The newsletter of Ireland's focal point to the EUDA

drugnet Ireland

Issue 95 | July 2026

In this issue

Drugnet Ireland is produced in collaboration with the HRB National Drugs Library. To have *Drugnet Ireland* delivered to your desktop, sign up at www.drugsandalcohol.ie

Launch of the first data report from the National DRIVE Project

On 8 May 2026, Jennifer Murnane O'Connor, Minister of State at the Department of Health with special responsibility for Public Health, Wellbeing and the National Drugs Strategy, launched the first data report for the DRIVE (Drug-related intimidation and violence engagement) Project.[1] The launch event was chaired by Antoinette Kinsella, Chairperson, National DRIVE Oversight Committee. Speakers included Assistant Commissioner Angela Willis, Organised and Serious Crime, An Garda Síochána; Dr Suzi Lyons, Health Research Board (HRB); and Vanessa Hoare, DRIVE Liaison, Dublin Northeast Regional Drug and Alcohol Task Force.

From L-R: Antoinette Kinsella, Chairperson, National DRIVE Oversight Committee; Dr Suzi Lyons, Head of Unit, HRB; Angela Willis, Assistant Commissioner, Organised and Serious Crime, An Garda Síochána; Jennifer Murnane O'Connor, Minister of State at the Department of Health with special responsibility for Public Health, Wellbeing and the National Drugs Strategy; and Siobhán Maher, National DRIVE Project Coordinator. Photo by: Julien Behal Photography.

(continued on page 3)

HRB Health Research Board

Research. Evidence. Action.

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**

First data report from the National DRIVE Project

continued

In attendance were stakeholders from the statutory, community and voluntary sectors. Speaking at the event, Minister Murnane O'Connor described drug-related intimidation (DRI) as 'very insidious and frightening', stating that it 'is an issue affecting every community and people from all walks of life'.

National DRIVE Project

The DRIVE Project is an interagency initiative funded by the Department of Health to respond to DRI and associated violence in Ireland. It was a key action under the *National Drug Strategy* (2017–2025), which recognised the impact that drug-related criminality and antisocial behaviour has on communities, and committed to tackling DRI.[2] The DRIVE Project will continue and expand its response to DRI, and is included as an action under Pillar 2 in the draft *National Drugs Strategy* (2026–2029).[3]

DRI is a pervasive and under-reported form of criminal activity that affects individuals, families and communities in Ireland. Research studies show that awareness of DRI is high, yet reporting remains low due to fear of reprisals, proximity to intimidators, stigma, and limited awareness of supports. A robust understanding of the nature and prevalence of DRI is essential for designing effective interventions and policies. The DRIVE Project aims to develop this understanding through a data-driven model that integrates routine monitoring of DRI within existing national systems. The DRIVE model was published in 2021 and provides a coordinated framework and data-driven model for prevention, support for those impacted by DRI, community response, and system-level change. The DRIVE Project offers a national approach that seeks to reduce incidents of DRI, reduce the harm caused, and create safer and healthier communities.

National DRIVE Project first data report

Methodology

The first national overview of DRI among people engaged with drug and alcohol services and supports to include family support services was produced by the HRB on behalf of the National DRIVE Oversight Committee. It is based on data collected through the HRB's National Drug Treatment Reporting System (NDTRS) during the 2025 reporting period.[4] The NDTRS is the national epidemiological database that records and reports on addiction treatment in Ireland. It is managed by the National Health Information Systems (NHIS) Unit in the HRB and is funded by the Department of Health. The NDTRS dataset captures demographic characteristics, referral/assessment details, treatment status, drug use, risk behaviour, activity details, and exit outcomes. This report presents data for cases who accessed drug and alcohol services and supports, and who disclosed DRI for the 2025 data collection period.

Key findings

Findings from the first national publication on DRI show 1,027 cases of DRI among people engaged with addiction and/or family support services in Ireland during the data collection period. DRI was reported across all Health Service Executive (HSE) Health Regions and in every county. Dublin accounted for the largest share of cases (42.8%). One-half of cases were aged 35 years or under (most cases were aged 20–44 years). The majority of cases were male (58.5%). Approximately three-quarters of cases (74.6%) were in stable accommodation; 12.3% were homeless. Most cases sought treatment for problem drug use (71.0%), most commonly cocaine (39.8%) and cannabis (11.1%). A further 19.2% of cases were affected family members (AFMs) impacted by a loved one's addiction.

First data report from the National DRIVE Project

continued

Over one-third of all cases (36.5%) were currently experiencing DRI at the time of treatment; 63.5% of all cases had previously experienced DRI but not currently. Nearly two-fifths of cases (38.5%) reported that this was their first experience of DRI. Cocaine was the most common problem drug linked to DRI (58.8%), and one-third (32.5%) reported the involvement of more than one drug.

Drug-related debt was common (67.1%) among cases reporting DRI. Drug-related debt varied from less than €100 to more than €20,000; the most frequent amount demanded was between €1,000 and €4,999 (23.8%). Where known, most intimidators were male. Types of intimidation most commonly reported were threats to the individual (64.2%), and threats to family members (25.1%). Other forms of DRI included violence to the individual (19.7%) and property damage (10.1%). In almost one-half of cases (46.4%), outcomes of the DRI were resolved informally (without the formal intervention of An Garda Síochána), while 20.2% of cases reported that intimidation was ongoing during treatment.

Key messages

- DRI is a widespread and persistent issue in Ireland
- DRI is reported across all HSE Health Regions and in every county
- DRI affects men and women, and all age groups, including those aged under 18 years
- It affects people who use drugs and also their family members
- Cocaine is the main drug linked to DRI
- Most have a drug debt
- A wide range of types of intimidation experienced

The key findings increase understanding of DRI prevalence and trends in local communities and inform responses to reduce the impact on families and communities. They provide strong evidence of the extent of harms from DRI, risk factors of social disadvantage, and impact on family members and communities. They also show the value of the DRIVE model and feasibility of NDTRS data collection as a national monitoring and intervention framework. The continued development of service capacity, improved information sharing, and enhanced integration with community safety and policing initiatives are essential in order to address the complexity of DRI and to protect those affected.

Recommendations

The recommendations are grouped into four main themes, which are derived from previous research evidence and the findings from the NDTRS data. They are:

- Strengthen supports for individuals and families experiencing DRI
- Enhance prevention and community-level interventions
- Strengthen interagency collaboration and policy development
- Use the NDTRS as a model for DRI monitoring

Contact the DRIVE Project for free and confidential support at:

Website: www.driveproject.ie
Email: drive@ndublinrdtf.ie
Telephone: 086 128 1782

Janet Robinson and Suzi Lyons

1 Robinson J, Carew AM, O'Sullivan M and Lyons S (2026) *Drug-related intimidation in Ireland: the first data report from the National DRIVE Project*. Dublin: National DRIVE Oversight. Available from: https://www.drugsandalcohol.ie/45617/

First data report from the National DRIVE Project

continued

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

3 Department of Health (2026) Draft. *National Drugs Strategy 2026–2029. An integrated, equitable and evidence-based response to drug and harmful alcohol use*. Dublin: Department of Health. Available from: https://www.drugsandalcohol.ie/45067/

4 Data collection for this report was undertaken in 2025. Figures are for years 2024 (154) and 2025 (873).

Policy and legislation

Women and Ireland's alcohol and drug strategies, 1996–2025

Introduction

Drug policy, practice and resource allocation have been driven largely by Ireland's national drug strategies since 1996. The *Drugs: Education, Prevention and Policy* journal has published a paper that examines how the needs of Irish women who use alcohol and other drugs have been addressed in these strategies and a selection of other key policy documents since 1996.[1,2,3,4,5,6,7] *From denial to pregnancy and motherhood to 'gender informed'? Women and Ireland's alcohol and drug strategies, 1996-2025* was published prior to the release of Ireland's draft *National Drugs Strategy* (2026–2029).[8] The paper's authors, Windle and Cronin, found that Irish alcohol and drug policy did not initially recognise women's drug use. When it was recognised, it focused almost exclusively on pregnancy and motherhood. Only since 2017 has it promoted gender-informed approaches.

Context

Women who use alcohol and drugs problematically in Ireland account for:

- 27% of people who entered treatment in 2022 for illicit drug use
- Close to 40% of those who entered treatment and reported alcohol as their 'main problem drug' in 2023
- 34% of Ireland's drug-induced deaths in 2020
- 27.3% of alcohol-related deaths in 2022 (p.2)[8]

The paper is grounded in an understanding that women's experiences of substance use and associated services are different to those of men. Therefore, services and the strategies and policies that guide them need to be gender sensitive. Windle and Cronin sought to critically assess how 'three decades of Irish alcohol and drug policy has framed the needs of women who use illicit drugs and/or alcohol' (p. 2).[8]

Women and Ireland's alcohol and drug strategies

continued

Methodology

Four national alcohol and drug strategies and three other key documents were analysed for this research (see Figure 2).[1,2,3,4,5,6,7] Two forms of analysis were carried out:

Content analysis: Windle and Cronin looked at the frequency counts for a range of words to describe men and women in each of the four strategies.

Critical policy analysis: Windle and Cronin's approach is based on Bacchi's work on problematisation that has its foundation in feminist policy analysis.[9] Bacchi identifies six questions that guide an analysis approach of how governments respond to problems and are active in the creation (or production) of policy problems (p 3).[8] The six questions are:

1 What is the problem represented to be in a specific policy or policies?

2 What deep-seated presuppositions or assumptions (conceptual logics) underlie this representation of the 'problem'?

3 How has this representation of the 'problem' come about?

4 What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be conceptualised differently?

5 What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?

6 How and where has this representation of the 'problem' been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?

Windle and Cronin focused on analysing the documents to answer questions 1–4. In doing so, they were interested in exploring both what is included in the documents and what is not, the 'policy silences' (p. 4).

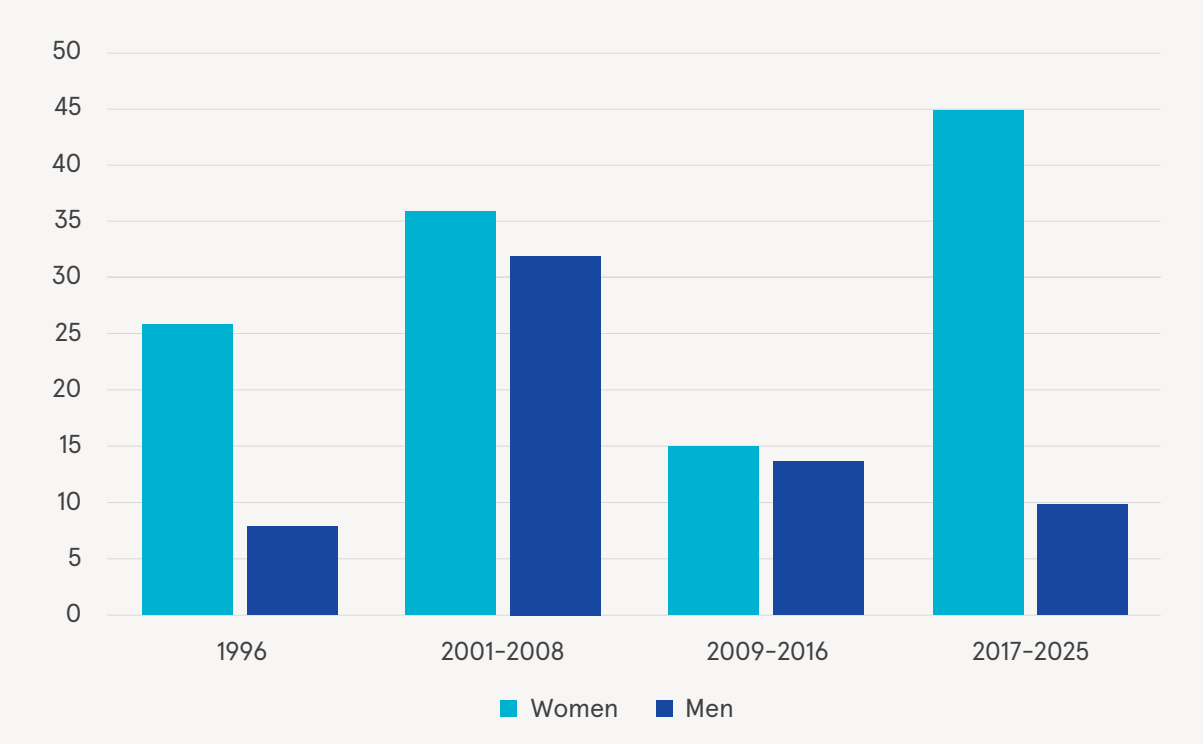


Figure 1: Content analysis. Overall counts of mentions of men and women in national drug strategies. (p. 3)[8]

Women and Ireland's alcohol and drug strategies

continued

Findings

The content analysis was described as 'useful but limited' (p. 2).[8] It found that words used to describe women were more commonly found in the documents than words to describe men (see Figure 1). It is argued that women are mentioned explicitly because they are seen as a special population. In contrast, men are considered by policy-makers to be the norm within the population of people who use drugs – 'if men are the norm, they do not need to be specifically mentioned' (p. 3).[8]

Figure 2 summarises the findings of the analysis and how the needs of women who use drugs and alcohol are addressed in the chosen documents. The first cohort of 'strategies' (*First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (the Rabbitte report)*, the *National alcohol policy*, and *Building on Experience: National Drugs Strategy 2001–2008*)[1,2,4] focused on problematic drug use as affecting young, working class, men. Where women were mentioned, it was in the context of pregnancy, sex work (to a lesser extent), and implicitly when discussing the childcare needs of parents who use drugs.

Progress appeared to be made with the publication of the *Report of the Working Group on Drugs Rehabilitation* in 2007.[5] For the first time, the differences between men and women's drug use were identified, and it illustrated an understanding of the need for gender-specific services. However, this progress was short-lived and the report's findings were not included in the subsequent national drugs strategy (2009-2016).[6] According to Windle and Cronin, 'the 2009-2016 strategy's denial of gendered drug use represents a regression from a very low baseline' (p. 5).[8]

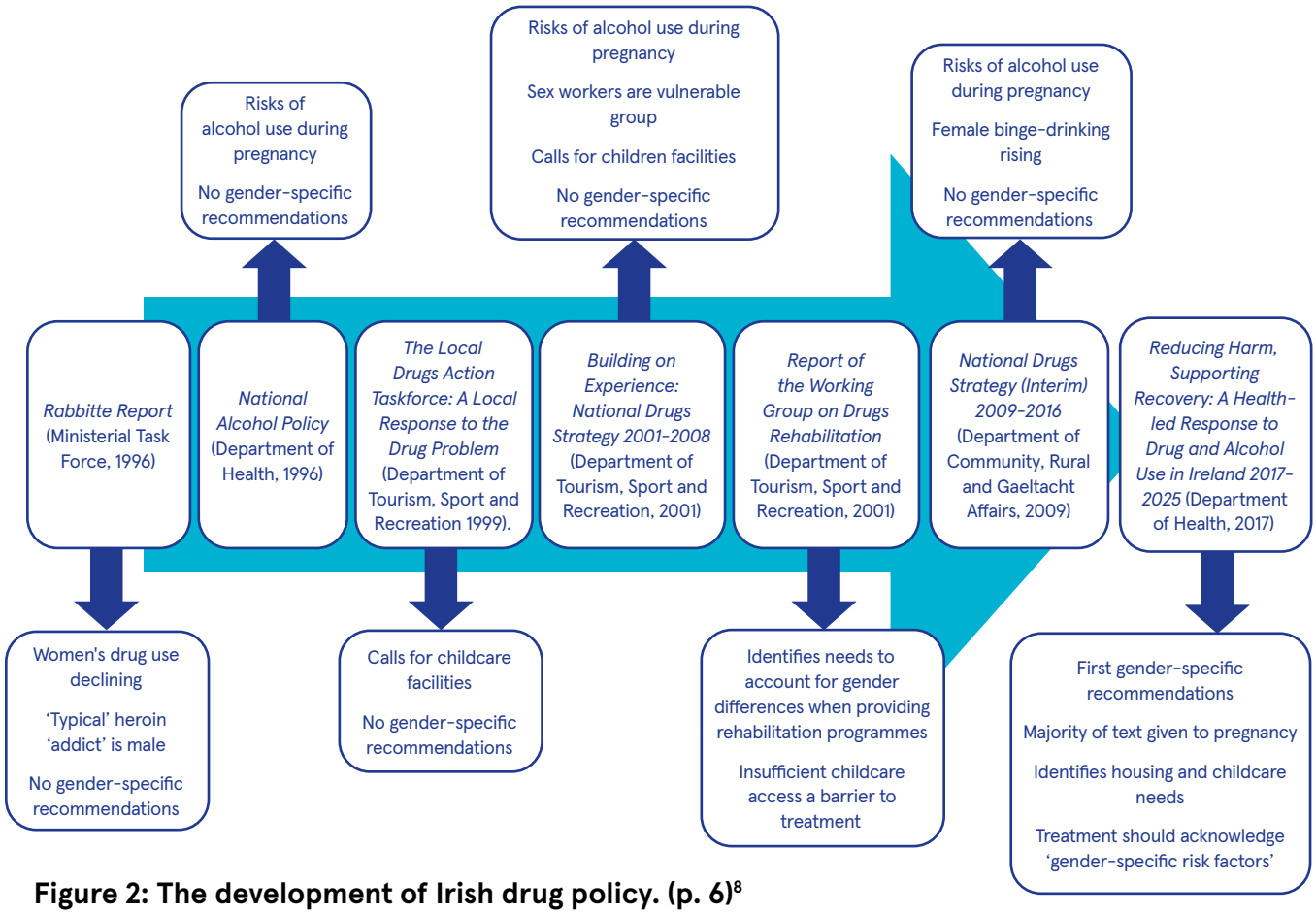


Figure 2: The development of Irish drug policy. (p. 6)[8]

Women and Ireland's alcohol and drug strategies

continued

In 2017, *Reducing Harm, Supporting Recovery* represented a significant change in Irish policy for how the needs of women who use alcohol and other drugs were addressed.[7] For example, the strategy identifies the need to address gender-specific risk factors and services. It was 'the first time that any Irish strategy identified the needs of women who were not pregnant, parents or sex workers.' (p. 5).[8]

A key finding of the analysis is that pregnancy has been the core women-specific theme across all alcohol and drug strategies since 1996. While Windle and Cronin recognise the importance of supporting this cohort of women given the risks to their health and well-being and that of their child, they are critical that the strategies are 'largely silent on women who are not pregnant, mothers, or sex workers' (p. 6).[8]

Discussion

In their discussion, Windle and Cronin place their findings within Ireland's wider social context. They discuss the traditionally patriarchal culture of Irish society and how this has impacted on policy and practice for women and their health more broadly. The paper concludes that progress over the past decade in relation to women's (reproductive) healthcare, an increased understanding of health inequalities, and signs from policy-makers that a more gendered perspective is required for the next national drugs strategy, make it more likely that the needs of women who use drugs may be better met by Irish policy-makers. This article was published prior to the draft of the new national drugs strategy in February 2026. The draft strategy's content suggests that the needs of women who use drugs will be a focus of the new strategy.

Lucy Dillon

1 Ministerial Task Force (1996) *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: The Stationery Office. Available from: https://www.drugsandalcohol.ie/5058/

2 Department of Health (1996) *National alcohol policy*. Dublin: The Stationery Office. Available from: https://www.drugsandalcohol.ie/5263/

3 Department of Tourism, Sport and Recreation (1999) *The local drugs action taskforce: A local response to the drug problem*. Dublin: The Stationery Office. Available from: https://www.drugsandalcohol.ie/3477/

4 Department of Tourism, Sport and Recreation (2001) *Building on Experience: National Drugs Strategy 2001–2008*. Dublin: The Stationery Office. Available from: https://www.drugsandalcohol.ie/5187/

5 Department of Community, Rural and Gaeltacht Affairs (2007) *National Drugs Strategy 2001-2008: Rehabilitation. Report of the Working Group on Drugs Rehabilitation*. Dublin: The Stationery Office. Available from: https://www.drugsandalcohol.ie/6267/

6 Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: The Stationery Office. Available from: https://www.drugsandalcohol.ie/12388/

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

8 Windle J and Cronin J (2025) From denial to pregnancy and motherhood to 'gender informed'? Women and Ireland's alcohol and drug strategies, 1996–2025. *Drugs Educ. Prev. Policy,* Early online, https://doi.org/10.1080/09687637.2025.2566004. Available from: https://www.drugsandalcohol.ie/44351/

9 Bacchi C (2009) *Analysing policy: What's the problem represented to be?* French's Forest, NSW: Pearson.

Registered tobacco and vaping lobbying activity in Ireland

Lobbying can be an important element of democratic governance but in the case of tobacco control or other substances harmful to health, it can undermine public health interests. A new paper published in the journal *Tobacco Control* explores the extent, nature and targets of registered lobbying activities related to smoking and vaping in Ireland from 2016 to 2024.[1]

Context

Preventing the harms caused by tobacco use is complicated by its link with commercial interests. Hanrahan and Kavanagh, the authors of the paper, argue that 'the commercial determinants of health, defined as the conditions, actions and omissions by commercial actors that affect health, are exemplified by the tobacco industry, which employs sophisticated strategies to shape policy, undermine regulation and delay or dilute effective tobacco control measures.' (p. 1).[1] In recognition of the efforts of the tobacco industry to influence public health policy, the World Health Organization (WHO) introduced Article 5.3 of the Framework Convention on Tobacco Control (FCTC) which requires countries to protect tobacco control-related public health policies from industry interference. Ireland is a signatory of the FCTC, but there are gaps in its implementation.

Data source and research aim

Under the Regulation of Lobbying Act 2015, Ireland established a publicly available online Lobbying Register to improve standards in public life. It provides information on the communications from lobbyists to designated public officials (DPOs). Hanrahan and Kavanagh describe the Register as 'regarded as comprehensive and robust' (p. 2).[1] They use data from this register to describe the landscape of lobbying on both tobacco and e-cigarette policy between 2016 and 2024, by identifying the lobbyists and exploring when, how and for what policy aims the lobbying happened.

Methods

Two forms of analysis were carried out on 511 entries that were found to be relevant to the research question and have substantive information.

First, entries were analysed using thematic analysis which was carried out on three fields for each lobbying entry in order to identify recurring themes: specific details (a free text description of lobbying activities); relevant subject matter (one of: 'legislation', 'matters involving public funds' or 'public policy or programme'); and, intended results (a free text description of purpose of lobbying activities). Some submissions had more than one lobbying purpose.

Second, quantitative analysis was carried out to describe the frequency and distribution of registered lobbying activities by reporting period, year, and lobbying group. Given the structure of the Register, the unit of study was a submission by a lobby group rather than the number of communications within a submission. Therefore, a single submission could include one email or 10. They were required to report the types of interactions (e.g. meetings, written communications) not the number.

Tobacco and vaping lobbying activity in Ireland

continued

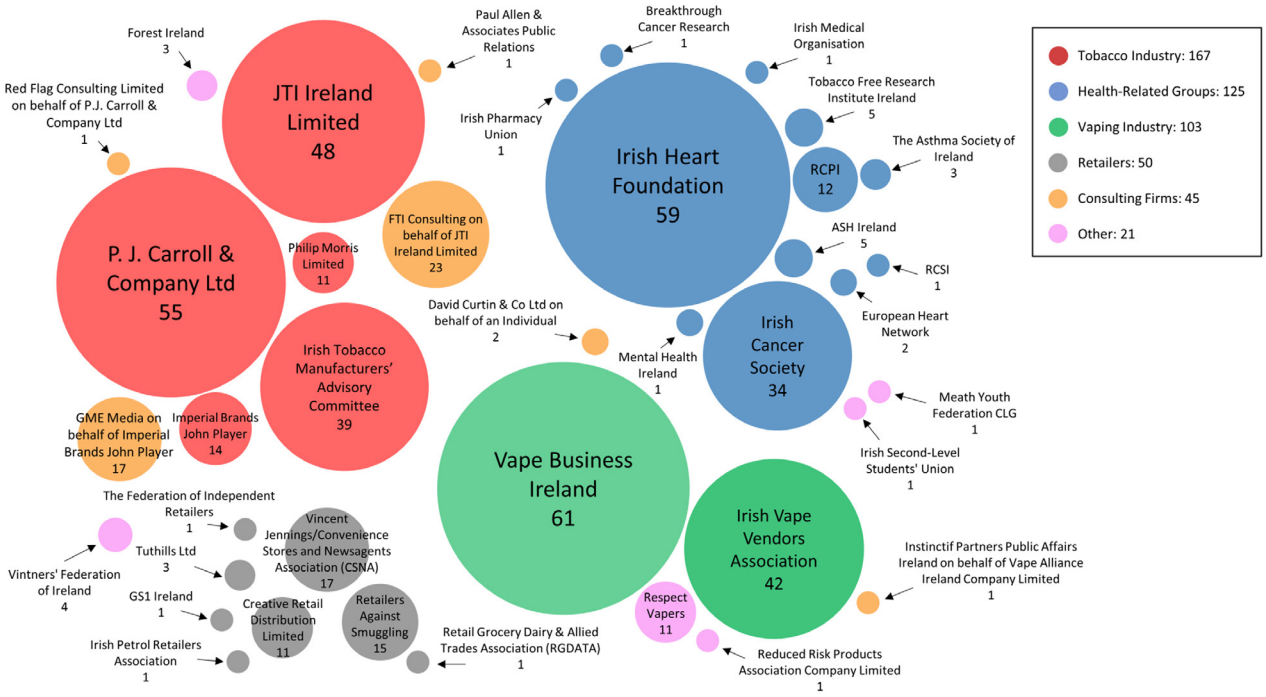


Figure 1: Number of lobbying submissions per lobbying group and entity. ASH, Action on Smoking and Health; CLG, Company Limited By Guarantee; JTI, Japan Tobacco International; RCPI, Royal College of Physicians Ireland; RCSI, Royal College of Surgeons in Ireland (p. 3)[1]

Findings

The findings of the paper are structured around five questions:

Who is lobbying?

- Thirty-nine lobbying entities were found to be active in the tobacco and vaping policy field between 2016 and 2024 (see Figure 1).
- While Vape Business Ireland was the most active, when submissions made by Japan Tobacco International (JTI) Ireland and a consulting firm that lobbied on its behalf (FTI Consulting) are combined, JTI Ireland was the most active.
- Health-related groups had 2.9 times fewer entries when compared with the commercial groups combined (tobacco and vaping industry, consulting firms and retailers) – 125 versus 365, respectively.

When did lobbying take place?

Between 2016 and 2024 there was a relatively constant flow of smoking and vaping-related lobbying in Ireland (except for some reduction in 2020, which is attributed to the COVID-19 pandemic).

How was lobbying conducted?

Given the structure of the Register, submissions could include more than one form of communication: 89% of submissions included

Tobacco and vaping lobbying activity in Ireland

continued

some form of written communication (email or letter), 24% at least one in-person meeting, and 22% a phone call or virtual meeting. Other forms of communication were holding events (4%), social media interaction (1%), informal communication (2%), and unknown (1%).

What were they lobbying for?

Hanrahan and Kavanagh's analysis identified six themes in the data on which groups were lobbying.

- **Taxation and excise duty:** 14.1% of submissions related to taxation and excise duty. Tobacco companies lobbied against increases, while health-related groups lobbied in favour of them.
- **Illicit tobacco trade:** 13.6% of submissions had the illicit tobacco trade as a theme. For example, the tobacco industry highlighted the associated economic costs, while health-related groups focused on the WHO FCTC protocols to eliminate such trade.
- **Vaping regulations and policies:** The Public Health (Tobacco Products and Nicotine Inhaling Products) Act 2023 was mentioned in 11.5% of submissions. The vaping industry and related groups advocated for e-cigarettes to be considered a harm-reduction/smoking cessation tool. While they also argued for strict enforcement of age restrictions, they lobbied against bans on flavours. Health-related groups lobbied for age-related restrictions and bans on flavours, and certain packaging and marketing that may be attractive to children and young people.
- **Raising the legal age of sale of tobacco ('Tobacco 21'):** The Public Health (Tobacco) Amendment Act 2024 arose in submissions later in the study period. A total of 6.6% of all submissions referred to it. There was relatively little opposition to the proposed measure.
- **Smoking cessation programmes**: 3.7% of lobbying submissions included this theme and only health-related groups lobbied on it.
- **Outdoor smoking bans:** Only 1.4% of submissions dealt with this theme, which looked at the expansion of the smoking ban to outdoor areas by health-led groups. There was one submission from the hospitality industry which queried its practical implementation.

Who were lobbying groups targeting?

A total of 481 individual DPOs were named 2,932 times across the submissions analysed. Seventy-two per cent of submissions targeted three or fewer DPOs. Seventy-two per cent targeted members of Dáil Éireann, 18% targeted members of the Seanad, 4% targeted city/county councils, 3% targeted members of the European Parliament, and 2% targeted other public servants (with a non-political role). The Minister of Health was listed in 20% of submissions (51% from commercial actors), and the Minister of Finance was listed in 11% (68% from commercial actors).

Discussion

Hanrahan and Kavanagh argue that 'this study shows that efforts to subvert tobacco-related and vaping-related policy-making are pervasive and persistent, including meetings with DPOs, especially where engagement is led through strategic consulting companies. The voice of health-related groups remains strong, although relatively crowded out in registered lobbying activity by commercial interests.' (p. 6).[1] A number of recommendations emerge from their discussion of the findings, which include:

- The presence of former DPOs as lobbyists for the vaping industry and retailers raised concerns. Hanrahan and Kavanagh suggest a 'cooling off' period for DPOs to ensure

Tobacco and vaping lobbying activity in Ireland

continued

that potential conflicts of interest can be addressed.

- The broader strategic framework included in FCTC Article 5.3 should be implemented to support good governance.
- DPOs should be provided with training to build resilience against tobacco and vaping industry interference in policy-making. This should include guidance on Article 5.3 adherence.
- The use of 'front groups' needs to be monitored; for example, groups such as Vape Business Ireland and Respect Vapers which have links to the tobacco industry.
- The Lobbying Register could be improved. For example, this could be done by providing more transparency on which DPOs attend meetings with lobbyists; require more detail about meetings such as meeting agendas, items discussed and any commitments made; and to mandate validation of the register by public officials.

In conclusion, they argue that Irish policy-makers need to renew their tobacco endgame commitment.

Lucy Dillon

1 Hanrahan M and Kavanagh P (2026) Registered tobacco and vaping lobbying activity in Ireland, 2016-2024: the case for strengthening implementation of the Framework Convention of Tobacco Control Article 5.3 to clear the path for tobacco endgame. *Tob. Control*, https://doi.org/10.1136/tc-2025-059758. Available from: https://www.drugsandalcohol.ie/45367/

From the launch of the first data report from the National DRIVE Project, L-R: Dr Michael O'Sullivan, Research Officer, National Health Information Systems, HRB; Janet Robinson, DRIVE Data, Research and Evaluation Coordinator; Jennifer Murnane O'Connor, Minister of State at the Department of Health with special responsibility for Public Health, Wellbeing and the National Drugs Strategy; Dr Suzi Lyons, Head of Unit, HRB; Dr Anne Marie Carew, Senior Researcher, National Health Information Systems, HRB. Photo by: Julien Behal Photography.

Examining tobacco control enforcement in Ireland 2014–2023

Tobacco control legislation is a critical element in reducing the harms of smoking. However, it will only be effective if enforced. The *Examining tobacco-control enforcement in Ireland 2014-2023: an observational study* analysed data on the enforcement of the Public Health (Tobacco) Act 2002 as amended between 2014 and 2023.[1] It explored the extent to which the laws have been followed, and what happens to those who break them.

Context

Despite tobacco control legislation, and various smoking prevention activities, Houghton and Lombard argue that smoking continues to impact negatively on health and well-being in Ireland. Data published in 2022 found that among those who were aged 15 years and over, 20% of males and 17% of females were current smokers.[2] This is far from Ireland's tobacco free target of a tobacco use prevalence rate below 5% by 2025.[3] Furthermore, the harms caused by smoking exacerbate health inequalities. According to Houghton and Lombard, there is a '20 percentage point gap between those in higher managerial, administrative, and professional occupations compared to those in routine manual occupations (11% versus 31%)' (p. 2).[1] Also, to support a reduction in smoking rates, Ireland has 'a strong track record on tobacco control measures' (p. 2). This includes high rates of taxation, and legislation on: a workplace smoking ban, plain packaging, a ban on point-of-sale display, and a legal minimum age of 18 years to purchase tobacco products. Houghton and Lombard argue that while it is critical that such legislation is in place, it is also critical that it is enforced. Given 'Ireland's continuing deficits in public health enforcement' (p. 3)[1], the aim of their research was to explore the extent to which this happened in the field of tobacco. Their research aimed to explore convictions, penalties, and associated costs imposed in the period 2014–2023 under various sections of the Public Health (Tobacco) Act 2002 as amended.

Methodology

This article is based on secondary descriptive statistical analysis of tobacco conviction data released annually by the HSE's National Environmental Health Service (NEHS) (https://www.hse.ie/eng/about/who/tobaccocontrol/enforcement/).[4] Data were collected on the number and outcomes of the inspections made by the NEHS of premises where tobacco is sold. Data were analysed using descriptive statistics, including 95% confidence intervals, in SPSS (Statistical Package for the Social Sciences). The data analysed that explored the number and types of penalties under various sections of the legislation were: the number of convictions; the value of any fine incurred; costs arising from the prosecution of the offence; and the time period of removal from the Tobacco Retail Register (inclusion on which is a requirement of eligibility to be allowed to sell tobacco products in Ireland). Allowances are made in the analysis for the COVID-19 pandemic years 2020/21.

Findings

Some of the key findings were:

- The average annual number of inspections made of sites where tobacco products were sold over the study period was 12,794.

Examining tobacco control enforcement in Ireland

continued

Table 1

EHO tobacco control inspections, compliance and convictions 2014–2023

Year	No. of inspections	No. non-compliant	% compliance (confidence intervals 79.43–84.17)	No. of convictions	% of convictions
2014	18,021	3568	80.20%	44	1.23%
2015	17,972	3055	83.00%	31	1.01%
2016	16,131	3134	80.57%	35	1.12%
2017	15,064	2956	80.38%	17	0.58%
2018	14,304	3204	77.60%**	31	0.97%
2019	14,997	2709	81.94%	45	1.66%
2020***	7494	999	86.67%*	22	2.20%
2021***	7458	911	87.78%*	6	0.66%
2022	7084	1387	80.42%	7	0.50%
2023	8969	1917	78.63%**	29	1.51%

Source: Tobacco Free Ireland annual reports and annual returns on the Health Service Executive's (HSE) National Environmental Service.
*Outside of the 95% confidence intervals (higher).
**Outside of the 95% confidence intervals (lower).
***Given the reduced number of inspections during 2020 and 2021 as a result of shutdowns resulting from the COVID-19 pandemic care should be taken in interpreting compliance rates in these years.

Source: Houghton and Lombard (2025), p. 4[1]

- Inspections were reduced in 2020 and 2021 in order to enable HSE staff to meet the demands of dealing with the COVID-19 pandemic. This number remained relatively low through 2022/23 when compared with pre-COVID-19 pandemic figures. In 2023, 8,969 inspections were carried out, compared with 14,997 inspections in 2019.
- The average annual number of inspections that identified evidence of non-compliance with the legislation for the study period was 2,384.
- Apart from 2020/21, the compliance rate was consistent at in and around 80% of all inspections.
- Only 1.12% of instances of non-compliance between 2014 and 2023 resulted in conviction under the legislation.
- Where convictions were achieved, the penalties invoked, at judicial discretion, were routinely far below the maximum possible under the Acts. In total, 93.1% of fines and 85.5% of costs charged were for sums of €1,500 or less. Where a ban from selling tobacco was imposed, it was a 1-day ban or less in 56.9% of convictions, and a 30-day or more ban in 6.9% of cases.
- Convictions for some sections of the Act between 2014 and 2023 were minimal. For example, Section 46 (display of signs) had eight convictions, and Section 48 (interference with an Environmental Health Officer carrying out their duties) had two.

Examining tobacco control enforcement in Ireland

continued

- Section 37 (being registered on the Tobacco Register) had 18 convictions and, Section 43 (vending machines) had 20.
- The sections under which most convictions were made were Section 47 (smoking in workplaces and the conformity of shelters) which had 113, and Section 45 (underage/test purchases) which had 106.

Discussion

In their discussion, Houghton and Lombard reflect on the consistent compliance rate of approximately 80%, and that there is no indication of improvements in this rate. They argue that enforcement of this legislation should be as close to 100% as possible. The findings suggest that while 'research on Environmental Health Officer enforcement in Ireland has noted a partiality towards soft mandates instead of sanctions' (p. 7), this is not enough to attain a higher compliance rate. Based on their findings, they make recommendations, including:

- The introduction of fixed charge notices whereby fines are issued automatically at a fixed rate for non-compliance.
- Tobacco control advocates need to focus not only on developing improved legislation but also the implementation and enforcement of existing legislation.
- Conviction rates for non-compliance ought to be raised. There needs to be a better understanding of existing data – for example, whether there exist special variations in the data.
- Qualitative research is required in order to explore the decision-making that happens between an EHO finding an instance of non-compliance and the decision to issue a summons. Houghton and Lombard describe this as a 'black box' (p. 7).

Concluding comment

Houghton and Lombard's paper discusses how the low level of enforcement and minimal penalties imposed undermine tobacco control in Ireland. It highlights the need for further research in the field of this and similar legislation in the Irish context – for example, under the Public Health (Alcohol) Act 2018.

Lucy Dillon

1 Houghton F and Lombard J (2025) Examining tobacco-control enforcement in Ireland 2014–2023: an observational study. *Perspect. Public Health*, Early online, https://doi.org/10.1177/17579139251371974. Available from: https://www.drugsandalcohol.ie/44365/

2 *The State of Tobacco Control in Ireland. HSE Tobacco Free Ireland Programme*. Second Report. Dublin: HSE, 2022. Available from: https://www.drugsandalcohol.ie/36370/

3 Tobacco Free Ireland. *Annual Report 2022*. Dublin: Tobacco Free Ireland, 2022. Available from: https://www.drugsandalcohol.ie/40262/

4 HSE (2024). *Compliance and Enforcement*. Available online at: https://www.hse.ie/eng/about/who/tobaccocontrol/enforcement/ (accessed by Houghton and Lombard on 22 Aug 2024).

Recent research

Corporate power in Ireland – food and drink

Background

A report compiled by Maynooth University Social Science Institute (MUSSI) outlines growing global concern about the expansion of corporate power and its implications for democracy, public policy, and social well-being.[1] Increasingly, large corporations exert significant influence over public institutions and policy-making, often shaping them to serve private profit rather than the public good. This trend is closely linked to extreme wealth concentration; the richest 1% own more wealth than much of the global population, and a substantial share of that wealth is embedded in corporate structures. Many of the world's largest corporations are controlled or heavily influenced by billionaires, thus reinforcing their ability to shape political and economic priorities.

While supporters argue that corporations drive innovation, employment, and economic growth, the report highlights a growing disconnect between rising corporate profits and worsening global challenges such as climate change, inequality, and economic insecurity. This raises concerns about the societal risks of allowing wealth and power to accumulate in the hands of a small corporate elite.

In Ireland, these dynamics are particularly pronounced due to the country's long-standing reliance on foreign direct investment. Multinational corporations are widely seen as central to Ireland's economic success, contributing significantly to jobs, tax revenue, and growth. As a result, they hold substantial political influence and public legitimacy. Over time, this has fostered a strongly pro-business policy environment, with corporate-friendly approaches embedded across government institutions and policy discourse.

However, this economic model has also contributed to imbalances. Decades of underinvestment in public services and community infrastructure have coincided with growing social and economic pressures, environmental challenges, and dissatisfaction with perceived government prioritisation of corporate interests over public needs. Despite these risks, corporations have largely maintained their influence, acting as key advisors, technical experts, and research partners within policy-making processes, thus further strengthening their position.

The report addresses a gap in comprehensive analysis of corporate power in Ireland by mapping how corporations influence policy and economic priorities, drawing on a wide range of sources including advocacy reports, journalism, and policy analyses to examine corporate influence across multiple sectors, including:

- Big tech and data
- Pharmaceuticals and health
- Farming and agriculture
- Food and drink
- Banking and financial
- Construction and housing
- Education and research
- Energy, fossil fuels, and mineral extraction

Corporate power in Ireland – food and drink

continued

- Gambling
- Military
- Plastics

For the purposes of this *Drugnet* article, we focus on just the food and drink sector.

Food and drink

The food, drink, and alcohol sectors play a significant role in driving non-communicable diseases, yet industries continue to prioritise profit by promoting unhealthy products. The WHO recommends effective public health measures such as taxation, advertising restrictions, and limits on availability, but their implementation in Ireland and across Europe has been limited, largely due to industry opposition.

Research shows that industry actors actively weaken public health measures through lobbying, framing strategies, and funding biased research. For example, studies funded by the sugar-sweetened beverage (SSB) industry are far more likely to report no link between consumption and health harms. Corporations also build alliances with health organisations and promote narratives that emphasise personal responsibility, positioning themselves as part of the solution rather than contributors to the problem. In Ireland, lobbying has influenced policy decisions such as the reduced VAT rate for hospitality, which primarily increased industry profits without lowering prices or benefitting workers.

Alcohol use and related harms continue to represent a significant public health challenge in Ireland. Government attempts to implement evidence-based population-level measures have consistently been challenged by the alcohol industry, which claims that its commercial goals align with promoting 'responsible drinking' and advocate for education-based approaches despite being largely ineffective. Public health advocates argue that these initiatives mainly serve to improve the industry's image rather than reduce alcohol-related harm. Industry involvement in policy-making bodies has created conflicts of interest, delaying and weakening the Public Health (Alcohol) Act 2018.

Conclusion

Overall, corporate lobbying has significant societal and environmental consequences, including weakened public health protections. This influence undermines evidence-based policy-making and prioritises economic interests over population health.

Anne Doyle

1 Stephens JC, McSharry Daly C, Ferrari E, Reilly L and Ó Maonaigh C (2026) *Corporate Power in Ireland: A Review*. Dublin: Maynooth University.

Geographical characteristics and other factors associated with alcohol-related fatal fires in Ireland 2014–2021

Background

Alcohol use is a major global health risk, linked not only to chronic disease but also to injuries and traumatic events, including residential fires, where intoxication reduces awareness and the ability to respond. In Ireland, alcohol use remains high and has increasingly shifted to drinking at home, a pattern associated with heavier and riskier drinking and increased vulnerability to fire incidents. This study examined individual, geographic, and contextual characteristics of alcohol-related fatal fires to inform targeted fire prevention efforts.

Methods

Details of all fatal fires that occur in Ireland are collected through the HRB's National Drug-Related Deaths Index (NDRDI) on behalf of the National Directorate for Fire and Emergency Management in the Department of Housing Local Government and Heritage. During the period 2014–2021, there were 273 fatalities due to fires, of which 112 (41.0%) had positive alcohol toxicology. Descriptive and multivariate logistic regression along with geospatial analyses was used to explore the characteristics of alcohol-related fatal fires.

Results

Of all fatal fires, over one in ten individuals had a blood alcohol concentration (BAC) reading of 250 mg/100 mL or higher (11.7%) or over one-quarter of alcohol-related fire fatalities (28.6%). Alcohol was the only drug detected on 47.8% of alcohol-related fires' toxicology results. A further 14.3% had one other substance detected, and 38.4% had two or more other substances detected. The most common additional substances were antidepressants and benzodiazepines.

Alcohol-related fire fatalities were more likely to be male (69.6%) and 53.6% were single. Two-thirds (67.0%) of those who died were alone at the time of the fire, 42.0% were known to be smokers, 21.4% had a history of mental health problems, and 30.4% had a history of alcohol dependency. In addition, 14.3% were reported to have mobility issues.

Based on the proportion of the population living in rural areas, alcohol-related fatal fire incidents were more common in rural areas. Almost one-half of alcohol-related fatal fires occurred in disadvantaged or marginally below-average areas (49.1%), higher than the proportion of the general population that live in these areas (44.7%). The mean distance from the nearest emergency response fire station to the location of the alcohol-related fatal fire was 7 kilometres and the mean travel time was 10.5 minutes.

Compared to fatal fires not involving alcohol, fire fatalities in the 35–49 years age group were significantly more likely to involve alcohol (65.9%) ($p < 0.001$). Alcohol-related fires were more likely when friends were present at the time of the incident ($p < 0.001$). History of alcohol dependency was a significant predictor of a fatal fire being alcohol related (OR=4.109, 95% CI: 1.118, 15.106, p=0.033).

Alcohol-related fatal fires in Ireland

continued

Conclusion

More than two in every five of those who died in a fire in Ireland had been drinking prior to the incident, indicating that alcohol is a key risk factor for fire accidents and mortality, which is not often recognised. The study found that alcohol-related fatal fires were strongly associated with alcohol dependency, and commonly co-occurred with other risk factors, particularly being alone, smoking, older age, and impaired mobility. Most fatalities were alone at the time of the fire, and smoking or cooking while intoxicated were frequent ignition sources, with rural locations overrepresented and longer emergency response times observed. Overall, alcohol increases fire fatality risk when combined with behavioural, social, and environmental factors, thus highlighting the need to explicitly include alcohol in fire prevention policy and targeted safety interventions.

Anne Doyle

Doyle A, Stevely AK, Lyons S, McBride J, Riordan F and Holmes J (2026) Geographical characteristics and other factors associated with alcohol-related fatal fires in Ireland 2014 – 2021. *HRB Open Research*, 9, 15. Available from: https://doi.org/10.12688/hrbopenres.14341.1

From the launch of the first data report from the National DRIVE Project, L-R: Chris O'Sullivan, North Dublin Regional Drug and Alcohol Task Force Coordinator; Siobhán Maher, National DRIVE Project Coordinator; Dr Suzi Lyons, Head of Unit, HRB; Antoinette Kinsella, Chairperson, National DRIVE Oversight Committee; Detective Superintendent Sé McCormack, An Garda Síochána; Stephen Cashman, National Voluntary Drug and Alcohol Sector; Jennifer Murnane O'Connor, Minister of State at the Department of Health with special responsibility for Public Health, Wellbeing and the National Drugs Strategy; Deirdre Matthews, Probation Service; Fran Byrne, HSE National Addiction Advisory Group; Hugh Greaves, Local Drug and Alcohol Task Force Coordinators Network; Janet Robinson, DRIVE Data, Research and Evaluation Officer; Eibhlin Smith, Tusla – Child and Family Agency; Kevin Byrne, DRIVE Project Officer. Photo by: Julien Behal Photography.

Deaths among people who were homeless at time of death in Ireland, 2022

The HRB has published its fourth report on deaths among people who were homeless at the time of death.[1] The report describes deaths in 2022, with key trends for 2019–2022.

Background

The HRB collects data on all sudden and unexplained deaths among people who were homeless at the time of death, in order to better understand and prevent premature death among people who are homeless. The data are extracted from closed coronial files, using the methodology of the NDRDI, even if the deaths do not meet the standard NDRDI inclusion criteria. The NDRDI validates these data with the Dublin Region Homeless Executive through its Pathway Accommodation and Support System.

The deceased were considered as homeless if living in any of the following circumstances at the time of death:

- Homeless – without accommodation (sleeping rough)
- Homeless – temporary or crisis accommodation
- Homeless – severely substandard or highly insecure accommodation
- Homeless – unknown (no further details were available)

These criteria reflect international classifications that were adapted to reflect the types of accommodation available to people who are homeless in Ireland.

This study examined the number of deaths, cause of death, and characteristics of those who died for deaths between 2019 and 2022, where the coroner's death investigation was complete.

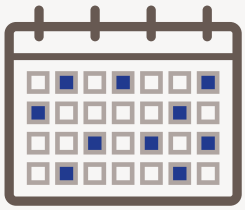
Deaths in 2022

The HRB recorded 124 deaths among people who were homeless at time of death in 2022. This represents a 31% increase on the number of deaths in 2019, but a 7% decrease on 2021 deaths.

Number of deaths

124
deaths

among people who were **homeless** in 2022



10 deaths
per month

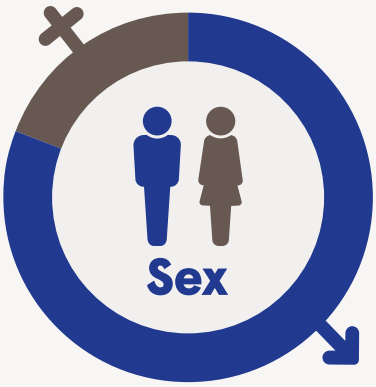
Homeless at time of death in Ireland, 2022

continued

Breakdown by sex

80.6%
Male

47 yrs
Median age of death



19.4%
Female

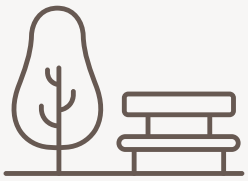
41 yrs
Median age of death

Place of death

57%
in Dublin

11%
in Cork

31%
Rest of Ireland



29%
died in a **public place, public building, or derelict building**

27%
died in **emergency accommodation**

Demographic characteristics

Eight in ten deaths were among males. The median age was 47 years for males, but younger for females at 41 years. In 2022, 85% of the deaths were in people aged under 60 years, compared with 13% of deaths in this age group in the general population.

Type of homelessness

In 2022, one in two (51%) people were in temporary or crisis accommodation, one in four (26%) were in severely substandard or highly insecure accommodation, and 16 people (13%) were sleeping rough (13%) prior to death. Most (57%) of the deceased were located in Dublin (city and county) and most (57%) incidents occurred there also.

Homeless at time of death in Ireland, 2022

continued

Place of incident

The majority of incidents occurred in a private dwelling (31%), followed by a public place, building, or derelict building (29%), and specific accommodation for people who are homeless (26%). More than one in two (57%) people were alone at the time of the incident leading to death.

Substance use history

In 2022, a history of substance use was recorded for the majority (84%, 104) of the deceased. Of those, 62% had used drugs and 62% had alcohol dependency or problem use. Of those who used drugs, cocaine (72%) was the most common drug, followed by heroin (54%), alcohol (47%), and benzodiazepines (32%). One in five (22%, 27) people had ever injected drugs, while 10 people were injecting at the time of death. A history of previous overdose was recorded for 16 (19%) people.

In the month prior to death, almost three in ten (27%) people were in substance use treatment, most commonly opioid agonist treatment (21%), which was accessed by 36% of females and 19% of males.

In 2022, 20 people (16%) had no recorded history of substance use.

Other co-morbidities

One in five (20%) people had a history of bloodborne virus, most commonly hepatitis C. Mental health issues, present in 38% of people who were homeless at the time of death, were recorded for a higher proportion of females (49%) than males (36%).

Cause of death

In 2022, 45 (36%) deaths were poisonings (drug overdose) and 79 (64%) were non-poisonings (i.e. due to all other causes, either traumatic or medical, irrespective of whether the coroner directly implicated drugs or alcohol in the death).

Poisonings

The median age of poisoning death was 43 years. Most (71%) poisonings involved more than one substance (polysubstance poisonings). Opioids (73%) were the most common drug group implicated, followed by benzodiazepines (58%), and cocaine (56%). Methadone (street

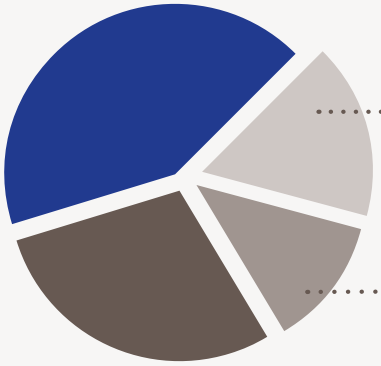
Homeless at time of death in Ireland, 2022

continued

Cause of death

64% Non-poisoning

36% Poisoning

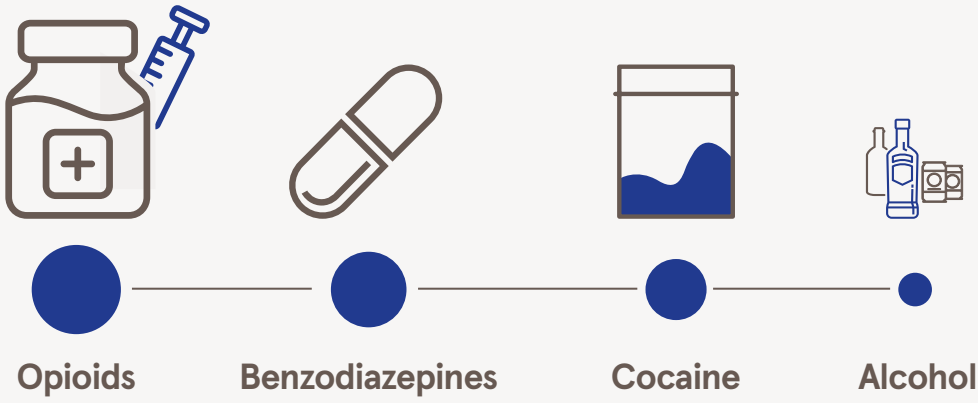


Of non-poisoning deaths:

15% deaths due to cardiovascular conditions

11% deaths due to hanging

Most common drugs implicated in poisoning deaths



or prescribed) (58%) was the most common specific drug implicated, and most (92%) methadone poisonings were polysubstance poisonings. Cocaine (56%) was the second most common poisoning drug after methadone and the most common poisoning drug among males. A known history of previous overdose was recorded in more than one in three (36%) poisoning deaths.

Non-poisonings

The median age of non-poisoning death was 48 years. Six in ten (61%) non-poisoning deaths had medical causes, while four in ten (39%) were traumatic deaths. The most common non-poisoning cause of death was cardiovascular conditions (15%), followed by falls (13%), hanging (11%) and respiratory conditions (11%).

Homeless at time of death in Ireland, 2022

continued

Table 1: Number of deaths and cause of death, 2019–2022

	2019	2020	2021	2022	Total
Poisoning	49 (52%)	72 (57%)	62 (47%)	45 (36%)	228 (48%)
Non-poisoning	46 (48%)	55 (43%)	71 (53%)	79 (64%)	251 (52%)
Total	95	127	133	124	479

Key trends 2019–2022

In total, 479 deaths were recorded for 2019–2022 (Table 1). The number increased from 95 in 2019 to 124 in 2022, while the highest number recorded was in 2021 (133). The median age at death increased from 40 years to 46 years. Males were in the majority (eight in ten) in every year.

Over the period, almost six in ten (58%) people were residing in temporary or crisis accommodation, while one in five (20%) were sleeping rough. There was an increase in the number who were in severely substandard or highly insecure accommodation (from 17 in 2019 to 32 in 2022). Over the period, most (57%) of the deceased were homeless in Dublin (city and county).

A history of substance use was recorded for the majority (88%) of the deceased over the period. The number of people with a recorded history of alcohol dependence or problem use increased, by 46%. However, the number of people with no substance use history also increased, by 67%.

Non-poisoning deaths (52%, 251) were more common than poisoning deaths (48%, 228) over the period, mainly due to increases in non-poisonings in 2021 and 2022 (Table 1).

Opioids (78%) were the most frequently implicated drug group in poisoning deaths, followed by benzodiazepines (61%). Methadone was the most implicated specific drug, involved in more than one in two (53%) poisonings, most of which were polysubstance poisonings. After methadone, alprazolam (41%) and cocaine (40%) were the most common.

Over the period, polysubstance poisonings increased from 76% of deaths in 2019 to 89% in 2021, before decreasing to 71% in 2022.

The most common cause of non-poisoning death over the period was cardiovascular conditions (19%), followed by hanging (16%), drowning (9%), and falls (9%).

Conclusion

The HRB will continue to collect and report these important data, which can be used to inform policy and other measures to support people who experience homelessness, and to reduce premature and preventable deaths.

Cathy Kelleher and Fiona Riordan

Riordan F, Gopalakrishnan A, Kelleher C and Carew AM (2026) *Deaths among people who were homeless at time of death in Ireland, 2022*. HRB StatLink Series 29. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/45132/

Enhancing naloxone provision in patients with mental illness and opioid use disorder

The rise of synthetic opioids known as nitazenes has created a growing public health concern in Ireland, particularly for individuals living with both severe mental illness and opioid use disorder. A recent article published in the *Irish Journal of Psychological Medicine* highlights the urgent need to expand access to naloxone, a life-saving medication that can reverse opioid overdoses, in response to this emerging threat.[1] The authors argue that patients with a 'dual diagnosis' of mental illness and substance use disorder are among the most vulnerable groups in society and require targeted interventions to reduce overdose deaths.

Research has shown that around one-half of people with severe mental illness also experience a substance use disorder.[2] Patients with opioid dependence face especially high risks because of the increasing presence of potent synthetic opioids in the Irish drug market. Nitazenes, which were first developed in the 1950s but never approved for medical use due to their extreme potency, are estimated to be between 50 and 500 times stronger than heroin. Their strength significantly increases the likelihood of fatal overdose, particularly when users are unaware that substances have been contaminated with nitazenes.

Ireland has already begun to experience the consequences of this trend. Drug-related deaths increased steadily between 2016 and 2020,[3] and in 2021 opioids were involved in the majority of overdose deaths. Since late 2023, several clusters of overdoses linked to nitazenes have occurred in Dublin and Cork, affecting dozens of individuals.[4] These synthetic opioids have been found mixed into heroin, cocaine, counterfeit tablets, benzodiazepines, and even cannabis products, making them difficult to detect and increasing the danger for users.

Naloxone has emerged as one of the most effective tools for preventing overdose deaths. The medication rapidly reverses opioid-related respiratory depression and has already saved lives during recent overdose incidents in Ireland. However, access to naloxone remains inconsistent, and uptake among patients is often low. The article describes an intervention carried out at the HSE National Drug Treatment Centre in Dublin, where patients received one-to-one overdose prevention training from doctors and pharmacists. Following this initiative, the percentage of patients receiving take-home naloxone kits increased dramatically from 12% to 61%.

The authors stress that naloxone provision should become a routine part of opioid agonist treatment services across Ireland. They also recommend broader public health measures, including peer-to-peer education, reducing stigma surrounding naloxone use, and improving collaboration between mental health, addiction, and community harm reduction services. Patients experiencing active symptoms of mental illness may struggle to engage with traditional healthcare services due to paranoia, disorganised thinking, or social isolation, making assertive outreach especially important.

On a national level, the article suggests that Ireland should consider allowing naloxone to be available over the counter in pharmacies, as has been done successfully in several European countries. The recent introduction of take-

Enhancing naloxone provision
continued

home naloxone kits for prisoners being released from custody is highlighted as another positive development.

Ultimately, the article warns that Ireland must prepare for the growing threat posed by synthetic opioids. Expanding access to naloxone and strengthening integrated mental health and addiction services could play a critical role in preventing overdose deaths and protecting some of the country's most vulnerable individuals.

Seán Millar

1 McNicholas R, Sweeney N, Fenton F and Keenan E (2025) Enhancing naloxone provision in patients with comorbid mental illness and opioid use disorder amidst the rise of nitazenes in Ireland. *Ir. J. Psychol. Med,* Early online, pp. 1-2. Available from: https://www.drugsandalcohol.ie/44146/

2 Drake RE, Mueser KT and Brunette MF (2007) Management of persons with co-occurring severe mental illness and substance use disorder: program implications. *World Psychiatry* 6, 131–136.

3 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.drugsandalcohol.ie/35856

4 Killeen N, Lakes R, Webster M, *et al.* (2024) The emergence of nitazenes on the Irish heroin market and national preparation for possible future outbreaks. *Addict.* 119(9), 1657–1658.

Prevalence and current situation

Information sources to inform the Irish drug early warning system: findings from a Nominal Group Technique workshop

Background

Drug early warning systems (EWSs) aim to identify emerging drug-related issues early so that timely action can be taken to reduce risks to public health.[1] The effectiveness of an EWS depends on the range and quality of information sources available to it. These sources may include laboratory analysis of samples obtained from a variety of settings, as well as non-laboratory information sources. Laboratory samples may be obtained from drug seizures, drug checking services, post-mortem testing, wastewater monitoring, clinical toxicology, and other settings.[1,2] Non-laboratory information sources may include healthcare data on drug use and harms, law enforcement data, poison centre data, pharmacovigilance system data, and reports from key informants (including people who use drugs and staff working in health

Irish drug early warning system
continued

and social care, outreach, and harm reduction settings).[1,2]

In Ireland, the Early Warning and Emerging Trends (EWET) network performs several functions related to drug EWS activities. Recent changes in drug use patterns in Ireland have highlighted the need for a practical, responsive, and robust EWS to detect emerging risks and protect public health.[3] A key step in developing this capacity involves understanding and prioritising the information sources available, and identifying the barriers that may impact their inclusion in an Irish EWS.

To this end, the authors conducted a structured workshop with Irish stakeholders to:

- Identify information sources perceived to be particularly important for an Irish EWS
- Describe the characteristics that should be considered when assessing these sources
- Identify information-related barriers to the implementation of an effective drug EWS in Ireland

Methods

A Nominal Group Technique (NGT) workshop was arranged with key Irish drug EWS stakeholders. NGT is a structured means to obtain qualitative information from a group of participants.[4] The workshop was two hours in duration and was held in person at the HRB in Dublin in February 2025. One representative from each organisation on the EWET committee was invited to attend. The workshop addressed three specific questions:

1 What existing information sources in Ireland should be considered for inclusion in an Irish drug EWS?

2 What aspects of these information sources should we collect further information on, in order to assess their potential for inclusion in an Irish drug EWS?

3 Overall, what are the main information-related barriers or gaps that need to be addressed in order to establish an effective drug EWS in Ireland at present?

In advance of the session, the group was provided with a brief summary of the project and the three questions. A structured approach was adopted, as outlined in published literature,[4,5] whereby participants initially shared their own ideas, followed by discussion and voting to prioritise the list of ideas or answers for each of the three questions posed.

Results

A total of 11 participants were involved. This included representation from Health Service Executive (HSE) Addiction Services, the HRB, the National Drug Treatment Centre Laboratory, Forensic Science Ireland, the Irish Prison Service, the Garda National Drugs and Organised Crime Bureau, the Medical Bureau of Road Safety, and the Ana Liffey Drug Project. The ten most highly ranked answers for each question are shown in Table 1. The key findings relating to each of the workshop questions are summarised below.

Workshop question 1 – What existing information sources in Ireland should be considered for inclusion in an Irish drug EWS?

When asked to identify which existing information sources should be considered for inclusion in a national drug EWS, participants placed the greatest importance on laboratory analyses. Frontline health services, encompassing both HSE and non-governmental organisations (NGOs), and frontline Garda reports, were the next highest

Irish drug early warning system
continued

ranked. Other sources reported to be important included event surrender bins and emergency department (ED) data. Service user information obtained through health service interactions and notifications from the European Union Drugs Agency (EUDA) early warning system also featured prominently.

Workshop question 2 – What aspects of these information sources should we collect further information on, in order to assess their potential for inclusion in an Irish drug EWS?

When discussing the characteristics by which these sources should be appraised, accuracy and the need for verification were ranked highest, followed by timeliness, speed of capture, and data availability. Participants further highlighted the reliability and longevity of the source, and the resources required to integrate each source into the system. Additional considerations included the clarity of data-sharing restrictions, the existence of a defined process for escalation to actions to protect public health, and overall data quality issues.

Workshop question 3 – Overall, what are the main information-related barriers or gaps that need to be addressed to establish an effective drug EWS in Ireland at present?

In relation to information-related barriers or gaps, the absence of standardised protocols for handling early warning information was the highest-ranked issue. This was followed by the lack of comprehensive computerised systems in many EDs and the need to avoid moral panic. Participants also cited the issue of reconciling disparate data sources, resource and prioritisation challenges across agencies, the absence of a national informatics database, and other IT system challenges.

Conclusion

This workshop provides an initial structured assessment of potentially important data sources and characteristics to consider for an Irish drug EWS, alongside practical barriers to implementation. Participants prioritised laboratory analyses, frontline health service and Garda reports, event surrender bins, and ED data. They identified accuracy, timeliness, reliability, and resource requirements as key criteria for assessing potential sources. Participants also highlighted key challenges in the Irish context at present, such as the need for formal procedures for handling early warning data and the need for appropriate IT systems to enable EWS reporting in various settings, including EDs. Limitations of the NGT workshop included its brief duration and the fact that stakeholders were primarily national-level professionals, with limited inclusion of community-based organisations or individuals with lived experience of drug use. Overall, the findings present an initial framework to help guide further research and decision-making regarding the optimal structure and processes for the development of Ireland's drug EWS.

Irish drug early warning system

continued

Table 1: Highest-ranked responses for each NGT workshop question. Responses are recorded in the participants' own words.

Question	Ten highest-ranked responses
What existing information sources in Ireland should be considered for inclusion in an Irish drug EWS?	1 Laboratories 2 Frontline health services (including NGOs, HSE) 3 Gardaí on the ground 4 Surrender bins at events 5 EDs (require a mechanism for recording information on attendances) 6 Service users (feeding into frontline health services) 7 European Union Drugs Agency (EUDA) information 8 Prisons (multiple sources, staff, people in prison) 9 EWET 9 Ambulance service
What aspects of these information sources should we collect further information on, in order to assess their potential for inclusion in an Irish drug EWS?	1 Accuracy and the need for verification (e.g. service user information) 2 Timeliness 3 Speed of capture 4 Reliability and longevity of the information source (e.g. Is the organisation going to still be here? Or one-off projects) 5 Resources needed (e.g. bringing information from the National Ambulance Service (NAS) to the EWS) 6 Restrictions on sharing of data 7 Process for escalation to action from receipt of information (i.e. How to decide to pull the trigger?) 8 Data quality 9 Ease of gathering and recording data 10 Coordination of ED data (needs to be readily available)
Overall, what are the main information-related barriers or gaps that need to be addressed to establish an effective drug EWS in Ireland?	1 Protocols – what to do with information 2 EDs – lack of computerised systems in EDs 3 The need to avoid moral panic 4 Synthesis (how to synthesise from diffuse different sources of information) 5 Resources and conflicting priorities 6 Lack of national informatics database (different systems, no one patient one record space, no central repository) 7 Overall IT infrastructure and lack of automation (resource intensive) 8 Lack of buy-in (with novelty of EWS) 9 Understanding relationships between informal information and formal data 10 Issues around sharing information (e.g. embargoes pending reports, willingness to share)

Irish drug early warning system
continued

Cian Dowling-Cullen and Mark O'Loughlin

1 Cooperation Programme between Latin America, the Caribbean and the European Union on Drugs Policies (COPOLAD II) (2020). *Early warning system on new psychoactive substances and emerging drug phenomena – implementation manual*. Madrid: International and Ibero-American Foundation for Administration and Public Policies; Government Delegation for the National Plan on Drugs.

2 European Monitoring Centre for Drugs and Drug Addiction (2019). *EMCDDA operating guidelines for the European Union Early Warning System on new psychoactive substances*. Luxembourg: Publications Office of the European Union.

3 Killeen N, Mongan D, Keenan E and Galvin B (2026). Strengthening Ireland's response to new and emerging trends within the next policy life cycle. *Supplement to Drugnet 93*. Dublin: Health Research Board.

4 Harvey N and Holmes CA. Nominal group technique: An effective method for obtaining group consensus. *Int J Nurs Pract*. 2012;18(2):188–94.

5 Mullen R, Kydd A, Fleming A and McMillan L (2021). A practical guide to the systematic application of nominal group technique. *Nurse Res*. 2021 Mar 11;29(1):14–20.

Understanding per capita alcohol use versus low-risk drinking guidelines

Introduction

Globally, alcohol use is quantified and compared across countries by determining the alcohol per capita (APC) use of a country and measuring against alcohol-related harms. Monitoring APC allows countries to assess public health, make international comparisons, track trends over time, and evaluate the impact of policies.

Defining per capita alcohol use

APC estimates are constructed by determining the amount of alcohol sold, expressed as litres of pure (100%) alcohol, within a country or region per year and applying the amount to the population aged 15 years and over (as this is typically the age at which young people start drinking alcohol). As a result, we end up with the litres of pure alcohol sold per person per year and these are used as a proxy for consumption.

In Ireland, alcohol sales are derived from Revenue excise receipts and volumes which itemise the amount of each type of beverage sold within a given year.[1] Revenue data are provided as total sales of beverage type and in either hectolitres or litres. Table 1 provides an overview of how each beverage is grouped and how the number of litres of pure alcohol is calculated.

Lower-risk drinking guidelines
continued

Table 1: Calculating litres of pure alcohol

Beverage type	Volume provided	Calculation to determine litres of pure alcohol
Beer	Litre of alcohol	As per Revenue spreadsheet
Wine	Hectolitre of product	Volumes are provided in hectolitres and are therefore multiplied by 100 to convert into litres of alcohol and then converted to pure alcohol based on an alcohol by volume (ABV) of 12.5%[8] – i.e. multiply wine sales in litres × 0.125
intermediate beverages	Hectolitre of product	
beverages other than cider and perry	Hectolitre of product	
Spirits	Litre of alcohol	As per Revenue spreadsheet
Cider and perry	Hectolitre of product	Volumes are provided in hectolitres and are therefore multiplied by 100 to convert into litres of alcohol and then cider volumes are converted to pure alcohol based on an ABV of 4.5% – i.e. multiply cider sales in litres × 0.045

Once the total litres of alcohol are determined (as per Table 1), the next step is to examine the population. The last Census was conducted in 2022 in Ireland and each year population figures are based on estimates and updated annually.[2] The population of those aged 15 years and over is calculated from these Central Statistics Office (CSO) population estimates. The total litres are then divided into the total population 15 years and over to determine per capita alcohol use (Figure 1).

Strengths and weaknesses of per capita alcohol use calculations

Using Revenue excise volumes represents the 'gold standard' of calculating and reporting per capita alcohol use as the data are complete coverage, and are consistently reported, offering trend reliability.[3,4] However, they are not without limitations. Excise volumes do not include alcohol consumed by Irish people abroad, cross-border trade, or home-brewed or illicit alcohol products.[5] Neither do they provide information on the prevalence of alcohol use, patterns of consumption across

$$\frac{\text{Total litres of alcohol sold}}{\text{Population aged 15 years and over}} = \text{Per capita alcohol consumption}$$

Figure 1: Calculation to determine per capita alcohol use

Lower-risk drinking guidelines
continued

different demographic groups, or variation in drinking behaviour within the population. Such information is essential for understanding alcohol-related harm, including disease burden and mortality.[6]

APC also masks important differences within the population. Healthy Ireland Survey data indicate that 29% of people do not drink alcohol and when these non-drinkers are excluded, estimated consumption among drinkers rises substantially to 13.01 litres per capita.

Per capita alcohol use Ireland – trends over time

In 2025, using the calculations outlined here, per capita alcohol use was 9.24 litres, representing a 2% decline in per capita alcohol use since 2024 (9.43 litres) and a 16.1% decline since the introduction of the Public Health (Alcohol) Act in 2018.

Despite declining APC, Ireland remains above both the Organisation for Economic Co-operation and Development (OECD) average (8.5 litres) and the Government target of 9.1 litres per capita, originally set in 2013 and to be achieved by 2020.

Ultimately, while APC and survey data are valuable indicators, their findings should be interpreted with caution, considering underlying assumptions, data limitations, and population-level variations.

Individual low-risk drinking guidelines

While per capita consumption describes overall population use, it should not be interpreted as a guide to individual drinking risk. The HSE acknowledges that there is 'no level of alcohol use that is safe for health'.[7] However, it provides guidelines for drinkers aged 18 years and over on 'low-risk' thresholds to reduce the risk of alcohol-related harm. Of note, children aged under 18 years and pregnant women or women planning a pregnancy should not consume alcohol. Current weekly low-risk alcohol guidelines for drinkers aged 18 years and over are:

- No more than 11 standard drinks* per week, if you are a woman
- No more than 17 standard drinks per week, if you are a man

The HSE advises that drinks should be spread out across the week, that drinkers should have at least 2 to 3 alcohol-free days per week and not to drink more than 6 standard drinks on any one occasion.

If every adult drinker in Ireland consumed the maximum low-risk guidelines

Based on the HSE low-risk guidelines, if every drinker drank this maximum limit every week of the year, a man would drink 11.05 litres pure alcohol per year (i.e. 17×12.5 mL=212.5 mL pure alcohol/week × 52 weeks = 11,050 mL or 11.05 litres). For females, it would equate to 7.15 litres pure alcohol per year (i.e. 11 × 12.5 mL = 137.5 mL pure alcohol/week × 52 weeks = 7,150 mL or 7.15 litres). For both sexes, this equates to 9.1 litres pure alcohol per year (i.e.11.05 + 7.15/2 = 9.1).

Therefore, if all the drinkers in Ireland restricted their drinking to this maximum limit, the average drinker would consume 9.1 litres pure alcohol per year, well below the 13.01 litres per capita calculated for drinkers only.

*In Ireland, a standard drink has 10 g or 12.5 ml of pure alcohol.

Lower-risk drinking guidelines
continued

Lower-risk drinking guidelines and the 'no safe level' message: Finding a balance in risk communication

An editorial in *Addiction* comments on the potential for confusion for drinkers distinguishing between low-risk guidelines and the 'no safe level' of alcohol use guidance.[8] The authors point out that the 'no safe level' message refers specifically to the absence of a biologically risk-free threshold for certain harms, particularly cancer, while 'low-risk' drinking guidelines provide pragmatic advice on consumption levels associated with relatively low overall risk. Although both are well established, their relationship is often unclear, and 'no safe level' can be mistaken as a strict call for abstinence rather than a narrow scientific statement. Evidence suggests that such messages may raise awareness but can also trigger defensive reactions or be seen as unrealistic, especially when people already are indifferent to drinking guidelines. The authors suggest that clearer communication is needed in order to explain how these messages complement rather than contradict each other, thus ensuring credibility and helping people make informed decisions about alcohol use.

Conclusion

APC, a population-level measure, differs from low-risk drinking guidelines, which are designed for individual behaviour and are not interchangeable with per capita estimates. Low-risk drinking guidelines provide a framework for communicating the potential risks associated with alcohol consumption at the individual level.

Anne Doyle and Deirdre Mongan

1 Revenue Commissioiners (2022) *Excise receipts by commodity*. Dublin: Office of the Revenue Commissioners. Available from: https://www.revenue.ie/en/corporate/information-about-revenue/statistics/excise/receipts-volume-and-price/excise-receipts-commodity.aspx

2 Central Statistics Office (2022) *Census of Population 2022 - Summary Results*. Available from: https://www.cso.ie/en/statistics/population/censusofpopulation2022/censusofpopulation2022-summaryresults/ (accessed 4 Jul 2023).

3 Kilian C, Manthey J, Probst C, *et al.* (2020) Why is per capita consumption underestimated in alcohol surveys? Results from 39 surveys in 23 European countries. *Alcohol Alcohol*.

4 Gmel G and Rehm J. Measuring alcohol consumption. *Contemp. Drug Probl.* 2004;31:467–540.

5 Manthey J, Braddick F, López-Pelayo H, Shield K, Rehm J and Kilian C (2023) Unrecorded alcohol use in 33 European countries: analyses of a comparative survey with 49,000 people who use alcohol. *Int. J. Drug Policy* 2023;116:104028. Available from: https://www.drugsandalcohol.ie/38718/

6 Bhattacharya A, Angus C, Pryce R, Holmes J, Brennan A, and Meier PS (2018) How dependent is the alcohol industry on heavy drinking in England? *Addict.* 2018;113:2225–32.

7 Health Service Executive. *Weekly low-risk alcohol guidelines*. Available from: https://www2.hse.ie/living-well/alcohol/health/improve-your-health/weekly-low-risk-alcohol-guidelines/ (accessed 10 Oct 2022).

8 Nicholls J (2026) Lower risk drinking guidelines and the 'no safe level'message: Finding a balance in risk communication. *Addict.*

Semi-synthetic cannabinoids remain a concern in Ireland

Semi-synthetic cannabinoids (SSCs) have emerged as a growing public health concern in Ireland despite recent legislative efforts aimed at restricting their sale. A recent article published in the *Irish Journal of Psychological Medicine* warns that these cannabis-like substances continue to be widely available across the country and may pose serious risks to both physical and mental health, particularly among young people.[1] The authors argue that Ireland's delayed response to the rise of SSCs highlights significant weaknesses in drug policy and enforcement systems that require urgent reform.

SSCs first gained international attention following the legalisation of hemp cultivation in the United States (US) in 2019. The change in legislation allowed manufacturers to extract cannabidiol (CBD) from hemp and chemically convert it into psychoactive compounds such as hexahydrocannabinol (HHC) and delta-8-tetrahydrocannabinol (Δ8-THC). These substances are often marketed in vape products, edibles, and oils as legal alternatives to cannabis. By 2025, SSCs had spread throughout Europe and were detected in 27 countries, including Ireland.

Although marketed as safer or 'legal' forms of cannabis, evidence increasingly suggests that SSCs can cause serious health problems. Reports from poison centres in the US recorded thousands of cases of Δ8-THC poisoning between 2021 and 2022, with many incidents involving children who accidentally consumed edible products mistaken for sweets or confectionery. Some cases required intensive medical treatment, demonstrating the potentially dangerous effects of these compounds.

In Ireland and across Europe, concerns have grown regarding the psychiatric effects of SSCs. HHC and related compounds have been linked to episodes of psychosis, anxiety, hallucinations, and dissociation. Research from University Hospital Galway found that more than one-third of first-episode psychosis patients admitted between 2023 and 2024 reported HHC use prior to their hospitalisation.[2] Findings from Ireland's European Web Survey on Drugs also revealed that many users experienced significant negative psychological effects after using HHC products.[3]

In response to these concerns, Ireland banned HHC and several related substances in July 2025 under the Misuse of Drugs Act, 1977. However, the article argues that this action came far too late. Many European countries had already introduced restrictions months earlier, while Irish retailers continued openly selling HHC products. Even after the ban, businesses quickly adapted by marketing new 'HHC alternatives' and cannabinoid blends that appear to fall outside current legislation. This rapid evolution mirrors previous trends seen during the rise of 'head shops' and new psychoactive substances in Ireland during the late 2000s.

The authors believe that Ireland's response demonstrates a broader problem with reactive drug policy. Instead of addressing emerging substances before widespread harm occurs, authorities often wait until significant health consequences have already been reported or international controls are introduced. The article calls for a review of why existing legislation, including the Criminal Justice (Psychoactive Substances) Act 2010, was not used more effectively to regulate HHC earlier.

Semi-synthetic cannabinoids in Ireland

continued

Ultimately, the article emphasises the need for stronger early warning systems, faster legislative action, and closer collaboration between policy-makers, clinicians, researchers, and public health experts. As the market for SSCs continues to evolve, the authors stress that Ireland must develop a more proactive approach to drug regulation in order to protect public health and prevent future harm.

Seán Millar

1 Bond B and Cannon M (2026) Semi-synthetic cannabinoids remain a potent concern in Ireland. *Ir. J. Psychol. Med*. Early online, pp. 1–2. Available from: https://www.drugsandalcohol.ie/45192/

2 O'Mahony B, Lanigan S, Lally N, *et al* (2025) Novel substance, same old problems: Admissions of psychosis precipitated by hexahydrocannabinol, a widely available semi synthetic cannabinoid. *BJPsych Bulletin* 1–6.

3 Mongan D, Killeen N, Millar SR, Matias J, Keenan E and Galvin B (2025). Hexahydrocannabinol (HHC) use and harms in Ireland: New findings from the 2024 European Web Survey on Drugs. *Int. J. Drug Policy* 145, 105011. Available from: https://www.drugsandalcohol.ie/44244/

Ana Liffey annual report, 2024

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

The services offered in Dublin include:

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

Midwest region

Ana Liffey 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.

Ana Liffey annual report
continued

Annual report

The 2024 Ana Liffey annual report was published in 2025.[1] The report noted that in 2024, Ana Liffey serviced 4,511 vulnerable adults who used drugs across Dublin and the Midwest. There were 680 individuals who accessed Ana Liffey's overdose prevention and needle/syringe programme in 2024, while 1,318 clients were provided with assessment, case management and overdose prevention.

The report also noted that 920 people used the 'VanaLiffey' outreach harm reduction service to access harm reduction equipment, support and advice. Ana Liffey additionally performed emergency harm reduction outreach out of hours, alongside the HSE in Dublin and Limerick, to provide education and overdose prevention equipment in light of synthetic opioid overdose clusters.

Seán Millar

1 Ana Liffey Drug Project (2025) *Ana Liffey Drug Project Annual Report 2024*. Dublin: Ana Liffey Drug Project. Available from: https://www.drugsandalcohol.ie/45094/

Merchants Quay Ireland annual review, 2024

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and those who use drugs. There are 27 MQI locations in 14 counties in the Republic of Ireland (see Figure 1). MQI aims to offer accessible, high-quality, and effective services to people dealing with homelessness and addiction to meet their complex needs in a non-judgemental and compassionate way. This article highlights services provided by MQI to people who used drugs in Ireland in 2024.[1]

Harm reduction services

The aim of harm reduction is to minimise the risks stemming from sharing drug paraphernalia. In 2024, a total of 2,956 unique clients were provided with 22,896 health-led, harm reduction interventions, including needle exchange, in MQI's Riverbank Centre. A total of 433 safer injection training sessions were provided for clients, with the aim of reducing the physical harm caused by unsafe practices. In addition, 139 clients were trained in the use of the overdose reversal medicine naloxone.

Community detoxification and opioid substitution therapy

In 2023, MQI increased from one to three the number of addiction case workers in the Riverbank Centre. Addiction case workers work closely with the mental health team to provide a dual diagnosis support structure for clients facing both addiction and mental health problems. The addiction team carried out 2,670 addiction interventions with clients in 2024, ranging from offering support to clients on opioid substitution therapy (OST), to ensuring

Merchants Quay Ireland annual review

continued

robust care planning, to supporting clients through community detoxification. This figure represented a 55% increase on 2023, with 1,197 addiction interventions provided that year.

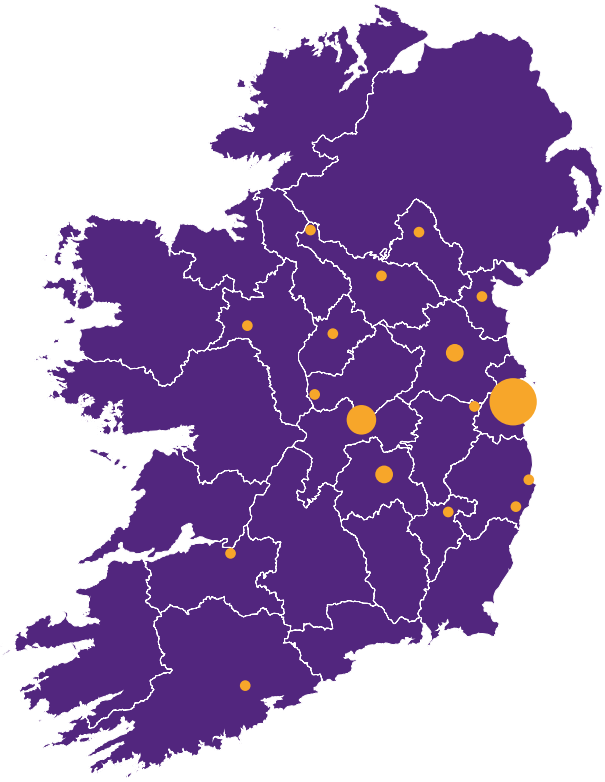
Community engagement

A Community Engagement Team operates in the neighbourhood around the Riverbank Centre, Dublin in order to strengthen relationships with the local community and stakeholders, and proactively engage with clients and people sleeping rough in the area. The team collects discarded drug paraphernalia and proactively engage with people who use drugs or are rough sleeping in the local area, supporting them to access services. In 2024, the team carried out 751 patrols, and engaged with 504 residents and local businesses while collecting 2,289 needles and 748 crack pipes.

Midlands services

Drug and Alcohol Treatment Supports

MQI's Midlands Drug and Alcohol Treatment Supports (MDATS) team provides a community-based drug and alcohol treatment support service for individuals aged over 18 years, and their families, in the Midlands area (counties Longford, Westmeath, Laois, and Offaly). Services provided include an outreach-based crisis support service, mobile harm reduction, needle and syringe exchange, rehabilitation and aftercare support, as well as support for families affected by substance use. In 2024, the MDATS team supported 603 individuals via 4,447 interventions. A total of 88 new clients were referred to the family support specialist, representing an increase of 20% on the previous year.



Source: *Merchants Quay Ireland Annual Review 2024*, p. 40. The 14 counties are Dublin, Wicklow, Carlow, Cork, Limerick, Offaly, Westmeath, Laois, Louth, Longford, Roscommon, Cavan, Monaghan, and Kildare.

Figure 1: MQI locations in the Republic of Ireland

Recovery services

St Francis Farm residential detoxification and rehabilitation

Located in Tullow, Co Carlow, the St Francis Farm (SFF) Detoxification Unit offers 24-hour medically supervised residential detoxification and individually tailored treatment plans for men and women aged over 18 years. The purpose-built detoxification unit can accommodate up to 10 residents at any one time. In 2024, there were 318 referrals to the detoxification unit, which was similar to the number recorded in 2023. Overall, during 2024, there were 54 admissions to the detoxification unit, which again represented an increase from 2023 of 10%. These admissions comprised a combination of

Merchants Quay Ireland annual review

continued

clients detoxifying from the following substances: methadone and benzodiazepine, methadone only, benzodiazepines only, and suboxone. The report noted that completion rates from the detoxification unit were extremely strong in 2024, at 100% (41 clients). Out of this group, 27 participants progressed to the SFF rehabilitation facility.

The rehabilitation programme offers one-to-one support and care planning, group work, self-esteem seminars, assertiveness training, anger management, art work and relapse prevention training. Service users also receive education in first aid, overdose prevention, life skills, and budgeting. There were 164 referrals into the rehabilitation programme during 2024 that met the programme criteria. Overall, there were 48 admissions to the rehabilitation unit, with an overall bed occupancy rate of 81% during the year, up from 77% in 2023.

Prison-based services

Addiction Counselling Service and Mountjoy Drug Treatment Programme

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

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

In 2024, counselling supports were provided to 1,283 people and these individuals were provided with a total of 15,364 interventions.

Medically supervised injecting facility

Following a tendering process, MQI was selected by the HSE as the preferred provider to operate Ireland's first medically supervised injecting facility. Located in the Riverbank Centre on Merchant's Quay in Dublin, where other healthcare and harm reduction services are currently provided, the facility opened in December 2024, and was delivered on time and within budget.

Seán Millar

1 Merchants Quay Ireland (2025) *Merchants Quay Ireland Annual Review 2024*. Dublin: Merchants Quay Ireland. Available from: https://www.drugsandalcohol.ie/44089/

Prison visiting committees annual reports, 2024

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 2024 is summarised below.[1]

Mountjoy Prison, Dublin

In its report, the Mountjoy Visiting Committee noted that prisoners had complained about a lack of drug treatment services and long delays in getting to see a drugs counsellor. The Committee stated that Mountjoy's Treatment and Recovery Programme had been spoken of positively by prisoners; however, difficulties of getting on a waiting list, and entry to the programme, were also frequently mentioned. The report stated that following detoxification, drug-free landings, occupational therapy and skills training along with psychological therapies are essential to the maintenance of positive mental health and well-being for prisoners. The Committee suggested that a lack of adequate staffing to provide drug and psychological treatment while in prison, coupled with the lack of community mental health and supportive housing services, may be contributors to a high level of reoffending and readmission to 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. As in previous reports, 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 suggested that there should be more strident support and counselling at Wheatfield Prison for those in addiction.

Cloverhill Prison, Dublin

In its report, the Cloverhill Prison Visiting Committee stated that the addiction counselling service team at Cloverhill is not large enough for the needs of the prison population. The Committee had heard that a high number of men who arrive in Cloverhill Prison are in what is regularly described as a 'chaotic state'; many have complex issues, including addiction. The length of waiting time to see an addiction counsellor is frequently raised by prisoners. The Committee highlighted that it is vitally important that those seeking help for addiction issues are met with the necessary care and support. As the addiction service in Cloverhill is currently not adequately staffed to meet the level of demand, the Committee stated that an additional full-time post is urgently needed.

Prison visiting committees annual reports

continued

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; and the Cork Alliance, Addiction, Psychology and Psychiatry Services. A significant component of the project is provided by Coolmine Community Addiction Services, which conducts the Here & Now programme within the prison once a month. This initiative enhances collaboration between the prison and residential/community addiction and mental health services, streamlining access to addiction assessments and counselling for prisoners upon their release.

Loughan House, Co Cavan

The Loughan House Visiting Committee heard that face-to-face addiction and counselling sessions are provided in Loughan House. Currently, there are two part-time addiction counsellors, while psychology services are provided by one part-time staff member

Shelton Abbey Prison, Co Wicklow

The Shelton Abbey Prison Visiting Committee's report noted that the prison has a full-time addiction counsellor and that all prisoners are assessed on entry in order to ascertain whether they have current or previous addiction issues, and that they are offered one-to-one addiction counselling if required. The report noted that there were no waiting lists in Shelton Abbey Prison.

Portlaoise Prison, Co Laois

The Portlaoise Prison Visiting Committee heard that the prison has one addiction counsellor who attends two days a week, and that there is a long waiting list for this service. The Visiting Committee recommended that the hours be further increased in order to reduce the waiting list. The report also noted that prison staff are not adequately trained to supervise and deal with the many complex mental health issues some prisoners have, and that these prisoners would probably receive better treatment in a non-prison environment.

Midlands Prison, Co Laois

The Midlands Prison Visiting Committee was informed that in addition to addiction counselling services in the prison provided by Merchants Quay Ireland, there are now two additional nurses who work 8am to 5pm on a Monday to Friday basis.

Seán Millar

1 Department of Justice (2025) *Prison Visiting Committee annual reports 2024 [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.

Launch of Clondalkin's Prevention Lab

Clondalkin Drug and Alcohol Task Force's Prevention Lab was launched on 13 May 2026 by Jennifer Murnane O'Connor, Minister of State at the Department of Health with special responsibility for Public Health, Wellbeing and the National Drugs Strategy

The Prevention Lab is a school-based programme that takes a whole-school approach. It supports students, parents and educators to address drug and alcohol misuse, and it aims to create a supportive environment where prevention and early intervention are prioritised. It does so by delivering supplementary substance use education opportunities for young people; guidance to schools on substance use policy; staff information events; and workshops for parents, among other elements. Grounded in evidence-based practice, the initiative aims to promote resilience, strengthen understanding of substance use, and empower young people to make informed decisions.

The Lab works to a partnership model, with the support of Crosscare and local school management. The Clondalkin Drug and Alcohol Task Force states that this 'has enabled the programme to become an established and effective response to substance use within participating schools'.

Research is a feature of the Lab. In partnership with Trinity College Dublin, research is being undertaken to evaluate the programme's development and impact, ensuring it continues to meet the evolving needs of young people and their communities.

At the time of the launch, the Prevention Lab was operating in eight post-primary schools and one Youthreach centre across Clondalkin, Lucan, Adamstown and Drimnagh. The Task Force plans to expand it to additional schools in the academic year 2026/27.

The Minister offered her support for the Prevention Lab, stating:

> *As Minister of State with responsibility for the National Drugs Strategy, I am a strong advocate for evidence-based prevention. We must ensure our younger population have the appropriate supports and care in place to build life skills, confidence, and the ability to make informed, healthy choices. The Clondalkin Drug and Alcohol Task Force have displayed leadership and expertise in advancing evidence-based drug prevention and can be viewed as a model in this area.*

From L-R: Eddie Mullins, CDATF Chairperson; Cathy Martin, CDATF Prevention Officer; Jennifer Murnane O'Connor, Minister of State at the Department of Health with special responsibility for Public Health, Wellbeing and the National Drugs Strategy; and Trevor Bissett, CDATF Coordinator.

Launch of Clondalkin's Prevention Lab

continued

Trevor Bissett, Coordinator of Clondalkin Drug and Alcohol Task Force, said:

> *The Prevention Lab represents a proactive and practical approach to supporting young people. By working closely with schools, families, and community partners, we are creating an environment where young people are better equipped to make positive, informed choices about their health and well-being.*

Lucy Dillon

2025 drug treatment demand

The latest report from the National Drug Treatment Reporting System (NDTRS) on drug treatment demand in Ireland was published in May, providing statistics and trends on drug treatment cases, excluding alcohol.[1] The publication includes data for the years 2017–2025.

The report outlines key findings on main problem drugs, sociodemographic characteristics, and health region of residence. It also focuses on three main themes: polydrug use, risk factors, and cocaine use.

The full report, along with accompanying data tables, are available to download from the HRB website.[1]

Key findings

In 2025, 15,422 cases were treated for problem drug use (excluding alcohol), the highest annual total recorded by the NDTRS. This reflects an increase in treated cases alongside improved data reporting from prison-based treatment services during 2025.

One in three cases (33.3%) were never treated before. The majority of cases were treated in outpatient facilities (65.8%).

Main problem drugs generating treatment demand

Cocaine was the most common main problem drug reported in 2025, accounting for four in ten (42.4%) cases entering treatment for problem cocaine use in that year. This represents a 335.7% increase from 2017.

Opioids, mainly heroin, were the second most common main problem drug reported in 2025, accounting for one in four cases (25.3%). Treatment demand for opioids has decreased since 2017, when opioids as a main problem drug accounted for 45.0% of cases.

2025 drug treatment demand
continued

Main problem drug

42% cocaine

25% opioids

15% cannabis

11% benzodiazepines

Main problem drug by age

age started treatment

cannabis 19 years or under

cocaine 20–44 years

opioids 45 years or over

Cannabis and benzodiazepines were the third and fourth, respectively, most common main problem drugs reported in 2025, similar to previous years. The number and proportion of cannabis-related treatment cases have declined since 2019.

The 2025 report also highlights some new trends in drug treatment demand:

- Cases where new psychoactive substances (NPS) were the main problem drug increased more than 400% between 2017 and 2025.
- The total number of cases recording ketamine as a problem drug (as a main problem or secondary problem) in 2025 was more than 12 times the number recorded in 2017.
- Vaping as a route of administration increased from 100 cases in 2024 to 249 cases in 2025.

Age groups

The most common problem drug varied by age group and this has changed over time:

- Cannabis was the most common problem drug among younger people, notably among cases aged under 19 years
- Cocaine was the most common problem drug among those aged 20–44 years
- Opioids were the most common problem drug among the older age groups of 45 years or over.

2025 drug treatment demand
continued

Sociodemographic characteristics

- Males comprised 69.4% of cases
- Irish Travellers comprised 2.9% of cases
- Almost two-thirds (59.2%) of cases were unemployed
- 11.6% of cases were experiencing homelessness at the time of starting treatment

The age profile of cases entering drug treatment continued to shift in 2025, indicating an increasingly ageing treatment population:

- The median age of cases increased from 30 years in 2017 to 35 years in 2025
- The proportion of younger service users has declined over the 9-year period
- The proportion of those aged 50 years or over has more than doubled since 2017

HSE health regions

The number of recorded treatment cases increased between 2024 and 2025 across all six HSE health regions. HSE Dublin and North East Health Region had the highest number of cases in 2025.

Cocaine treatment demand

A total of 6,535 cases reported cocaine as a main problem drug in 2025, an increase of 23.6% since 2024 and an increase of 335.7% since 2017. Almost three-quarters of the cases in 2025 (73.3%) were for powder cocaine and just over one-quarter (26.6%) were for crack cocaine.

Overall, females accounted for 29.3% of cases treating cocaine as the main problem drug in 2025, increasing from 18.9% in 2017. Females comprised a considerable proportion of cases treated for crack cocaine, accounting for 44.8% of cases, compared with 23.6% of cases treated for powder cocaine.

The median age of those entering treatment for cocaine increased from 30 years in 2017 to 34 years in 2025. Cases treated for crack cocaine had an older age profile than cases treated for powder cocaine. Compared with powder cocaine, cases treated for crack cocaine also more commonly reported unemployment, homelessness, and a history of injecting.

Polydrug use

In 2025, 61.8% of cases reported using more than one drug (polydrug use). This has increased from 60.4% of cases in 2024 and from 57.2% of cases in 2017.

Among new cases with polydrug use in 2025, the most common additional substances were:

1 Alcohol (50.2%)
2 Cannabis (43.2%)
3 Cocaine (27.8%)
4 Benzodiazepines (18.2%)

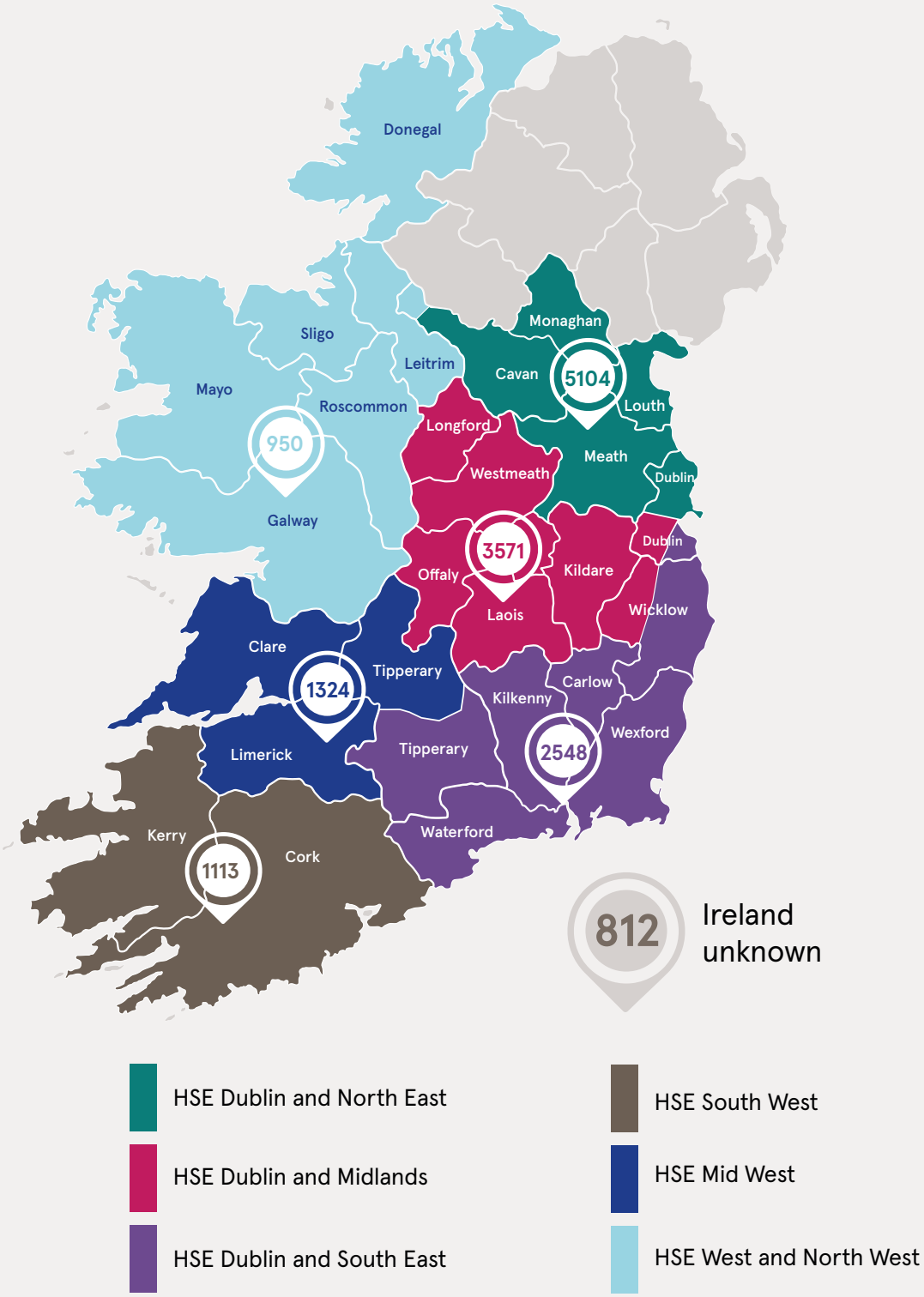
Among previously treated cases with polydrug use in 2025, the most common additional substances were:

1 Cocaine (45.8%)
2 Cannabis (45.2%)
3 Benzodiazepines (39.6%)
4 Alcohol (29.0%)

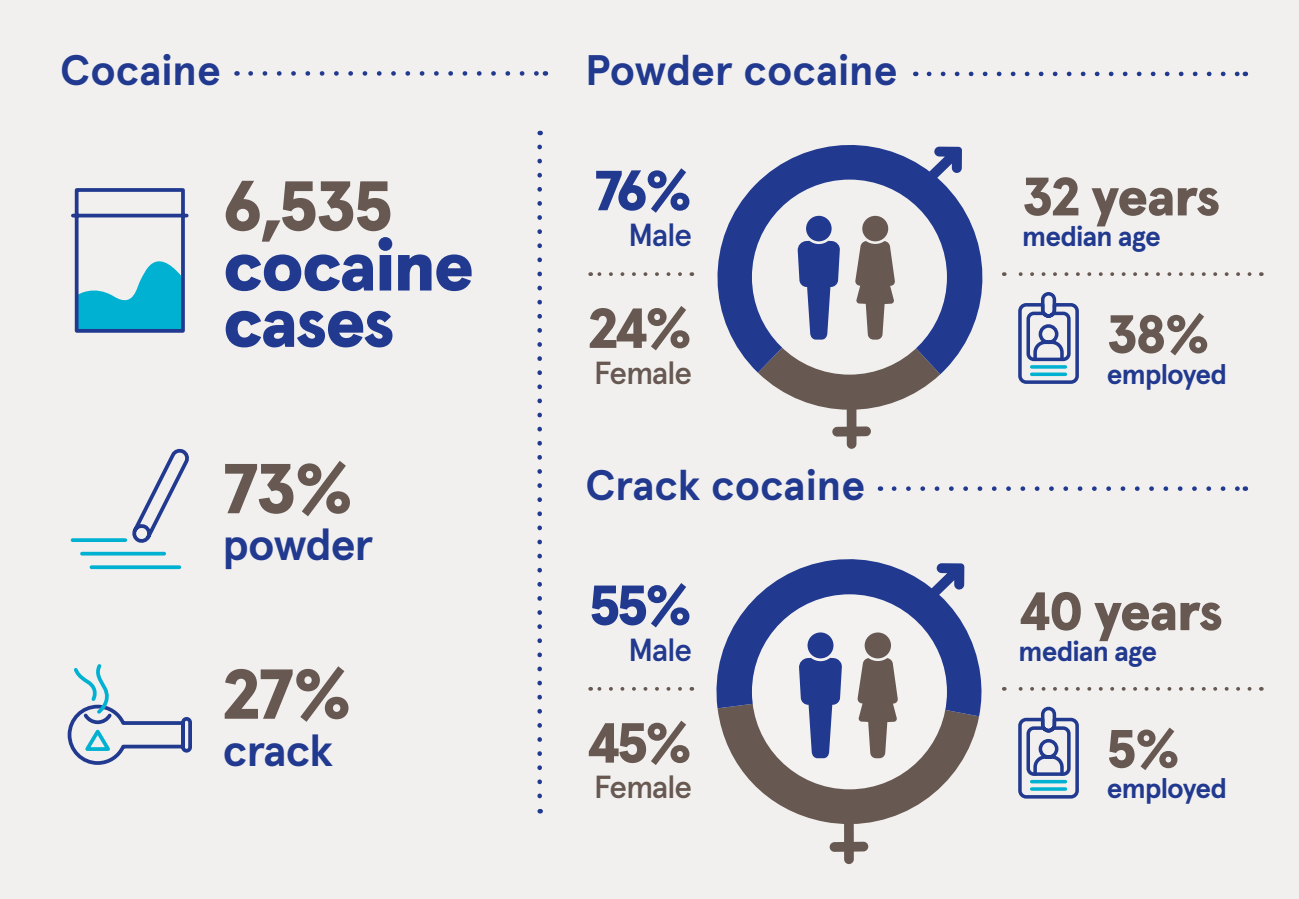
The most common drugs used together were (1) cocaine plus alcohol, followed by (2) cocaine plus cannabis, and (3) opioids plus cocaine plus benzodiazepines plus cannabis.

2025 drug treatment demand

continued



2025 drug treatment demand
continued



Risk factors

In 2025, 17.7% of cases reported that they had ever injected. Most of those were previously treated cases (89.9%). Among cases reporting ever injecting, 27.8% were currently injecting (i.e. in the 30 days prior to treatment).

- The proportion of cases reporting injecting has declined in the long term, from 29.7% in 2017 and from 18.7% in 2024
- Opioids were the most common main drug among cases currently injecting (76.7%), followed by cocaine
- Cocaine as a main problem drug has increased from 3.7% of cases currently injecting in 2017 to 10.1% of cases currently injecting in 2025

In 2025, 34.8% of cases who had ever injected also reported sharing needles and syringes, compared with 40.3% in 2024.

- Among cases currently injecting in 2025, 12.1% shared needles and syringes in the 30 days prior to starting treatment
- Since recording of information on sharing needles and syringes began in 2019, the proportion of cases reporting sharing has declined from 37.2% in 2019 to 34.8% in 2025

2025 drug treatment demand

continued

Risk factors

18%
of all cases ever injected

4%
of new cases ever injected

26%
of previously treated cases ever injected

Paula Tierney

1 Tierney P, Lynch T, O'Sullivan M and Carew AM (2026) *National Drug Treatment Reporting System, 2025 Drug Treatment Demand.* HRB StatLink Series 30. Dublin: Health Research Board. Available from: https://www.hrb.ie/publication/drug-treatment-demand-in-ireland-2025/

Digital marketing of health-harming products to children in Ireland – a focus on alcohol marketing

Background

A report prepared by the Institute of Public Health for the Online Health Taskforce examined children's engagement with marketing of specific health-harming products, namely: tobacco; e-cigarettes; alcohol; sunbeds; gambling; and high-fat, salt, sugar (HFSS) foods and drinks.[1] For the purposes of this *Drugnet* article, we focus on alcohol marketing.

Introduction

Children in Ireland are highly engaged in digital environments from an early age, with common access to smartphones, social media, and online platforms such as YouTube, TikTok, and Snapchat. This exposes them to extensive marketing of health-harming products, including alcohol, tobacco, e-cigarettes, gambling, and unhealthy foods, despite legal restrictions on their sale to children. Digital marketing is sophisticated and often indistinguishable from regular content, appearing through advertisements, influencer endorsements, embedded promotions, and interactive features. As a result, children may not recognise it as marketing.

Unlike traditional advertising, digital marketing is highly personalised. Platforms collect and analyse user data to deliver targeted content, increasing both the frequency and relevance of marketing exposure. This contributes to shaping children's attitudes, normalising harmful products, and influencing behaviours. Evidence shows that such exposure is linked to earlier experimentation and increased likelihood of long-term use, with associated health risks.

What do we know about the nature of digital marketing of health-harming products to children in Ireland?

The available evidence indicates near-universal internet access and increasing screen time among children. Many use social media below official age limits, with limited parental control; however, measuring the extent of children's exposure is difficult. There is a dearth of systematic evidence on the scale or type of digital marketing they encounter and no comprehensive monitoring systems, such as real-time screen capture, to accurately assess children's experiences online. Existing survey methods rely on recall, which is unreliable given the embedded and covert nature of digital marketing.

Marketing techniques used include influencer content, gamification, personalised advertisements and user-generated material, and alcohol marketing illustrates the issue clearly.

Alcohol and children – online sales and digital marketing

Although a delay in alcohol initiation has been noted, the majority of adolescents aged 17 and over drink. Studies show high levels of exposure to digital alcohol marketing, with many young people actively encouraged to engage with alcohol brands online. Greater exposure is strongly associated with increased likelihood of drinking, intentions to drink, and risky behaviours

Digital marketing of health-harming products to children

continued

such as binge drinking. However, evidence of up-to-date data on children's exposure to digital marketing or online alcohol sales is limited.

What is the Government's approach to children's engagement with digital marketing of health-harming products in Ireland

Ireland's policy response involves a mix of national legislation, European Union (EU) regulation, and industry self-regulation. Frameworks such as the Audiovisual Media Services Directive, the Online Safety and Media Regulation Act 2022, and the Digital Services Act (implemented in 2022 by Coimisiún na Meán, under the responsibility of the Department of Tourism, Culture, Arts, Gaeltacht, Sport, and Media, (now known as the Department of Tourism, Culture, Communications and Sport) set standards for protecting children, including restrictions on harmful advertising and requirements for online platforms to manage risks. The Public Health (Alcohol) Act 2018 provides additional protections. However, key gaps remain, particularly in relation to digital advertising, which is not fully covered by existing alcohol legislation. Age verification systems for online sales are weak, often relying on self-declaration, and there is no consistent requirement to verify age at delivery. Platform-level controls vary and rely on self-regulation.

What have Government Departments committed to do within their policies and strategies?

Government policies acknowledge the issue but are fragmented, with no single body responsible for monitoring children's exposure or coordinating actions. To address this gap and strengthen protections, the report recommends improved age verification (including potential use of banking controls), enhanced monitoring systems, and greater transparency from digital platforms. It also calls for routine inclusion of digital marketing exposure in national surveys and more comprehensive research on its impact.

Specifically for alcohol marketing, the report outlines short, medium and long-term goals outlined in Table 1.

Conclusion

Overall, addressing children's exposure to harmful digital marketing is identified as a significant public health and children's rights issue requiring coordinated and sustained action.

Digital marketing of health-harming products to children

continued

Table 1: Options to reduce digital sales and marketing of alcohol to children in Ireland

Term	Action
Short term (research)	Explore children's experience with alcohol sales through online markets (official and unofficial) and their experience of online marketing
	Include questions on children's exposure to online alcohol marketing through the Department of Health commissioning of the European School Survey Project on Alcohol and Other Drugs (ESPAD) study
	Include survey questions on online alcohol sales and marketing within the Department of Health Health Behaviour in School-aged Children (HBSC) survey
	Include survey questions on online alcohol sales and marketing to children within the Department of Children, Disability and Equality's Growing Up in Ireland (GUI) longitudinal study of children
	Develop a business case for introduction of an integrated monitoring system for online alcohol marketing exposures in Ireland
	Develop robust mechanisms to test age verification online
Medium term (legislation, policy/ strategy)	Assess the impact of the Public Health (Alcohol) Act 2018, and the advertising components in particular, on reducing children's overall exposure to alcohol marketing
	Commit to monitoring of children's online exposures to alcohol marketing within the forthcoming drug and alcohol strategy
	Having established a baseline level of children's exposure to online alcohol marketing, commit to reducing exposure by setting targets.
Long term (legislation)	Introduce regulations to limit digital alcohol marketing and sponsorship for all sporting events

Anne Doyle

O'Connor L, Reynolds CME and McAvoy H (2025) *Digital marketing of health-harming products to children in Ireland – options for further protections. A report developed by the Institute of Public Health for the Online Health Taskforce*. Institute of Public Health. Available from: https://www.drugsandalcohol.ie/44764/

National Drugs Library

Updates

Recent publications

Prevalence and current situation

School-level differences in self-harm and psychosocial problems associated with self-harm in adolescents

McEvoy D, Brannigan R, Healy C, Dooley N, Arensman E and Clarke M (2026) *Ir. J. Psychol. Med.*

Available from:
https://www.drugsandalcohol.ie/45486/

Dual disorders: an overview

Torrens M, Fonseca F, Gonzalez-Saiz F and Mestre-Pintó J (2026) *Ir. J. Psychol. Med.*

Available from:
https://www.drugsandalcohol.ie/45459/

Recreational nitrous oxide use: a growing trend with unintended consequences

Bakhshi S, O'Mahony S and McGorrian C (2026) *Ir. Med. J.*, 119, (4), p. 65.

Available from:
https://www.drugsandalcohol.ie/45513/

Advancing addiction science through the study of recovery trajectories

Ivers JH (2026) *Addiction*, Early online.

Available from:
https://www.drugsandalcohol.ie/45483/

Nurse prescribing of opioid agonist treatment in Ireland: evidence, governance, and the politics of drug policy decision-making

Kelly P, Comiskey C, McBrien B, Winstock AR and James P (2026) *Int. J. Drug Policy*, 149, 105153.

Available from:
https://www.drugsandalcohol.ie/44914/

Demographic and route to treatment differences between people using different substances in the Republic of Ireland: a comparative analysis using data from an EU-wide treatment demand protocol

James PD, Nash M, Comiskey C and Prakashini Banka Cullen S (2026) *J. Drug Issues*. Early online.

Available from:
https://www.drugsandalcohol.ie/45038/

Childhood gambling experiences and adult problem gambling

Ó Ceallaigh D, Timmons S, Robertson DA and Lunn P (2026) *Int. Gambl. Stud.* Early online, pp. 91-108.

Available from:
https://www.drugsandalcohol.ie/45005/

Recent publications

continued

Recreational nitrous oxide use: a growing trend with unintended consequences

Bakhshi S, O'Mahony S and McGorrian C (2026) *Ir. Med. J.*, 119, (4), p. 65.

Available from: https://www.drugsandalcohol.ie/45513/

'I don't really want to speak up because they're on a different level to me': the stigma of not engaging in trauma talk

Windle J and Cronin J (2026) *Int. J. Drug Policy*, 151, 105244.

Available from: https://www.drugsandalcohol.ie/45489/

Responses

Understanding and preventing drug-related interpersonal violence in Ireland through a public health approach

Comiskey CM, Marder ID and Corbally M (2026) *Int. J. Drug Policy*, 149, 105156.

Available from: https://www.drugsandalcohol.ie/45036/

Patterns of drug and polydrug detection in drivers suspected of driving under the influence of an intoxicant in Ireland 2019–2020: a latent class analysis

Durand L, O'Kane A, Maguire R, Cusack D, Keenan E and Cousins G (2026) *Drug Alcohol Rev.*, 45, (1), e70087.

Available from: https://www.drugsandalcohol.ie/44775/

Policy

An examination of public concerns relating to combined text and graphic alcohol warning labels: an all-Ireland cross-sectional study

Houghton F, Moran Stritch J, Shorter GW and Campbell A (2026) *Epidemiol. biostat. public health*, 21, (1).

Available from: https://www.drugsandalcohol.ie/44743/

Drugnet Ireland is the quarterly newsletter of Ireland's focal point for the EUDA and is produced in collaboration with the HRB National Drugs Library. *Drugnet Ireland* is published by the Health Research Board.

Managing editor: Brian Galvin
Copyediting: O'Hanlon Media

Health Research Board
Grattan House
67–72 Lower Mount Street
Dublin 2
D02 H638

T: 01 234 5168
E: drugnet@hrb.ie
W: www.hrb.ie