023. The number of prescriptions for diazepam and alprazolam decreased between 2018 and 2023.

Overprescribing of benzodiazepines

continued

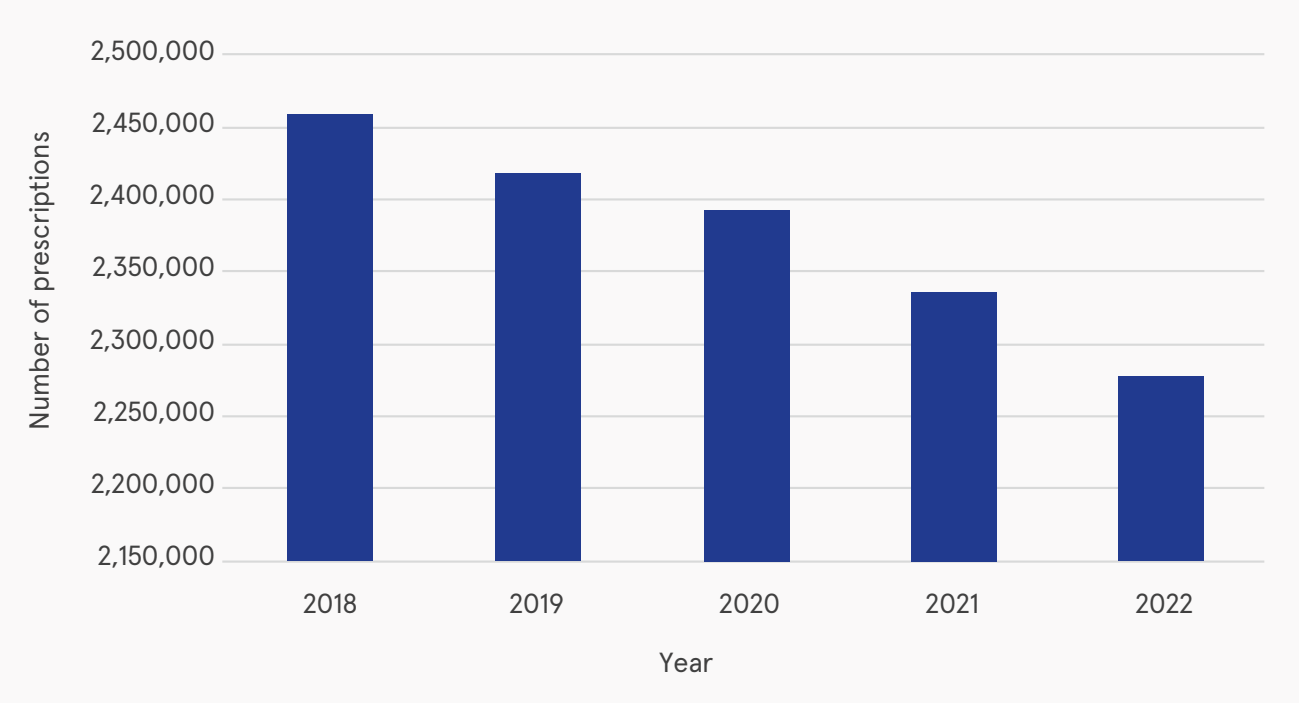


Figure 1: Number of prescriptions dispensed under the GMS for benzodiazepines and Z-drugs, 2018–2022

Source:Multiagency Working Group on Overprescribing (2025)[1]

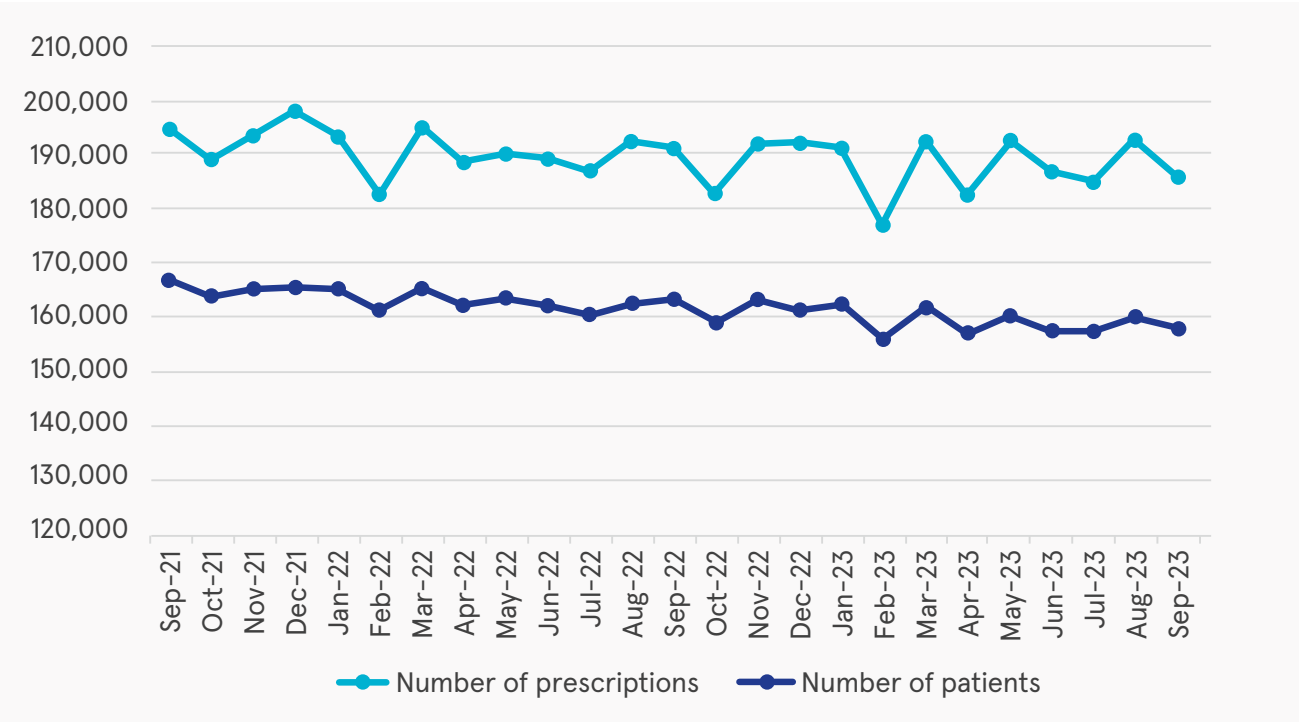


Figure 2: Total prescriptions and patients for benzodiazepines or Z-drugs between September 2021 and September 2023

Source: Multiagency Working Group on Overprescribing (2025)[1]

Overprescribing of benzodiazepines

continued

Outside public health system

No data are collected for non-GMS private prescriptions. This has been identified as an area of concern by the Working Group, who believe that legislative change will be needed in order to overcome this problem. Therefore, it is not possible to determine how much overprescribing occurs. Currently, getting access to a doctor's private prescribing history is challenging in the event of prescribing complaints.[1] It involves piecemeal trawling of prescriptions and contacting several individual pharmacies for records if patients have prescriptions dispensed in more than one pharmacy. The report acknowledges that this process is time-consuming, expensive, and inadequate with regard to patient safety and public protection.[1] Moreover, no dispensing data are collected for patients in secondary care.[1]

Tracking internationally

Within the European Union, prescribing data are tracked by different countries in different ways.[1] For example, in the Netherlands, there are three sources (general pracitioner (GP) electronic health records, community pharmacy databases, and insurer claims data). However, data linkage is not available.[5] In contrast, prescription databases in Denmark, Finland, Iceland, Norway, and Sweden represent the overall population and contain data that could potentially be linked.[1] Nordic countries have also started to implement processes to monitor medication use. The authors believe that the steps taken to establish these databases might provide important insights that could be considered within the Irish context (p. 27).[1] In the United Kingdom, prescription data are stored centrally in the English Prescribing Dataset. This dataset does not include prescriptions prescribed and dispensed in prisons, hospitals, or privately; neither does it include prescriptions issued outside of England (in other words, in Scotland, Wales, or Northern Ireland). The National Health Service (NHS) also has a data warehouse called ePACT2. Authorised users are given access to these data in order to analyse them.

Specific issues in patient safety

Not having a centralised record of all prescriptions is deemed a risk to patient safety.[1] However, due to amendments to the Medicinal Products (Prescription and Control of Supply) Regulations 2003 (as amended), prescriptions could be sent to patients' chosen pharmacy electronically via Healthmail. Nonetheless, paper prescriptions are still used. The Working Group recognised that:

- Inappropriate use of benzodiazepines can result in addiction, adverse reactions, and poorer quality of life.
- Misuse of Z-drugs can result in sedative effects that may persist the next day.
- Higher doses of gabapentinoids are often used by those dependent on opioids to achieve a faster high and lower withdrawal.[1]

Complaints

The Medical Council's Preliminary Proceedings Committee (PPC) is responsible for investigating complaints that arise regarding a doctor's fitness to issue controlled drug prescriptions.[1] Complaints relate not only to overprescribing but also to other prescribing issues. Between January 2018 and December 2022, 201 complaints were made in relation to the professionality of the prescribing doctor. Of these 201 complaints, 44 were referred for further investigation by the Fitness to Practise Committee. A further analysis of these complaints indicated that 32 complaints were in relation to overprescribing only. Of these 32 complaints, 23 (71.9%) were in relation to benzodiazepines, Z-drugs, and/or gabapentinoids.[1] Complaints made regarding a doctor's prescribing practice in relation to overprescribing fall into a 'most serious

Overprescribing of benzodiazepines

continued

category' (p. 38).[1] When this happens, the Medical Council may take immediate action, which can result in the suspension of the doctor's registration in Ireland until the complaint is concluded.[1] Between January 2018 and December 2022, immediate action was taken against 19 doctors.

Patient supports

In September 2019, the Medical Council advised doctors to reduce overprescribing of benzodiazepines, Z-drugs, and gabapentinoids (pregabalin). However, it was acknowledged that this was challenging due to patients' demands and having no access to counselling and services. The Working Group believe that the focus of this guidance is on GPs' practice. However, GP prescribing has its limits because there is no system in place to report hospital-initiated prescriptions. The rationale for the advice was to move the focus towards patient safety.[1] Moreover, public health campaigns outlining the risks of these benzodiazepines, Z-drugs, and gabapentinoids and their long-term addictive potential are lacking. The Working Group argue that having these campaigns would help doctors manage the dialogue with their patients.[1] Further education and training for GPs, and more access to counselling and addiction services, would allow GPs to further support their patients.

Conclusion and recommendations

The Working Group have examined the issues of patient safety in relation to overprescribing and inappropriate prescribing of benzodiazepines, Z-drugs, and gabapentinoids. In light of their work, they encourage a more comprehensive understanding of patient safety issues. In addition, while they acknowledge the importance of existing data and the ability to identify trends, they identify the need to get access to all prescribing data. Finally, although a decrease has been evident in prescriptions for benzodiazepines and Z-drugs, the Working Group recognise the impact of overprescribing these drugs and how it affects patient safety.[1]

Drawing on evidence-based practice, the Working Group put forward several recommendations that aim to reduce dependence on these drugs. The main focus is on improved service delivery, education, and advancing transparency in prescribing practices. Moreover, consideration should be given to including pregabalin and gabapentin in the Controlled Drugs List. The Working Group believe that the effective implementation of the recommendations will need input from agencies across the Irish healthcare system. To achieve this, an implementation group should be established to evaluate ongoing progress.

Ciara H Guiney

1 Multiagency Working Group on Overprescribing (2025) *Examining the overprescribing of benzodiazepines, z drugs and gabapentinoids in Ireland*. Dublin: Medical Council. Available from: https://www.drugsandalcohol.ie/42740/

2 Medical Council of Ireland (2024) *Guide to Professional Conduct & Ethics for Registered Medical Practitioners* (9th edition). Available from: https://www.medicalcouncil.ie/news-and-publications/publications/guide-to-professional-conduct-and-ethics-for-registered-medical-practitioners-2024.pdf

3 Health Service Executive (nd) Annual reports. Available from: https://www.sspcrs.ie/portal/annual-reporting/report/annual

4 Cousins G and Keenan E (2024) Gabapentinoids in Ireland (2010-2020): trends in prescribing, law enforcement drug seizures & post-mortem toxicology. *Policy Brief*, February 2024. Available from: https://www.lisbonaddictions.eu/lisbon-addictions-2024/presentations/gabapentinoids-ireland-2010-2020-trends-prescribing-law-enforcement-drug-seizures-post

Overprescribing of benzodiazepines

continued

5 Barbazza E, Verheij RA, Ramerman L, Klazinga N and Kringos D (2022) Optimising the secondary use of primary care prescribing data to improve quality of care: a qualitative analysis. *BMJ Open*, 12(7): e062349. Available from: https://doi.org/10.1136/bmjopen-2022-062349

Review of Prevention Systems in Ireland

The United Nations Office on Drugs and Crime (UNODC) has developed a tool to assess a national prevention system based on the *International standards on drug use prevention*.[1] Following a pilot of the tool (Review of Prevention Systems (RePS)) in Norway, the tool is now being applied to the Irish context. It will explore the range of prevention interventions in Ireland and the system underpinning them in relation to the international standards for effective practices in prevention.

What is RePS?

In 2018, the UNODC, in collaboration with the World Health Organization (WHO), published the *International standards on drug use prevention*.[1] The standards present an overview of the international evidence for prevention interventions and policies that promote the health and well-being of children, young people, adults, families, and communities. RePS is a tool developed by the UNODC to assess 'the extent to which the drug prevention system of a country or sub-national entity (e.g. a municipality) is in line with the *Standards* with a view to identifying areas of strength and weakness to allow improvement' (p. 1).[2] Data are collected at the intervention level and the system level. The findings of the pilot of the RePS tool in Norway were published in September 2023 and were covered alongside a detailed description of the tool in an article in *Drugnet Ireland* Issue 89.[3]

RePS in Ireland

RePS in Ireland is being managed by a team from the Health Research Board (HRB) and the Department of Health Drug Policy Unit. The lead investigator on the project is Professor Ross Macmillan, Department of Sociology, University of Limerick. The project is being carried out with the support of the UNODC, which will draw upon the Irish experience to further refine and develop the tool. In addition, a Strategic Advisory Group will help guide the project. It is expected that data collection will begin in Q2 2025 and a final report will be submitted to the HRB at the start of Q2 2026.

For further information, please contact Ross Macmillan at: rmacmillan@hrb.ie

Review of prevention systems
continued

Lucy Dillon

1 United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO) (2018) *International standards on drug use prevention*. Second updated edition. Vienna: UNODC. Available from: https://www.drugsandalcohol.ie/30048/

2 United Nations Office on Drugs and Crime and KORUS Oslo (2023) *Review of national prevention systems based on the UNODC/WHO international standards on drug use prevention. Final report of the pilot in Norway.* Vienna: United Nations Office on Drugs and Crime. Available from: https://www.drugsandalcohol.ie/41014/

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Commercial determinants of health: the case of the alcohol industry

Background

In February 2025, in the shadow of the Guinness brewery (part of Diageo), often synonymous with Dublin, a workshop event, 'The other side of the coin', was held in Rialto's F2 Centre. The workshop, organised by the Canal Communities Local Drug and Alcohol Task Force, Irish Community Action on Alcohol Network (ICAAN), and the Health Service Executive (HSE), aimed to explore the challenges and strategies for building understanding of alcohol harm in communities where the alcohol industry has created a narrative of embodying virtue in the Dublin 8 area.

Friend or foe?

Often referred to fondly in this part of Dublin as a great employer, a 'family', or an 'institution', the Guinness brewery and its by-product are, in fact, associated with high levels of alcohol-related harm within this community and farther afield. Professor Mark Petticrew, Professor of Public Health in the London School of Hygiene and Tropical Medicine, drew on the darker, overlooked side of an industry whose primary product is harmful to population health, a commercial determinant of health.[1]

Distracting tactics

Professor Petticrew outlined some of the tactics used by the alcohol industry, such as the lobbying of policy-makers, advertising and marketing to drive demand and consumption, supply chain and waste practices that harm human and planetary health, scientific practices, labour and employment practices, and certain financial practices such as tax avoidance.

Professor Petticrew went on to highlight examples of strategies specifically used by the alcohol industry, but which are reminiscent of those used by the tobacco industry in the 1920s–1930s. These include responsibility messaging, whereby the blame for the harms associated with alcohol use are shifted to the individual (not to the industry); a focus on a minority of 'harmful drinkers' and on 'problem behaviours', while avoiding mentioning that the harms associated affect a much wider group

Commercial determinants of health

continued

than the drinker alone, or that the product causes the problem; and strategic ambiguous messaging, sometimes delivering mixed messages (e.g. messages may appear to be warning about harms but can also be promoting the products and brands at the same time). Evidence of the latter indicates that industry responsibility messaging can, in fact, increase consumption, as those who view such messaging have been shown to focus on the positive alcohol-related imagery rather than the health messaging.[2]

Evidence also exists to indicate that strategies to misinform about alcohol are often used, creating doubt about alcohol harms, including cancer denialism through the hiding, denying, and distorting of the risk of cancer from alcohol use.[3] This has also been noted in denialism of fetal alcohol spectrum disorders (FASDs) and of the harms of drinking during pregnancy.[4] Denialism of the association of alcohol use with cardiovascular disease (CVD) has also been evident, as has a greater emphasis on the so-called 'health benefits' of wine. Although studies have found some positive association, the most up-to-date and robust evidence indicates that the harms significantly outweigh any health gains.[5-7]

Corporate social responsibility

Corporate social responsibility (CSR) tactics have been noted to be utilised by the alcohol industry to enhance its public image and reputation. Some common ways of doing this have been observed, including by funding charities (such as Drinkaware), supporting community groups, sponsoring sports or the arts, sustainability initiatives, and other 'greenwashing' initiatives. Although these tactics are commonly used by profit-making industries and can deliver some benefits to society, the concern relates to the negative impacts associated with alcohol industry CSR practices. These can include policy substitution, where CSR is used by the alcohol industry to undermine evidence-based policies (e.g. minimum unit pricing), or partnerships and charity work that is used to give a 'health halo' to their activities. Other industry CSR practices include where industry actors are afforded additional opportunities to influence public health policy and research in ways that are most aligned with their commercial interests, and ethical harms through public-private partnerships whereby it has been noted that such industries 'create subtle reciprocities and influence that undermine the integrity of government bodies, as well as public trust in those institutions'.[8]

What to do?

But all is not lost. Professor Petticrew highlighted a number of actions that individuals, communities, and policy-makers alike can take, including challenging our ways of thinking and assumptions that have become the norm; to consider the evidence; to not just think about unhealthy products but to also consider the practices and strategies of these companies; to consider who really benefits; and to challenge and raise awareness of these practices.

The workshop concluded with a presentation from Paula Leonard, CEO of Alcohol Forum Ireland, who explained and encouraged the use of the i-mark initiative. i-mark was developed in response to concerns about the conflict between the motives of the alcohol industry and the health and well-being of the population.[9] Organisations can sign up to i-mark to signify that they are independent from the alcohol industry.

Anne Doyle

1 Gilmore AB, Fabbri A, Baum F, *et al.* (2023) Defining and conceptualising the commercial determinants of health. *Lancet*, 401: 1194–1213

Commercial determinants of health

continued

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4 Lim AW, Van Schalkwyk MC, Maani Hessari N, *et al.* (2019) Pregnancy, fertility, breastfeeding, and alcohol consumption: an analysis of framing and completeness of information disseminated by alcohol industry-funded organizations. *J Stud Alcohol Drugs*, 80: 524–533.

5 Peake L, van Schalkwyk MC, Maani N, *et al.* (2021) Analysis of the accuracy and completeness of cardiovascular health information on alcohol industry-funded websites. *Eur J Public Health*, 31: 1197–1204

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7 Krittanawong C, Isath A, Rosenson RS, *et al.* (2022) Alcohol Consumption and Cardiovascular Health. *Am J Med,* 135: 1213–1230. Available from: doi:10.1016/j.amjmed.2022.04.021

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Trends in alcohol and drug admissions to psychiatric facilities

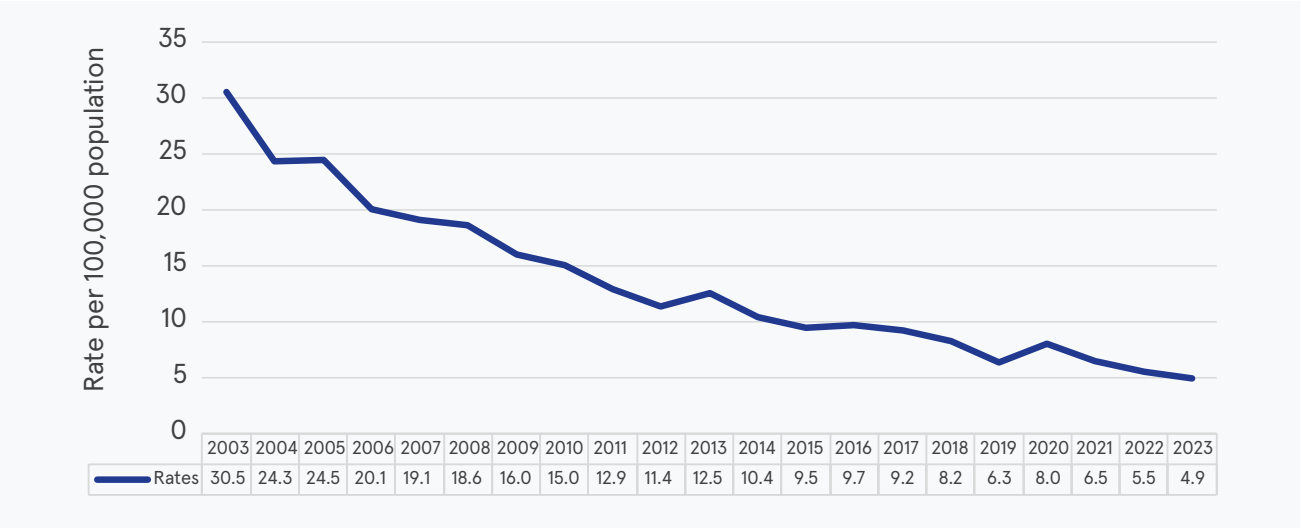
The *National Psychiatric Inpatient Reporting System (NPIRS) annual report on the activities of Irish psychiatric units and hospitals 2023,* published by the Health Research Board (HRB) Mental Health Information Systems Unit,[1] shows that the rate of new admissions to inpatient care for alcohol disorders has remained stable.

In 2023, 606 cases were admitted to psychiatric facilities with an alcohol disorder; of these cases, 253 were treated for the first time. Figure 1 presents the rates of first-time admissions between 2003 and 2023 for cases with a diagnosis of an alcohol disorder. Trends over time indicate an overall decline in first-time admissions. In 2023, two-thirds (66.4%; n=168) of cases of first-time admissions for an alcohol disorder were male and 93.7% (n=237) were voluntary.

In 2023, 845 cases were also admitted to psychiatric facilities with a drug disorder. Of these cases, 394 were treated for the first time. Figure 2 presents the rates of first-time admissions between 2003 and 2023 for cases with a diagnosis of a drug disorder. The admission rate in 2023 was higher than in 2022, which was the lowest rate recorded since 2008. It should be noted that the report does not present data on drug use and psychiatric comorbidity; it is therefore not possible to determine whether or not these admissions were appropriate.

Alcohol and drug admission to psychiatric facilities

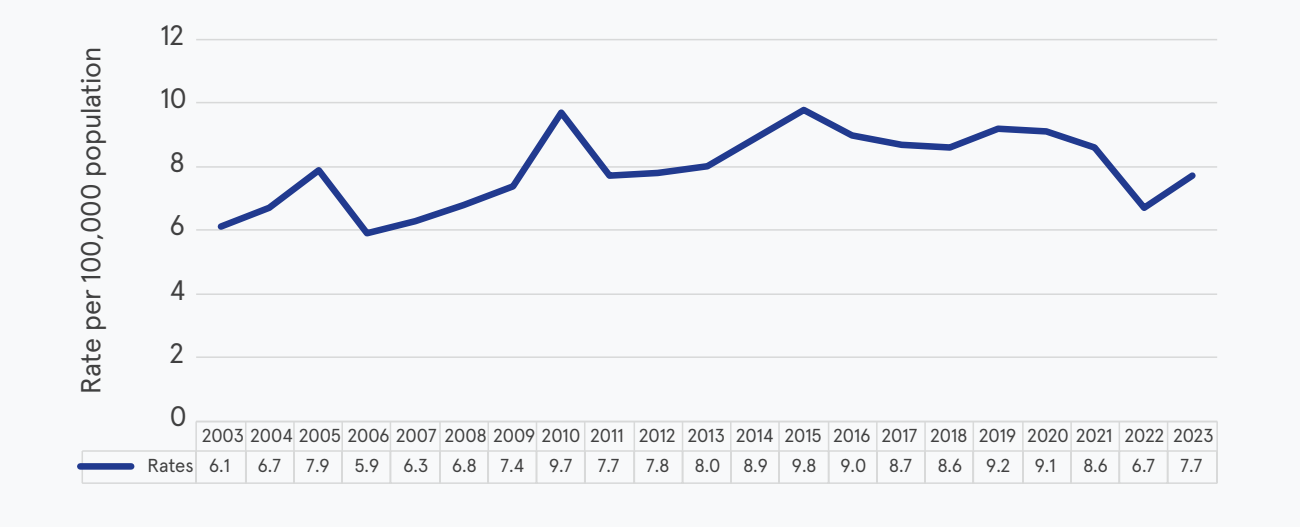
continued



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rates	30.5	24.3	24.5	20.1	19.1	18.6	16.0	15.0	12.9	11.4	12.5	10.4	9.5	9.7	9.2	8.2	6.3	8.0	6.5	5.5	4.9

Figure 1: Rates of psychiatric first-time admissions of cases with a diagnosis of an alcohol disorder per 100,000 population in Ireland, 2003–2023

Source: Daly *et al.* (2024)[1]



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Rates	6.1	6.7	7.9	5.9	6.3	6.8	7.4	9.7	7.7	7.8	8.0	8.9	9.8	9.0	8.7	8.6	9.2	9.1	8.6	6.7	7.7

Figure 2: Rates of psychiatric first-time admissions of cases with a diagnosis of a drug disorder per 100,000 population in Ireland, 2003–2023

Source: Daly *et al.* (2024)[1]

Similar to previous years, the rate of psychiatric first-time admissions with a diagnosis of a drug disorder was higher for men (11.6 per 100,000 population) than for women (3.8 per 100,000 population). In 2023, 83.2% (n=328) of psychiatric first-time admissions of cases with a diagnosis of a drug disorder were voluntary.

Seán Millar

1 Daly A, Lovett H and Lynn E (2024) *National Psychiatric Inpatient Reporting System (NPIRS) annual report on the activities of Irish psychiatric units and hospitals 2023.* Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/42203/

Prison visiting committees annual reports, 2022

A visiting committee is appointed to each Irish prison under the Prisons (Visiting Committees) Act, 1925 and the Prisons (Visiting Committees) Order, 1925. Members of the 12 visiting committees are appointed by the Minister for Justice for a term not exceeding 3 years. The function of prison visiting committees is to visit, at frequent intervals, the prison to which they are appointed and to hear any complaints that may be made to them by any prisoner. The committees report to the Minister for Justice regarding any abuses observed or found, and any repairs which they think are urgently needed. Prison visiting committee members have free access, either collectively or individually, to every part of the prison to which their committee is appointed. Information from prison visiting committee reports relating to drug use in prisons for 2022 is summarised below.[1]

Mountjoy Prison, Dublin

In its report, the Mountjoy Visiting Committee noted that the entry of illegal substances into Mountjoy Prison continues to be a problem and has had a significant impact on staff and prisoners. The lack of access for prisoners to drug treatment programmes, counselling, and the availability in Mountjoy Prison of a drug-free wing or landing has been reported by prisoners to be a gap in any meaningful service for those with addiction difficulties. Prisoners report using drugs to ease distress from feelings of paranoia, alienation, and depression; in addition, a number of people who were drug free at the time of sentencing leave Mountjoy Prison with an established addiction to drugs gained while they were in prison.

Wheatfield Prison, Dublin

The Wheatfield Place of Detention Visiting Committee's report observed the continuing issue of illicit drugs being thrown over the prison perimeter wall, and that this was very disruptive and caused great stress to both prison staff and prisoners. The Visiting Committee suggested that a more permanent plan/solution in dealing with the numerous State-owned lands at the back of the Prison could assist in drastically reducing drug throws. The Visiting Committee also questioned how adequate the opioid substitution therapy programme was at Wheatfield Prison and suggested that research on the success of the programme (i.e. does it give prisoners with drug issues on arrival in prison the tools to sustain them when they leave prison?) would be desirable.

Cloverhill Prison, Dublin

In its report, the Cloverhill Prison Visiting Committee noted that addiction counselling services in Cloverhill Prison continue to be very busy and face high demand. Remand prisoners are particularly vulnerable and many prisoners arrive in Cloverhill Prison with existing addiction issues; prisoners frequently refer to the long waiting time for addiction counselling services, and to the frustration that this can cause. The Visiting Committee heard that in 2022, waiting lists for addiction counselling services averaged 60 people. Consequently, the wait time for a prisoner to receive an appointment varied between 12 and 20 weeks. The Visiting Committee was concerned that this wait time appears to be growing. It recognised that several factors contribute to the length of waiting time for services, such as the increase in the number

Prison visiting committees annual reports

continued

of prisoners in Cloverhill, the level of staffing within the addiction counselling service, and the availability of prison staff to ensure that prisoners can access the service. In 2022, there was one full-time counselling post in Cloverhill Prison, which was filled by two part-time counsellors. Counsellors see 5 people per day, with an average of 25 people per week. The Visiting Committee suggested that an additional full-time counselling post is urgently needed in order to alleviate the demand for this service, which is necessary for prisoners' well-being and rehabilitation.

Arbour Hill Prison, Dublin

The Arbour Hill Prison Visiting Committee's report noted that Arbour Hill Prison remains fully committed to ensuring that the prison remains drug free. All prisoners are fully aware that they are expected to be 100% drug free, and access to the prison's facilities and services depends on this. Random drug testing is part of the day-to-day routine at the prison.

Cork Prison, Co Cork

The Cork Prison Visiting Committee heard that the prison's Post Release Project continued to work within a multi-agency setting alongside the Prison Service, Education, Probation, Irish Association for Social Inclusion Opportunities, Cork Alliance, Addiction, Psychology and Psychiatry Services. The project maintained strong links with addiction and mental health services in order to ensure access for addiction assessment and counselling services. The provision of naloxone training recommenced in 2022 after being suspended in 2021 due to COVID-19 pandemic restrictions.

Loughan House, Co Cavan

The Loughan House Visiting Committee heard that face-to-face addiction and counselling sessions had recommenced in 2022 after being suspended in 2021 due to COVID-19 pandemic restrictions. However, during 2021, counselling staff made themselves available via a telephone-based service. Prisoners in Loughan House are permitted to use their own mobile phone, meaning that Merchants Quay Ireland addiction team specialists remained fully accessible throughout the year.

Shelton Abbey Prison, Co Wicklow

The Shelton Abbey Prison Visiting Committee's report noted that the prison has a full-time addiction counsellor who works closely with medical, chaplaincy, and probation services. All prisoners are assessed on entry in order to ascertain whether they have current or previous addiction issues and they are offered one-to-one addiction counselling if required. In the absence of a psychology service, they are also offered general counselling if they have issues other than addiction. If they require follow-on treatment, they are referred to residential services or day services pre-release for addiction support post-release.

Portlaoise Prison, Co Laois

The Portlaoise Prison Visiting Committee heard that many prisoners had addiction issues and mental health problems and questioned whether a prison environment was suitable for some prisoners. It noted that the prison has one addiction counsellor who attends 2 days a week, and that there are long waiting lists. The Visiting Committee recommended that the addiction counsellor's hours be increased in order to reduce this waiting list.

Midlands Prison, Co Laois

The Midlands Prison Visiting Committee was informed that a general practitioner (GP) addiction specialist holds weekly sessions as part of the drug treatment service within the prison. In

Prison visiting committees annual reports

continued

addition, the addiction counselling service in the prison is supported by Merchants Quay Ireland and includes one-to-one counselling and assessments.

Seán Millar

1 Department of Justice (2024) *Prison Visiting Committee annual reports 2022 [Arbour Hill Prison, Castlerea Prison, Cloverhill Prison, Cork Prison, Dóchas Centre, Limerick Prison, Loughan House, Midlands Prison, Mountjoy Prison, Portlaoise Prison, Shelton Abbey Prison, Wheatfield Prison]*. Dublin: Department of Justice. Available from: https://www.drugsandalcohol.ie/41817/

Ana Liffey Drug Project annual report, 2023

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

The services offered in Dublin include:

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

Midwest region

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

Annual report

The ALDP annual report 2023 was published in 2024.[1] The report noted that in 2023 the Dublin Private Emergency Accommodation Assertive Case Management Team assessed 1,099 people, with 882 individuals being provided with personal care plans. A total of 836 outreach interventions were conducted as part of the Dublin Law Engagement Assisted Recovery Programme. In 2023, the ALDP nursing team moved permanently into a premises on Dominick Place in Dublin, which now has a new, high-tech treatment room. A range of health issues is

Ana Liffey Drug Project annual report

continued

treated, including chronic venous ulcers, which are common among intravenous drug users. ALDP also addresses related health concerns such as poor nutrition, housing problems, diabetes, and anaemia.

In the Midwest region, there were 3,488 Needle and Syringe Programme/harm reduction interventions in 2023. ALDP also launched a dedicated team in Limerick to reduce harm from crack cocaine use. The project, part of the Law Engagement and Assisted Recovery (LEAR) initiative, received €200,000 in funding from the Health Service Executive's Mid West Regional Drug and Alcohol Service. The launch followed the publication of a study by University of Limerick researchers on the health and social impacts of crack cocaine in Limerick.[2]

Seán Millar

1 Ana Liffey Drug Project (2024) *Ana Liffey Drug Project annual report 2023*. Dublin: Ana Liffey Drug Project. Available from: https://www.drugsandalcohol.ie/41996/

2 Duopah YA, Elmusharaf K, Moran L and Kelly D (2023) *Doing more: the health and social impacts of crack cocaine use in Limerick City*. Dublin: Ana Liffey Drug Project. Available from: https://www.drugsandalcohol.ie/38132/

Self-harm in Irish prisons, 2020 and 2021

The Self-Harm Assessment and Data Analysis (SADA) Project was set up in Ireland in 2016 to provide robust information relating to the incidence and profile of self-harm within prison settings, as well as individual-specific and context-specific risk factors relating to self-harm. In addition, it examines patterns of repeat self-harm (both non-fatal and fatal). The Health Service Executive's National Office for Suicide Prevention and the National Suicide Research Foundation assist the Irish Prison Service with data management, data analysis, and reporting. This article highlights findings from a report presenting data in the analysis of all episodes of self-harm across the Irish prison estate during the years 2020 and 2021.[1]

Episodes of self-harm

Between 1 January 2020 and 31 December 2021, there were 421 episodes of self-harm recorded in Irish prisons; these involved 217 individuals.

The majority of prisoners who engaged in self-harm were male (79.0%), but taking into account the male prison population, the rate of self-harm among males was 2.8 per 100 prison population in 2020 and 2.3 per 100 prison population in 2021, with a decrease of 17.9% recorded between 2020 and 2021. Thirty-one female prisoners engaged in self-harm in 2020 and 14 in 2021, which equates to rates of 36.9 per 100 prison population in 2020 and 15.6 per 100 prison population in 2021, respectively.

Methods, severity, and intent

The most common method of self-harm recorded was self-cutting or scratching, which was present in 60.8% of all episodes in 2020 and in 62.7% of all episodes in 2021. The other common method of self-harm was attempted hanging, involved in 27.9% of episodes in 2020 and 15.9% of episodes in 2021. No medical treatment was required for almost one-half of episodes in 2020 (44.9%)

Self-harm in Irish prisons
continued

and one-quarter of episodes in 2021 (24.0%). In 2020 and 2021, 44.5% and 55.6% of episodes, respectively, required minimal intervention or local wound management in the prison. One in 10 required hospital outpatient or accident and emergency department treatment in 2020 (n=23; 10.2%), while 1 in 20 required hospital outpatient or accident and emergency department treatment in 2021 (n=9; 4.6%). Self-harm episodes by male prisoners were associated with increased severity. One in 20 in 2020 and 1 in 10 in 2021 (4.4% versus 10.7%) episodes were deemed to have a high degree of suicidal intent.

Contributory factors

The most common contributory factors to self-harm are shown in Figure 1. The majority of contributory factors recorded related to mental health issues and poor coping/difficulties in managing emotions. Substance misuse, including drug use and drug seeking, was recorded in 4.5% of self-harm episodes in 2020 and 7.0% of episodes in 2021.

Other findings

Other findings highlighted in the report include the following:

- Three-quarters (77.3% and 71.9%) of self-harm episodes involved prisoners in single cell accommodation in 2020 and 2021, respectively. In 2020, 52.1% of the overall prison population was accommodated in single cells, and 56.7% was accommodated in such cells in 2021.
- The rate of self-harm was higher among prisoners on remand or awaiting trial than among sentenced prisoners (3.0 versus 1.5 per 100 prisoners on remand or awaiting trial in 2020 and 3.1 versus 1.5 per 100 of this population in 2021).
- In line with findings from previous reports, substance misuse continues to be one of the factors associated with self-harm among the prison population in Ireland.

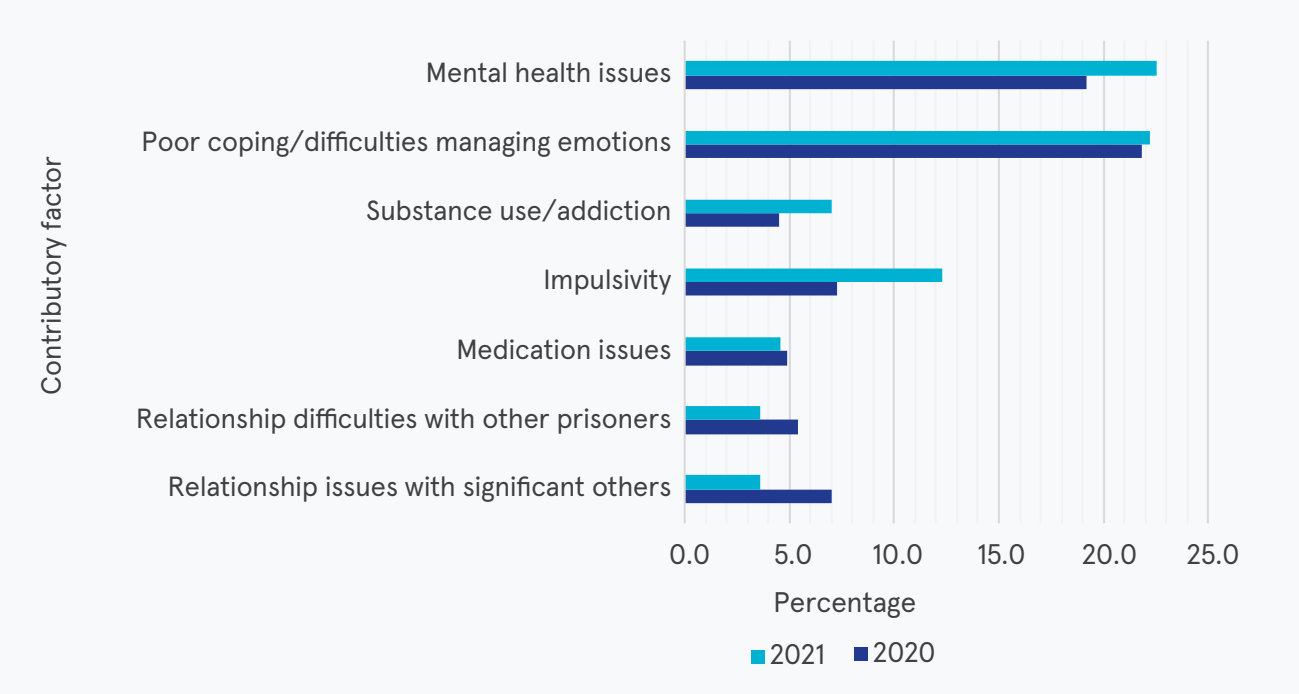


Figure 1: Most common contributory factors to self-harm in Irish prisons, 2020 and 2021
Source: Irish Prison Service *et al*. (2024)[1]

Self-harm in Irish prisons
continued

Seán Millar

1 Irish Prison Service, National Office for Suicide Prevention and National Suicide Research Foundation (2024) *Self-harm in Irish prisons 2020-2021 report. Fourth report from the Self-Harm Assessment and Data Analysis (SADA) project*. Dublin: Irish Prison Service. Available from: https://www.drugsandalcohol.ie/41833/

Responses

Communities That Care in Ireland

Communities That Care in Ireland

Communities That Care (CTC) is a place-based initiative that develops a prevention operating system in a community in order to prevent drug use and other harmful behaviours.[1] It provides a method for communities to assess the needs of their young people, coordinate stakeholders to develop a response, select and implement suitable evidence-based programmes to meet these needs, and evaluate the outcomes achieved. CTC is being implemented in Ireland for the first time in 2025. It is being led by the South Western Regional Drug & Alcohol Task Force's Substance Use Regional Forum (SURF), with support from the Department of Health, the Department of Justice, and Kildare County Council.

Background to CTC

Community mobilisation/community coalitions

CTC was developed in the 1980s in the United States of America (USA) by J David Hawkins and Richard F Catalano. Since then, it has been implemented in sites across the USA, and more recently in Europe – in Germany, Croatia, and the Netherlands. At the core of CTC is the strategic approach of 'community mobilisation' or 'community coalitions'. Broadly speaking, this refers to a process through which members of communities work together to take action and bring about change, collaborating with a range of stakeholders from the public, statutory, and private sectors to identify the changes they want to bring about in their area. Based on the best evidence available, the different stakeholders work together to plan how to bring about the desired changes. They then implement the plan and monitor its progress in reducing the target behaviours.[2]

Social Development Strategy

Underpinning the CTC model is the Social Development Strategy. This is an approach to working with young people that puts the evidence of what works effectively to prevent them from developing health and behavioural problems into a strategy that can be implemented in families,

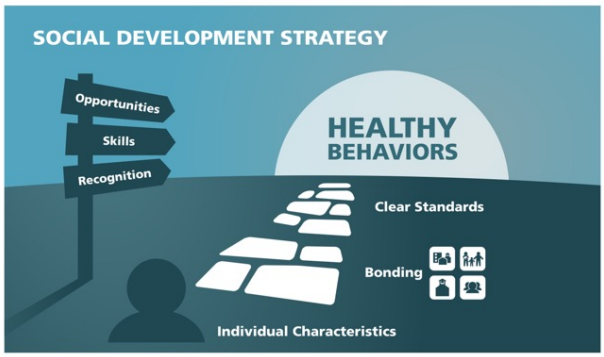
Communities That Care

continued

schools, and communities. This approach is not unique to CTC, however, and reflects the way in which a lot of work with young people is carried out more broadly. Under the Social Development Strategy, a young person is provided with opportunities for active participation and meaningful interaction with others and the skills necessary to succeed in this participation. This is followed by recognition for their efforts and achievements. Consequently, this young person will feel more bonded to their environment and the other people within it; for example, within the family, school, or community. Strong bonds motivate young people to adopt the healthy standards of the person or group to which they are bonded. For more information go to the following link: The Science Behind the Programs | The Center for Communities That Care.[3]

Phases of CTC

In 2024, the Health Research Board (HRB) published *Integrative review on place-based and other geographically defined responses to drug-related threats in communities,* the aim of which was to provide a summary of the international evidence on place-based initiatives in the context of drug-related harms.[4] CTC is one of the initiatives that was covered by the review. In CTC, a community coalition of stakeholders promotes the use of effective interventions for preventing problem behaviours among young people, based on evidence of the risk and protective factors specific to young people in that community. While Pratschke *et al.* note that CTC coalitions in different locations may have different structures and leadership, they also identify five phases that are common to the initiative across different sites: mobilisation of community leaders; creation of a prevention/community board; identification of risk and protective factors for young people in the community through a survey; selection of evidence-based prevention programmes to meet the needs identified; and evaluation of effectiveness.



Communities That Care (CTC) is a prevention system that activates a coalition of stakeholders to develop and implement a science-based approach to prevention in the community to achieve collective impact on youth development community wide. The CTC prevention system seeks to achieve this goal by increasing the use of tested, effective preventive interventions that address risk factors for adolescent problem behaviours prioritized by the community. This is expected to produce community-wide reductions in targeted risk factors and, in turn, decreased adolescent substance use, delinquency, and violence. (Hawkins et al. 2014, p. 123) cited in Pratschke et al. p. 40[4]

Challenges faced

As with all initiatives, CTC faces challenges in implementation. A review examined by Pratschke *et al.* provides a useful summary of the challenges faced by CTC communities:

Community-based models typically rely on local coalitions to coordinate the implementation of multiple prevention strategies across agencies, and it can be very difficult to engage and ensure collaboration among diverse stakeholders who may have different skills, needs, resources, and ideas about what is needed ... In addition, ensuring the adoption and high-quality implementation of a single prevention strategy is difficult, and problems are likely to be multiplied when implementing several programs across a variety of settings ... Furthermore, enacting multiple programs and delivering them at a scale large enough and long enough to produce community-wide changes is likely to require significant human and financial resources, as

Communities That Care

continued

Darren Shanahan CtC Coordinator with Drug Prevention Education Initiative, Emma Berney, Coordinator Kildare CYPSC, Steven Joyce, SURF, Dalene Beaulieu, University of Washington, CTC Specialist, Senator Aubrey McCarty, SURF, Chairperson, Pat Leogue, SWRDATF clg

well as long-term investments ... securing funds can be challenging, particularly if benefits may not be seen for many years. Kuklinski et al. (2015) (p. 166) cited in Pratschke et al. p. 42[4]

CTC in Ireland

The implementation of CTC has now begun in Ireland for the first time and is based in the community of Newbridge, Co Kildare. It is expected that this initial cycle of CTC, including its five phases, will run from January 2025 until the end of 2026. Darren Shanahan is the CTC Coordinator and he is carrying out this role alongside his work in the Foróige Drug Prevention & Education Initiative. CTC will build on existing structures, resources, and services in the community.

On 26 February 2025, a CTC key leader orientation meeting was held with representatives from Tusla, SURF, An Garda Síochána, local representatives, Kildare County Council, Kildare's Children and Young People's Services Committee, Kildare and Wicklow Education and Training Board, Youthreach, Foróige, Safer Newbridge, Family Resource Centre, and local schools. It was delivered with the support of the Director of Training and Family Programs, Center for Communities That Care, based in the USA. It is expected that CTC in the Newbridge area will continue to expand and engage with more local services, with the aim of achieving the best outcomes possible for young people in the community.

Lucy Dillon

1 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2017) *Communities That Care (CTC): a comprehensive prevention approach for communities*. EMCDDA Papers. Luxembourg: Publications Office of the European Union. Available from: http://www.drugsandalcohol.ie/26931/

2 Dillon L (2017) Communities That Care: a review. *Drugnet Ireland*, Issue 62 (Summer): 21. Available from: https://www.drugsandalcohol.ie/27745/

3 The Science Behind the Programs | The Center for Communities That Care. https://www.communitiesthatcare.net/prevention-science/

4 Pratschke J, Glanville J and Kelly P (2024) *Integrative review on place-based and other geographically defined responses to drug-related threats in communities*. HRB Drug and Alcohol Evidence Review 9. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/40846/

National Drugs Library

Updates

Recent publications

Prevalence and current situation

The internalization of stigma and the shaping of the grief experience for peers bereaved by a drug-related death

O'Callaghan D and Lambert S (2024) *Omega (Westport)*, early online. Available from: https://www.drugsandalcohol.ie/41693/

The impact of the introduction of tobacco product plain packaging on consumer responses in Ireland: a real-world policy evaluation stratified by socioeconomic groups

Sheridan A, Conway R, Murphy E, *et al.* (2024) *Eur J Public Health*, 34(5): 970–978. Available from: https://www.drugsandalcohol.ie/41701/

Inequalities in smoking and e-cigarette use in young adults with mental ill-health, 20 years after Ireland's smoking ban

Hanafin J, Sunday S and Clancy L (2024) *Tob Use Insights*, 17. Available from: https://www.drugsandalcohol.ie/41834/

Drivers and facilitators of HIV-related stigma in healthcare settings in Ireland

Vaughan E and Költő A (2024) *Aids Behav*, 29: 22–36. Available from: https://www.drugsandalcohol.ie/41825/

Trends in polysubstance use among patients in methadone maintenance treatment in Ireland: evidence from urine drug testing 2010–2020

Durand L, O'Kane A, Stokes S, *et al.* (2024) *J Subst Use Addict Treat*, 167: 209507. Available from: https://www.drugsandalcohol.ie/41799/

Understanding mediated sports consumption by Irish children: a qualitative study exploring their exposure and understanding of gambling marketing, risks and harms

Kitchin PJ, McEvoy E, Kerr A and O'Brennan J (2024) *BMC Public Health*, 24: 2478. Available from: https://www.drugsandalcohol.ie/41826/

A qualitative study of psychological stress and coping among persons using crack cocaine

Duopah YA, Moran L, Elmusharaf K and Kelly D (2024) *BMC Psychol*, 12: 537. Available from: https://www.drugsandalcohol.ie/41993/

Etizolam and Irish drug poisoning deaths

Keenan E, Kelleher C, Lyons S, *et al.* (2024) *Ir J Psychol Med*, 41(4): 506–507. Available from:. https://www.drugsandalcohol.ie/42044/

Women attending the sexual assault treatment unit services in the Republic of Ireland: a 7-year review

Kane D, Walshe J, Maher N, *et al.* (2024) *Int J Gynaecol Obstet*, 168(3): 1276–1284. Available from: https://www.drugsandalcohol.ie/41991/

Recent publications
continued

Informing the cannabis policy debate: a cross-sectional study of current and former cannabis users in Ireland

James PD and Comiskey C (2024) *J Subst Use*, early online. Available from: https://www.drugsandalcohol.ie/41947/

Factors affecting implementation of a National Clinical Programme for self-harm in hospital emergency departments: a qualitative study

O'Connell S, Cully G, McHugh S, *et al.* (2024) *BMJ Qual Saf*, early online. Available from: https://www.drugsandalcohol.ie/41992/

Responses

'It's a group-on-one': social disconnection as a tool of and defence against child criminal exploitation in the Republic of Ireland

Sheehan K, Walsh C and Cusack A (2024) *Crime Prevention and Community Safety*, 26: 266–284. Available from: https://www.drugsandalcohol.ie/41649/

REPAIRS Delphi: A UK and Ireland consensus statement on the management of infected arterial pseudoaneurysms secondary to groin injecting drug use

REPAIRS Collaborative. MacLeod CS, Nagy J, Radley A, *et al.* (2024) *Eur J Vasc Endovasc Surg*, 68(4): 530–540. Available from: https://www.drugsandalcohol.ie/41879/

"Boxing Clever Cork saved my life": a snapshot of an early addiction recovery fitness and education program

Brennan R and Wright M (2024) *J Subst Use*, early online. Available from: https://www.drugsandalcohol.ie/41916/

Policy

Illicit drug use in Limerick City: a stakeholder and policy analysis using multiple streams model.

Duopah YA, Moran L, Elmusharaf K and Kelly D (2025) *Int J Health Plann Manage*, 40(1): 86–107. Available from: https://www.drugsandalcohol.ie/41913/

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