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Irish findings from the European Web Survey on Drugs

The National Drug and Alcohol Survey (NDAS) has been conducted five times in Ireland.¹ However, although the NDAS provides prevalence rates regarding drug use, it can only collect robust information on patterns of use for the more commonly used drugs, such as cannabis. It does not collect data from a sufficiently large sample of people who use drugs to provide reliable information on patterns of use for less frequently used drugs such as ecstasy, amphetamines, and new psychoactive substances (NPS).

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has developed the European Web Survey on Drugs (EWSD) to collect data from a wide range of people who use drugs. In 2021, Ireland participated in the EWSD for the first time. The rationale for this was to generate new data on patterns of drug use, as set out in Action 5.1.45 of Ireland's National Drugs Strategy. The data collected provided information on:

- The frequency of drug use by drug type
- Drug use patterns according to sex and age
- The reasons why people use drugs, by drug type
- The main sources used to obtain drugs
- The impact of the Covid-19 pandemic on drug use.



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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

In brief

There has been a great deal of commentary recently on the United Kingdom (UK) government's stumbling efforts to increase economic growth through a combination of radical changes in tax and in employment and environmental regulations. The goal itself is seen as desirable: who would be against a sustained effort to increase national income and make resources available to pay people more and provide for the type of services expected in an advanced economy? It is the UK government's reckless approach and strangely politically illiterate arguments that have generated the most interest, not the pursuit of economic growth as a policy goal. Ireland has measured its relative success in terms of increases in national wealth and, while the narrow basis on which this is built and the gloomy global outlook are causes for concerns, the nature of the growth being sought has changed little in recent decades.

Some commentators have taken the opportunity presented by the political and economic upheaval in the UK to look more closely at what economic growth means and what it contributes to improving the lives of ordinary citizens and providing security for the future. Green political thinking has often questioned the pursuit of growth, sometimes even championing an economic policy that eschews growth as a realisable or desirable goal, as it necessarily entails the exploitation of scarce resources and environmental damage. While this approach is unlikely in modern industrial economies, some governments have explored ways to integrate measurements of factors besides industrial output into assessments of national wealth. Instead they have developed non-economic indicators to measure quality of life, encompassing spheres such as family and relationships, health, education, and sustainability. New Zealand has incorporated a wellbeing budget into its economic planning, recognising expressions of life satisfaction as a gauge of its population's capacity to contribute to economic and social goals.

This is a very different challenge to economic orthodoxy than we have seen from the revolutionaries currently governing the UK, but it is more thoughtful and anticipates possible changes across policy fields in the coming decades. The rhetoric of the European Union's mid-2000s 'health in all policies' project has not been fulfilled but there are clear indications that Western democracies will see an expansion of the public sphere in the coming years and with it an extension of health policy beyond medicine and health services. Governments are asking what are the determinants of poor health outcomes and how can they be changed? Some are societal, which is particularly true regarding problematic substance use, and some are behavioural and biological, reinforcing negative outcomes for those already at risk.

Trends do not necessarily predict what will happen in the future. Governments can use what we know about the determinants of health to develop a more holistic and integrated approach to health planning and produce better health outcomes. Health planning will not just be about inputs and an ever-expanding health budget, but will be built on a clear understanding of how work, education, environmental factors, and social equity can be combined to bring about a healthier population and greater prosperity. For those working in alcohol and other drug policy and response development, this changing policy environment presents challenges and opportunities. There is no other sector with a clearer understanding of the social determinants of health and the importance of a community approach to realising a better future. These experiences and insights, the capacity for collaborative work, and a recognition of the importance of democratic participation will be real assets in the wider project of building a healthier and safer society.

European Web Survey on Drugs

continued

The 2021 Irish EWSD was an online, convenience, non-probability survey. The study population included people aged 18 years and over, who lived in Ireland, and who had used drugs in the previous 12 months. A total of 27,001 web users clicked onto the Irish EWSD survey link and landed on the homepage of the survey: 8,104 web users agreed to participate in the survey, of whom 5,796 were eligible. The main findings from the Irish EWSD are discussed below.²

Last-year and last-month drug use

Last-year and last-month use of each drug is presented in Table 1. Cannabis was the drug most commonly used in the last year (91%), followed by cocaine (49%) and ecstasy (31%). The proportion of respondents reporting last-year ketamine use was also high (24%). For most drugs, the proportions of males and females reporting use were similar; however, males were more likely than females to report last-year and last-month use of magic mushrooms and LSD.

For most drugs, last-year and last-month use varied by age group. While there was little difference in cannabis use between age groups, younger respondents were more likely than older respondents to report use of stimulants such as cocaine and ecstasy. One-third (34%) of 18–24-year-olds reported last-year ketamine use, compared with 20% of 25–34-year-olds, 9% of 35–44-year-olds, and 5% of those aged 45 years and over. The top three most commonly used drugs in the last year were the same for each age group; however, older respondents were more likely to use amphetamines and magic mushrooms, while ketamine was more commonly used among younger age groups (see Figure 1).

More than one-third (36%) of respondents reported use of one drug in the last year, while 44% reported using at least three different drugs in the last year. Males were more likely than females to have used three or more drugs in the last year (46% vs 41%), while those aged 18–24 years were most likely to have used three or more drugs in the last year (53%).

Reasons for using drugs

The main reasons respondents used drugs varied by drug type. The primary reason for using cannabis (all types) was to reduce stress (80%), while getting high was the primary reason for using cocaine, ecstasy, amphetamines, and NPS (see Figure 2). Males were more likely than females to use cannabis to get high (79% vs 69%) and to socialise (50% vs 41%). A high proportion of cannabis users reported using cannabis to treat a number of physical and mental ailments: 46% used it to treat depression or anxiety and 32% used it to reduce pain. Older respondents (aged 35 years and over) were most likely to use cannabis to reduce pain (42%) and were least likely to use it in order to get high (67%) or to socialise (34%). Amphetamines were the drug most commonly used to enhance performance, with 26% of respondents using them for this purpose. NPS users were much more likely than users of other drugs to cite curiosity as a reason for use (58%).

How drugs are sourced

Those who had purchased drugs in the last year were asked what methods they usually used to do so. For each drug, with the exception of NPS, the majority of users typically obtained the drug through direct contact with their source (see Figure 3). Social media was used by 22% of cannabis herb users; however, this decreased to 7% among amphetamine users. The darknet was most commonly used by those purchasing NPS (20%); in comparison, just 3% of cocaine users obtained cocaine using the darknet.

Table 1: Last-year and last-month drug use among respondents, by sex

	Last-year drug use (%)			Last-month drug use (%)		
	All	Males	Females	All	Males	Females
	n=5796	n=3815	n=1895	n=5796	n=3815	n=1895
Cannabis	91.2	92.0	89.8	69.5	73.0	62.4
Cocaine	48.5	48.3	49.4	22.9	23.0	23.0
Ecstasy	30.8	30.7	31.4	6.2	6.3	6.0
Ketamine	23.8	24.9	22.0	7.1	7.4	6.4
Magic mushrooms	22.1	24.5	17.2	4.9	5.5	3.8
LSD	18.8	21.5	13.3	4.4	5.1	2.9
NPS	14.3	14.4	14.2	5.8	5.4	6.6
Amphetamines	10.8	11.3	10.0	3.0	3.3	2.4
Methamphetamine	3.9	4.3	3.3	1.1	1.3	0.7
GHB	2.1	2.6	1.0	0.7	0.8	0.3
Heroin	1.1	1.2	0.8	0.6	0.7	0.3

Source: EWSD, 2022

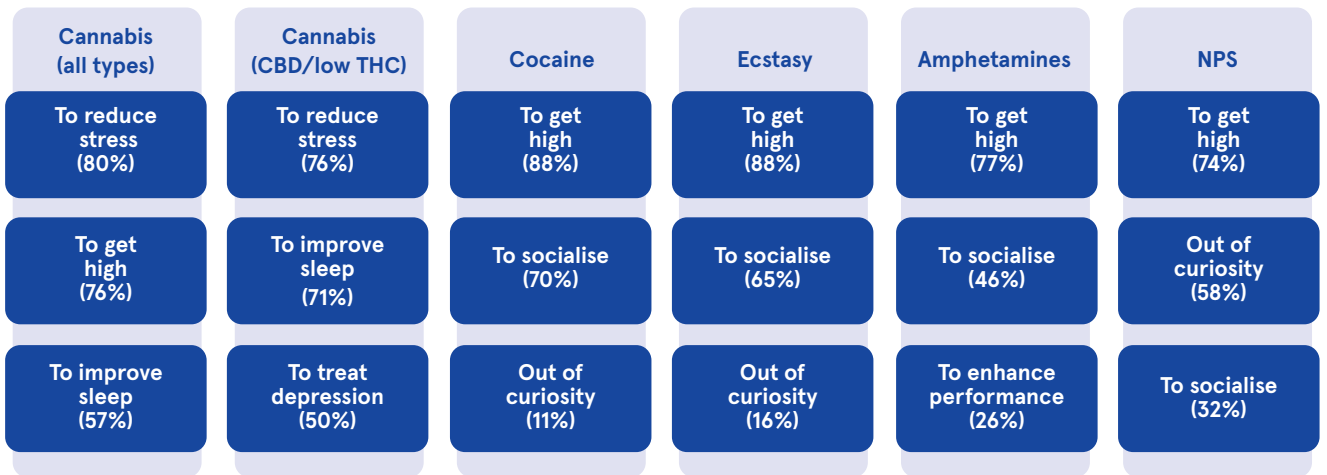
NPS: new psychoactive substances; GHB: gamma-hydroxybutyrate.

European Web Survey on Drugs continued

18–24 years	25–34 years	35–44 years	≥45 years
<ul style="list-style-type: none"> • Cannabis (95%) • Cocaine (51%) • Ecstasy (35%) • Ketamine (34%) • LSD (25%) 	<ul style="list-style-type: none"> • Cannabis (89%) • Cocaine (51%) • Ecstasy (30%) • Magic mushrooms (24%) • Ketamine (20%) 	<ul style="list-style-type: none"> • Cannabis (87%) • Cocaine (42%) • Ecstasy (25%) • Magic mushrooms (19%) • Amphetamines (12%) 	<ul style="list-style-type: none"> • Cannabis (88%) • Cocaine (28%) • Ecstasy (19%) • Magic mushrooms (15%) • Amphetamines (9%)

Source: EWSD, 2022

Figure 1: Drugs most commonly used in the last year, by age group

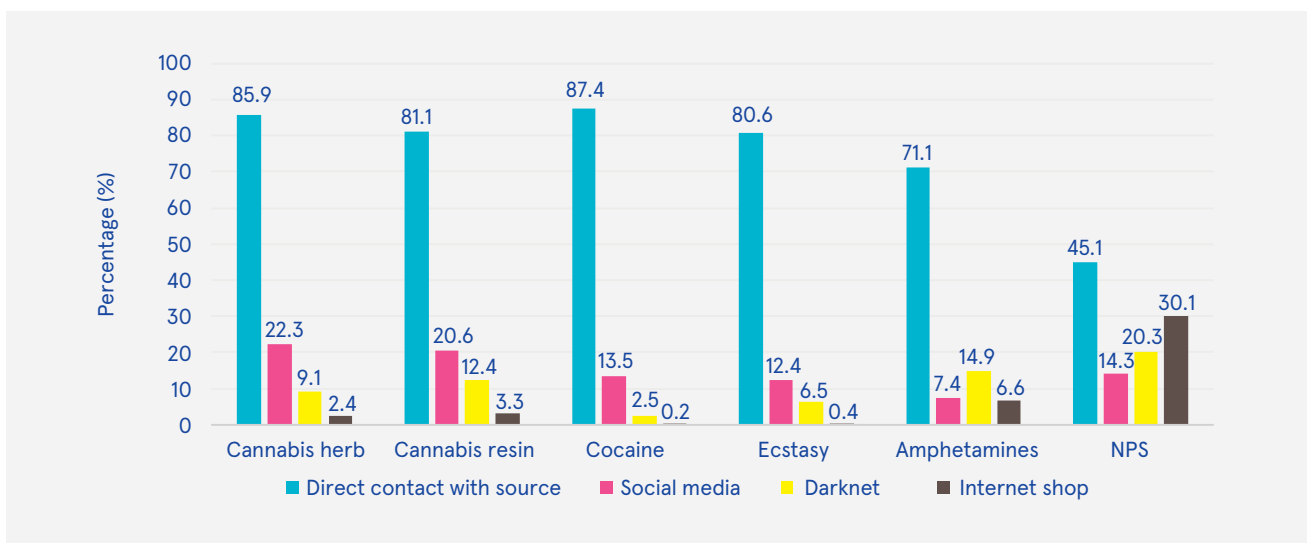


Source: EWSD, 2022

CBD: cannabidiol; THC: tetrahydrocannabinol; NPS: new psychoactive substances.

Note: Respondents could select more than one option.

Figure 2: Top three reasons for using drugs, by drug type



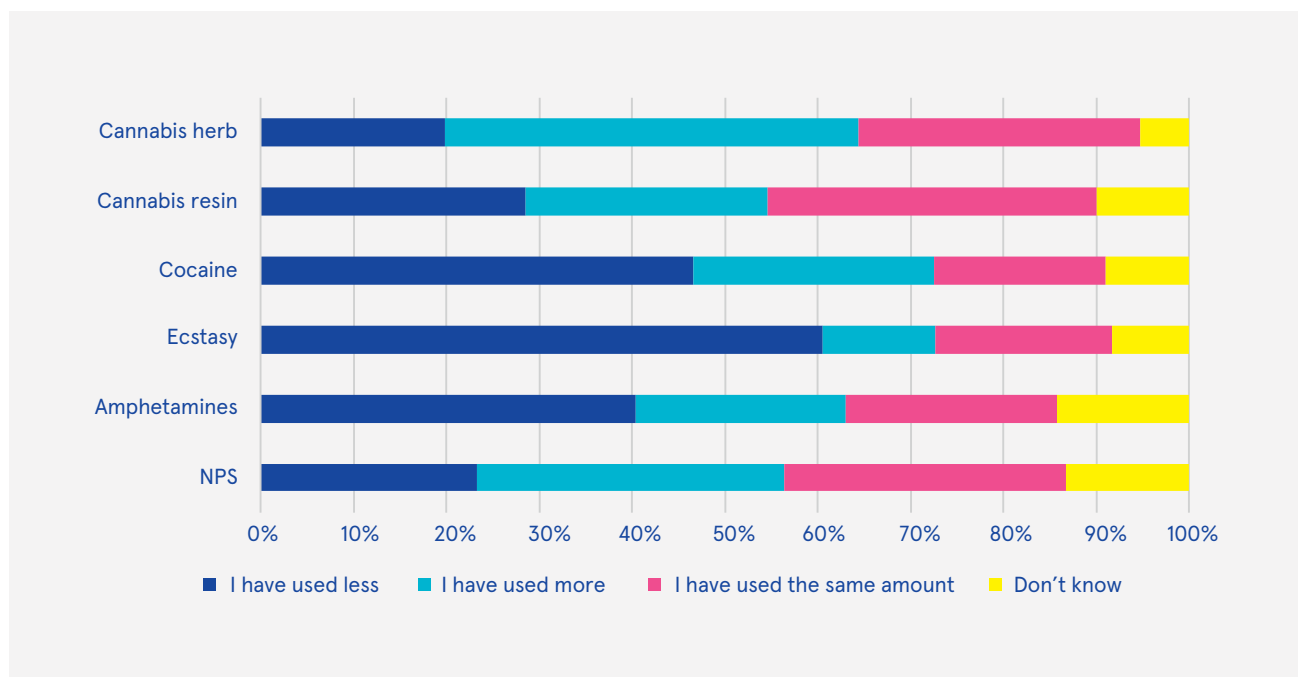
Source: EWSD, 2022

NPS: new psychoactive substances.

Note: Respondents could select more than one option.

Figure 3: Methods used to buy drugs among those who bought drugs in the last year, by drug type

European Web Survey on Drugs continued



Source: EWSD, 2022

NPS: new psychoactive substances.

Figure 4: Change in drug use due to the Covid-19 pandemic, by drug type

Impact of Covid-19 pandemic on drug use

In each of the EWSD modules, respondents were asked if their use of that drug had changed as a result of the Covid-19 pandemic. A high proportion of respondents reported using less ecstasy (61%), while 12% reported increased use. In comparison, just 20% of cannabis herb users reported reduced use, while 45% reported increased use. One-third (33%) of NPS users and one-quarter (26%) of cocaine users also reported increased use (see Figure 4).

Conclusions

The report authors note that when interpreting the Irish EWSD results, it is important to acknowledge that they are likely to have been influenced by the Covid-19 pandemic and the resultant restrictions on movement that arose from it. The finding that 24% of respondents indicated that they had used ketamine in the last year is of particular interest, as this is considerably higher than the overall proportion reported by the EMCDDA (13%).³ This suggests that ketamine use should be included in future NDAS surveys in Ireland. The last-year prevalence of cocaine use was also high among Irish EWSD respondents at 49%, compared with 34% among the entire European EWSD sample.³ In their conclusion, the EWSD report authors suggest that online surveys may be a useful tool for collecting information on patterns of drug use from a large number of people, both quickly and cost-effectively, and that online surveys may complement other traditional data sources such as general population and school surveys.

Seán Millar

- 1 Mongan D, Millar SR and Galvin B (2021) *The 2019–20 Irish National Drug and Alcohol Survey: main findings*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/34287/>
- 2 Mongan D, Killeen N, Evans D, Millar SR, Keenan E and Galvin B (2022) *European Web Survey on Drugs 2021: Irish results*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/36571/>
- 3 European Monitoring Centre for Drugs and Drug Addiction (2022) *European Web Survey on Drugs 2021: top level findings, 21 EU countries and Switzerland*. Luxembourg: Publications Office of the European Union. <https://www.drugsandalcohol.ie/35518/>



POLICY AND LEGISLATION

Gender and drug policy

The mission of the Pompidou Group (Council of Europe International Cooperation Group on Drugs and Addictions) is to contribute to the development of multidisciplinary, innovative, effective, and evidence-based drug policies in its member states.¹ Since the late 1980s, it has worked to support the integration of a gender dimension into drug policies and has delivered on a number of activities in this area.² Its latest output on this issue is *Implementing a gender approach in drug policies: prevention, treatment and criminal justice. A handbook for practitioners and decision makers*.³

Handbook development

Due to restrictions linked to the Covid-19 pandemic, the handbook is the result of extensive online consultation involving 13 countries, including Ireland. The Irish team is made up of representatives from academia, the Department of Health, and drug services. As part of their work, they published a paper on gender and Irish drug policy in April 2020, which was reported in issue 74 of *Drugnet Ireland*.^{4,5}

Aim of the handbook

The handbook aims to support the integration of a gender dimension into drug policy and practice. It provides policymakers and practitioners in the field with 'evidence-based and operational recommendations to develop and implement policies and interventions that better integrate specific gender needs (gender-sensitive approach⁶) and support more gender equity (gender-transformative approach⁷) for people concerned with the provision of drug-related prevention and care (risk and harm reduction, treatment, reintegration), including in the criminal justice system' (p. 11).³

Gender diversity

The handbook also represents the first attempt by the Pompidou Group to be trans-inclusive in an output from their work on gender. However, given that the vast majority of the existing evidence relating to gender and drugs relates to women, this forms the basis of the handbook's analysis and recommendations. The authors recognise the need to take account of greater gender diversity and, where possible, integrate evidence relating to transgender people of all genders.

Handbook content

The handbook presents evidence and draws on the experiences of member states to illustrate innovative and relevant practices for readers to draw upon. The introduction explores the gender-related concepts used in the handbook, as well as the rationale for supporting gender-sensitive approaches and the associated principles for sustaining them. The first of three core chapters provides an overview of the epidemiological evidence on gender-based differences in drug use and related consequences, as well as how gender issues are taken into account in existing European drug policies and interventions.

Chapter 2 is aimed at policymakers. It identifies what the authors consider 'essential elements' that decision-makers can incorporate into drug policies and the implementation of plans and programmes. Underpinning this chapter is the concept of gender mainstreaming, which is defined as 'systematic consideration of the differences between the conditions, situations and needs of women and men in all policies and actions' (p. 88). Essentially this means incorporating the gender perspective as part of the whole process – monitoring and describing the situation; developing strategies and action plans; evaluating action plans; and budget development and allocation.

Chapter 3 is targeted at practitioners working in drug prevention, harm reduction, treatment, and criminal justice. The authors acknowledge the challenges faced by practitioners in implementing more gender-sensitive and transformative approaches to existing interventions. They outline examples of where needs are being addressed with a view to highlighting innovations in theory and practice.

Lucy Dillon

- 1 For more information on the activities of the Pompidou Group, visit: <https://www.coe.int/en/web/pompidou/about>
- 2 For more information on the gender-related activities of the Pompidou Group, visit: <https://www.coe.int/en/web/pompidou/activities/gender>
- 3 Mutatayi C, Morton S, Robles Soto N, Pálsdóttir KI and Vale Pires C (2022) *Implementing a gender approach in drug policies: prevention, treatment and criminal justice. A handbook for practitioners and decision makers*. Strasbourg: Council of Europe. <https://www.drugsandalcohol.ie/36974/>
- 4 Morton S, Devaney E, O'Connor K, McKeown P and Harris A (2020) *Gender and Irish drug policy: report submitted to the working group as part of the 'Implementing a gender approach in different drug policy areas: from prevention, care and treatment service to law enforcement' project*. Dublin: University College Dublin and Department of Health. <https://www.drugsandalcohol.ie/31888/>
- 5 Dillon L (2020) Gender and drug policy. *Drugnet Ireland*, 74 (Summer): 9–11. <https://www.drugsandalcohol.ie/32730/>
- 6 Gender-sensitive policies and programmes (WHO definition, as cited on p. 88 of Mutatayi *et al.* above): 'Consider and acknowledge gender norms, roles and inequalities but take no action to address them; and/or are similar to gender aware (awareness of the issue), which does not necessarily mean that something is then done about it'. See World Health Organization (WHO) (2021) *Classification framework for gender responsiveness of policies and programmes*. Geneva: WHO.
- 7 Gender transformative (WHO definition, as cited on p. 89 of Mutatayi *et al.* above): 'Recognize differences in gender roles, norms and access to resources; and/or actively try to change these, to promote gender equality'. See WHO (2021) *Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2016–2021: actions for impact*. Geneva: WHO. <https://www.drugsandalcohol.ie/34388/>

Assessment tool for human rights

The Pompidou Group (Council of Europe International Cooperation Group on Drugs and Addictions) is the Council of Europe's drug policy cooperation platform. Upholding the core values of the Council of Europe – human rights, democracy, and the rule of law – is central to the group's mission. To support a human rights approach to drug policy internationally, it has published *Human rights in drug policy: a self-assessment tool* to be used in assessing drug policy compliance with human rights.¹

Human rights in drug policy

Internationally, there is an increasing emphasis on adopting a human-rights-based approach to drug policy. In their foreword, the authors argue that 'promoting and supporting worldwide evidence-based policies, strategies and interventions that are based on a public health and human rights can be an important way to reduce drug use and the health and social burden it causes' (p. 5). However, translating the principles of human rights into policy and practice can be challenging, with growing calls for the development of human rights indicators for drug policies.

Pompidou Group response

In response to this, the Pompidou Group set up an expert group in 2020 to develop a tool that allows for a self-assessment and internal evaluation of drug policies and programmes with respect to human rights standards under existing legal instruments. These include the work undertaken by the United Nations Office on Drugs and Crime; United Nations High Commissioner for Refugees; Office of the United Nations High Commissioner for Human Rights; and other stakeholders. The new tool is the output of the work of this expert group on drug policies and human rights.

Aim and approach of the tool

This strand of work by the Pompidou Group aims to help address the challenge of assessing human rights in drug policy. The authors recognise the complexities involved in making such an assessment given that there tends not to be standardised indicators in this area, and that both human rights laws and drug policies are both very broad and complex topics. In its simplest terms, 'the aim of this tool is to provide a straightforward entry point for human rights assessment across key issues. ... By linking key topics to human rights standards and more specific probing questions, its aim is to provide a practical framework to investigate and assess the human rights implications of drug laws, policies and practices' (p. 8). It is envisaged as a tool to be used by member states internally, on a voluntary basis, and not with the aim of comparing states. It should support work across ministries to understand, reform, and progress drug policies so that they are more compatible with human rights. The authors describe the tool as 'exploratory, aiming to assess the current situation and invite discussion, debate and inquiry across responsible ministries' (p. 12).

Conceptual framework

The tool is a framework presented in table format and is structured around three themes.

- 1 Social and welfare:** Assessing general anti-discrimination protection, social welfare conditionality, data protection and privacy, child custody, and school-based prevention.
- 2 Health and treatment:** Assessing access to drug treatment and risk and harm reduction services, compulsory drug treatment, detention due to addiction or intoxication, and conditions of drug treatment.
- 3 Law enforcement and criminal justice:** Assessing alternatives to criminal sanctions for drug use/possession for personal use, arrest and interrogation, crimes involving freedom of expression, imprisonment and pre-trial detention, and conditions of detention (drug treatment and risk and harm reduction services).

Under each theme there is a column that looks at the issue and rationale; followed by a column with a set of assessment questions; three columns for assessment criteria (low risk of human rights concerns, need for further investigation, and potential need for remedial action); and a final column for the human rights treaty provisions and sources for guidance and enhancing policies.

For example, school-based prevention is explored as part of the social and welfare theme. The aim of the section is to draw attention to the human rights/child rights aspects of drug prevention in school. Among the 'issues and rationale' raised about this are concerns about the use of drug testing, sniffer dogs, and strip searches. The assessment questions include whether national guidelines on school-based prevention take account of the child's right to privacy and education, and if there are consequences for a refusal to do a drug test, for example. An assessment is then made depending on the responses to these questions and the relevant parts of the human rights laws and treaties cited.

Concluding comment

This self-assessment tool provides a user-friendly framework through which complex questions can be approached. Its use could provide valuable opportunities for cross-ministry discussion on key policies and their compliance with a health-led and human rights approach to dealing with drug issues.

Lucy Dillon

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



New funding for drug prevention in Ireland

On 22 September 2022, the Department of Health launched its new Prevention and Education Funding Programme.¹ As part of a wider suite of activities, the Department is undertaking to enhance the area of prevention and education. The fund aims to increase the focused delivery of prevention programmes, supported by the best possible evidence, among the school/university age population. The programme is designed to strengthen the prevention of drug, alcohol, and tobacco use and the associated harms among this cohort.

Background

The new fund reflects an ongoing focus on prevention in Ireland's national drugs strategy.² Prevention has been a goal of the national drugs strategy since its inception in 2017. The mid-term review of the strategy, published in late 2021, identified six strategic priorities which aim to strengthen the implementation of the national drugs strategy for the period 2021–2025.³ They take account of the lessons and the stakeholder feedback from the mid-term review, as well as reflecting commitments in the Programme for Government.⁴ The first of the six strategic priorities focuses on prevention. It aims to strengthen the prevention of drug and alcohol use and the associated harms among children and young people. Given the strategy's commitment to prevention programmes that are evidence-based, adhere to quality standards, and involve participants in programme design and implementation, activities under this strategic priority (including the new fund) are to adhere to international prevention standards, including those of the European Prevention Curriculum (EUPC) and the United Nations Office on Drugs and Crime (UNODC)/World Health Organization (WHO).

Call for applications for funding

The Department has opened applications for funding under the new Prevention and Education Funding Programme. It is open to drug and alcohol taskforces, Health Service Executive (HSE) Community Healthcare Organisations (CHOs), the community and voluntary sector, and academic bodies. The programme will support up to five prevention initiatives, costing up to €100,000 a year for a period of three years. Initiatives are to be delivered at local level across Ireland. The funding is aimed specifically at introducing effective, evidence-based programmes, or building on current evidence-based initiatives already in Ireland within school, youth work or community-based settings.

There are five funding streams within the programme that reflect a range of delivery settings: school, general youth/community, family, higher education, and broader environmental prevention activities. The deadline for applications is 11 November 2022. More details of the funding streams and the application process can be found on the Department of Health's website.¹

Lucy Dillon

- 1 For further information on the funding streams and application process of the Prevention and Education Funding Programme, visit: <https://www.gov.ie/en/publication/25a2f-department-of-health-prevention-and-education-funding-programme/?referrer=http://www.gov.ie/pefp-opencall/>
- 2 Department of Health (2017) *Reducing Harm, Supporting Recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/27603/>
- 3 Drugs Policy and Social Inclusion Unit (2021) *Mid-term review of the national drugs strategy, Reducing Harm, Supporting Recovery and strategic priorities 2021–2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/35183/>
- 4 Fianna Fáil, Fine Gael, and the Green Party (2020) *Programme for Government: our shared future*. Dublin: Department of the Taoiseach. <https://www.drugsandalcohol.ie/32212/>

What Works Ireland Evidence Hub – call for submissions

The Department of Children, Equality, Disability, Integration and Youth (DCEDIY) has issued a call for submissions to their new prevention and early intervention (PEI) What Works Ireland Evidence Hub.^{1,2}

What Works

DCEDIY's What Works: Sharing Knowledge, Improving Children's Futures initiative was launched in June 2019. It seeks to embed and enhance knowledge and quality in PEI in children and young people's policy, service provision, and practice. There are four core strands to this work, which focus on data, evidence, professional development and capacity, and quality. Adding to this work, DCEDIY is setting up a What Works Ireland Evidence Hub and in September 2022 called for programmes to populate the evidence hub.

DCEDIY is working with the Early Intervention Foundation (EIF)³ and the Centre for Effective Services⁴ to develop the evidence hub of PEI programmes. It will be an online tool designed to increase access to effective PEI programmes for policymakers, service commissioners, providers, and other audiences. To support this work, DCEDIY has launched a call for submissions from those who have developed and provided PEI programmes in Ireland (or were involved in their evaluation) and who would like their programme to be included on the evidence hub. It is interested in programmes from a wide range of areas meeting PEI needs. Among the essential qualifying criteria is that the programme must be designed to improve one or more of a set of specified outcomes in children and young people. These outcomes include preventing substance use. Assessment for inclusion on the evidence hub will be based on the existing EIF Guidebook⁵ in the United Kingdom, which provides details of PEI programmes that have been evaluated and show some evidence of improving outcomes for children and young people.

The Irish evidence hub will contain information on over 100 PEI programmes that are already included on the EIF Guidebook, in addition to 10 programmes in Ireland that will be assessed for evidence of their impact. Programmes will be assessed by

What Works Evidence Hub continued

the EIF using its standards of evidence, which appraise the strength of the evidence for a programme's effectiveness. Five programmes will be selected for assessment in the 2022–23 financial year, while an additional five will be assessed in 2023–24. The closing date for submissions of an expression of interest for inclusion on the evidence hub is 8 November 2022 and DCEDIY plans to launch the hub in 2023.

Lucy Dillon

1 For further information on the DCEDIY evidence hub, visit: <https://whatworks.gov.ie/what-works-ireland-evidence-hub/>

2 Department of Children, Equality, Disability, Integration and Youth (DCEDIY) (2022) *What Works Ireland Evidence Hub: open call for programmes*. Dublin: DCEDIY. <https://www.drugsandalcohol.ie/37151/>

3 For further information on the Early Intervention Foundation, visit: <https://www.eif.org.uk/>

4 For further information on the Centre for Effective Services, visit: <https://www.effectiveservices.org/>

5 For further information about the EIF Guidebook, which is an online searchable database of PEI programmes, visit: <https://guidebook.eif.org.uk/>

No place for cheap alcohol – the potential value of minimum pricing for protecting lives

Background

Alcohol use as well as the associated harms in the World Health Organization (WHO) European Region is among the highest in the world. A combination of population-level measures are recommended by WHO to address alcohol use and related harms. Key to the recommendations are measures that focus on limiting alcohol advertising, availability, and affordability, the latter including minimum pricing. The use of minimum pricing and minimum unit pricing (MUP), along with its strengths and limitations and evidence of its impact, are examined in a 2022 WHO report.¹

Objections commonly raised in response to minimum pricing and MUP are also addressed in the report and evidence-based counterarguments are provided. The report also examines legal issues relating to minimum pricing policies and provides an overview of different minimum pricing models as well as offering considerations for implementation, enforcement, monitoring, evaluation, and revision of minimum pricing policies.

Key findings

Policy mapping – which countries and regions have a minimum price for alcohol?

The report highlights that many countries do not use alcohol pricing policies and alcohol taxation approaches in their alcohol policies, despite being recommended by WHO, as well as being an economical approach with proven effectiveness in reducing alcohol use in heavier drinkers (and consequently alcohol-related harms). Alcohol taxation is common throughout the WHO European Region but is implemented in such a way that it has limited effectiveness in reducing harms. Eleven of the 14 countries globally with minimum pricing policies in

place are located in the WHO European Region. Ireland is one of just four countries with a MUP on all alcoholic drinks. The report compares the minimum price for alcohol products internationally and notes that the MUP in Ireland (€1 per 10 g) is among the highest.

Evidence for minimum pricing

The report outlines the evidence available to support the effectiveness of minimum pricing. This includes the indirect evidence that increasing the price of alcohol reduces the amount of alcohol consumed and in turn reduces alcohol-related health and social harms. Simulation modelling studies also conclude that greater benefits are seen with the highest minimum price and conclude that minimum pricing can reduce healthcare costs, crime, and workplace absences caused by alcohol. Direct evaluation studies demonstrating the impact of minimum pricing are also outlined in the report. They include how in Australia's Northern Territory, alcohol use declined by 8% in the year following the introduction of MUP and that rates of alcohol-related ambulance callouts, emergency department presentations, assaults, arrests for being dangerously intoxicated, road-traffic collisions, and child protection cases all declined.²

Common objections to minimum pricing policies

Those who challenge minimum pricing argue that it costs moderate drinkers financially, despite being specifically targeted at the heaviest drinkers. However, this has been rebutted by the evidence outlined in the report.³ It has also been claimed that minimum pricing penalises those on lower incomes and indeed the report does acknowledge that more deprived heavier drinkers are more affected by minimum pricing. However, they are also the drinkers suffering the most harm and thus the cohort specifically targeted to reduce harm and health inequalities. A common objection are the costs to businesses and the economy, and it is acknowledged in the report that minimum pricing policies do reduce the total volume of alcohol sold. However, it is countered by an increase in the average prices paid, meaning little or no negative impact on the alcohol sector. In addition, less alcohol-related harm and associated gains in economic productivity will accrue to all sectors of the economy.

Also proposed as an argument against minimum pricing is that it costs the government money as it reduces government revenue from alcohol taxes. Although true, the costs borne are undoubtedly exceeded by reductions in costs associated with alcohol harm. Illicit consumption or production and/

Value of minimum pricing for protecting lives continued

or cross-border trade may increase with the introduction of minimum pricing. However, the evidence suggests this is not common and the authors recommend complementary policies to address unrecorded alcohol use.

It is also argued that dependent drinkers will not change their drinking. However, the authors make an important observation: the majority of very heavy drinkers are not dependent and there is strong evidence that they will reduce their consumption when prices rise. However, there is evidence of some unintended negative impacts on dependent drinkers, and additional supports should be considered for this group. Finally, it is claimed by those who oppose minimum pricing policies that it will increase alcohol industry revenue. The authors agree, but also propose that complementary use of taxation or other policies could be used to recoup some of this revenue.

Legal issues relating to minimum pricing policies

The report includes a chapter analysing the compatibility of minimum pricing policies with relevant free movement of goods provisions in legislation pertaining to the European Union (EU), World Trade Organization, and Eurasian Economic Union.

Considerations after minimum pricing has been implemented

Once legislation commencing minimum pricing has been passed, of equal importance is how the policy will be practically implemented and enforced, monitored and evaluated, and reviewed and revised over time. The report outlines examples of how this is done in countries with minimum pricing in place along with recommendations.

Choosing the most appropriate pricing policies

Throughout the report, minimum pricing and MUP have been shown to be an effective approach to reducing alcohol use and associated harms, and the evidence indicates that such policies are most effective when used in combination with other measures to reduce alcohol affordability and improve public health. This chapter of the report outlines important considerations for policymakers to assist in informing decision-making by examining different minimum pricing models.

Conclusion

This report outlines the growing evidence that the potential minimum pricing (including MUP) has in reducing alcohol-related harms across the WHO European Region when implemented as part of a suite of measures. By targeting the cheapest, highest-strength alcohol, the heaviest drinkers who experience the highest rates of harm will be the most impacted. Policymakers considering introducing minimum pricing measures should consider the drinking patterns and harm profiles unique to their jurisdictions as well as their needs and technical capacity.

Anne Doyle

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RECENT RESEARCH

An integrative review on service user participation

The Irish national drugs strategy¹ aims to encourage those who are using drug services to play a greater role in their own treatment and actively participate in service development through consultation with service providers and health service management. On behalf of the Department of Health, the Health Research Board (HRB) commissioned a report to systematically review and synthesise the international evidence on service user consultation in drug treatment, harm reduction, and recovery services.²

This report presents a narrative synthesis of selected literature on this topic and the findings from consultations with stakeholders in Ireland and other countries and interviews with service users.

This study is described as an integrative review because it draws on several different sources of information on service user involvement, including different kinds of publications and interviews with a range of different actors.

Review questions

This evidence review answers the following research questions:

- 1 What are the characteristics of service user involvement in drug treatment services as understood in official guidelines, research literature, and advocacy documents?
- 2 What are service users' experiences of the consultative process and what aspects of service user involvement have been shown to facilitate or impede successful participation?
- 3 What are service providers' experiences of the consultative process and in what ways does their understanding of the goals of participation differ from that of service users?
- 4 What outcomes are associated with service user consultation in drug treatment and recovery services?

Methods

To address the first question, the review team undertook an extensive search of the academic literature and of official reports, unpublished research, and advocacy documents.

An integrative review on service user participation continued

The review followed an eight-step process, starting with the definition of the literature search and ending with a narrative synthesis of eligible documents. The search included a range of bibliographic databases, including Embase.com, as well as the websites of relevant organisations. In total, the search identified 10,024 records using research databases and found a further 579 potentially eligible documents by searching websites. After carefully reading each eligible article and report, the authors identified themes and gathered the empirical evidence. The themes were defined in an iterative fashion as the literature was analysed.

The second and third research questions inquire about the experiences of service users and providers with respect to user involvement, including any tensions and conflicts that may emerge between these two groups. To address these two questions, the review team drew on interviews with stakeholders and service users, which were carried out specifically for this purpose.

The authors extended the scope of the evidence review and consulted 18 stakeholders from Ireland and other countries, including researchers, administrators, user representatives, and professionals. These consultations took the form of semi-structured online (Zoom) interviews lasting between 45 and 90 minutes each.

Key findings

The review presents the findings of the literature review, the consultation with stakeholders, and the interviews with service users under three thematic headings.

Theme 1: The relationship between service users and practitioners

The issue that is most consistently emphasised in the academic literature on service user involvement is the need to establish collaborative relationships between staff and the people who use services. Researchers have presented strong evidence to support the view that being treated with respect, not being judged, and being valued as a person are fundamental characteristics of this two-way relationship. This facilitates the establishment of a bond that is based on trust, which in turn leads to more effective and open communication and a stronger focus on mobilising the resources and knowledge that the service user brings to the encounter. In the absence of trust, service users may avoid sharing sensitive information, resist or oppose the recommendations of staff, or drop out of treatment.

Theme 2: Social power

One of the most important structural features that inhibits the development of trusting, collaborative relationships within the treatment setting derives from asymmetries in power, status, resources, and professional authority. Because of the inherited culture of drug treatment systems, service users are often stigmatised at the same time as they are provided with assistance. This places great pressure on treatment providers to distance themselves from service users.

Academic research has described the links between societal, institutional, and internalised forms of stigma, which impact on all aspects of the encounter between people who use drugs and treatment services. Stigma often imposes a penalising identity on service users, which affects how they are treated

by health services, pharmacies, social welfare services, housing organisations, and drug treatment services. Stigmatisation processes are also refracted by gender, ethnicity, social class, and other characteristics, creating specific difficulties for women with young children, immigrants, Travellers, and the residents of poor neighbourhoods, as these forms of stigma interact and reinforce each other.

Theme 3: Organisational practices

The organisational context of drug treatment, recovery, and harm reduction services generates a number of mechanisms that can either facilitate or impede service user involvement. A fundamental insight emphasised in the academic literature is that formalistic approaches to service user involvement, which equate this with institutional innovations like service user forums, care plans, or charters, are unlikely to achieve their goals. This is because they ignore the fact that relationships, power, and rules are closely intertwined, and making progress towards user involvement requires coordinated movement along all three axes.

Researchers often contrast shared decision-making with the paternalistic model of service provision, where practitioners are assumed to know what is best for their clients. Although the evidence is somewhat mixed, the concept of shared decision-making appears useful. For example, the evidence on choice of treatment provider and personal treatment budgets suggests that these can contribute to the empowerment of service users. The study also summarised research showing that relatively small-scale innovations can facilitate new styles of interaction and pave the way for greater user involvement if staff are supported and ready to make this shift.

The literature on service user involvement also highlights the importance of person-centred care, which seeks to be respectful of the service user's preferences and needs. There is a close link between person-centred care and building trusting relationships: it is through providing person-centred care (and thus helping to resolve difficulties in other areas of the client's life) that service providers demonstrate that they care about them and can be trusted, and develop the skills and motivation that are needed in order to promote the client's autonomy.

Conclusion

Service users have a unique perspective on drug use and drug treatment. In order to effectively meet their needs, service providers must listen to what service users have to say and respond appropriately. Implementing this principle is a complex challenge, as it brings to light the different ways in which structural factors and features such as fear, stigmatisation, unequal power, lack of resources, and the management of services have shaped interactions between service users and providers over many years. The people who attend drug treatment services often have complex needs, implying that treatment providers must be able to provide a solid multidisciplinary and interorganisational response. Service users greatly appreciate all genuine attempts to help them, but they would be even more appreciative if these responses were not simply left to the goodwill and individual initiative of staff members.

The narrative summaries and evidence presented in this report show that researchers, policymakers, managers, and practitioners in Ireland and other countries sometimes struggle to understand the role of service user involvement in relation to drug treatment services. However, there is enough evidence to state with confidence that considerable benefits can be gained from pursuing this new paradigm, although this

An integrative review on service user participation continued

process poses challenges. Meaningful forms of service user involvement – including collaborative relationships between practitioners and service users and ways of representing the latter in decisions about services – are not going to emerge spontaneously without targeted interventions. Policy statements are not sufficient on their own and must be transformed into a programme of change that can win the support of the actors most centrally involved in drug treatment, harm reduction, and recovery services.

Brian Galvin

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- 2 Pratschke J, Glanville J and Engling F (2022) *An integrative evidence review on service user participation in the design and delivery of drug treatment, recovery and harm reduction services*. HRB Drug and Alcohol Evidence Review 8. Dublin: Health Research Board.

Contents unknown – how alcohol labelling still fails consumers

Background

Following on from the United Kingdom's (UK) Alcohol Health Alliance (AHA) 2020 report on alcohol labelling,¹ further research was carried out by AHA to examine if alcohol labelling provides information on low-risk guidelines, ingredients, calories, and health information.²

Alcohol use is associated with seven different types of cancer and many other health conditions and is the leading risk factor for morbidity and mortality among those aged 15–49 years. Yet many people are unaware of this risk and it is not legally binding to display this information on alcohol products.^{3,4}

Methodology

In the 2022 AHA study, photographs of 369 labels on alcohol products were assessed to examine what information was provided and compared to the findings from the 2020 report.¹

Key findings

Low-risk guidelines: Low-risk guidelines were visible in 65% of the alcohol products, an improvement on the 2020 study figures (29%). Over one-third of products were not providing accurate information despite an agreement between the Scottish government and the alcohol industry that the guidelines would be provided on all alcohol products.

Health warnings: Despite alcohol classified as a group 1 carcinogen, just 3% of products contained this information on their labelling and only one product had a specific cancer warning.

Nutritional information: The nutritional information shown on the alcohol products were as follows: 41% displayed calorie content; 6% displayed the sugar content; 5% displayed full nutritional content; and 20% had a full list of the ingredients.

Unit information: Not all alcohol products had unit information displayed (85%). Unit information is important for consumers to determine how much of their weekly low-risk limit they are consuming.

Other warnings: The majority of products had pregnancy warnings displayed (97%), 24% had drink-drive warnings, and 16% had age warnings.

Signposting to further information: Over three-quarters of labels advised consumers of an industry-funded organisation to obtain further information (76%). The authors noted that it would be preferable if an independent source be displayed for evidence-based information.

Legibility and presentation: The authors noted a variety of fonts, colours, and sizes that impacted the legibility of the information displayed. For example, one label featured in the study combined health warning messages with recycling information.

Conclusion

The study found an inconsistency in the labelling of alcohol products, with the majority of products examined failing to provide a full list of ingredients, low-risk guidelines, and health warning messages informing the drinker of the risks associated with alcohol use. The absence of such information means that drinkers are likely to be poorly informed about the contents of the product they are consuming as well as the carcinogenic nature of alcohol and associated health risks. In addition, failure to provide low-risk drinking guidelines means that drinkers are unable to monitor their intake effectively. The AHA recommends that the UK government intervene by giving a new or existing independent agency powers to ensure that labels become mandatory and are consistent, provide sufficient information for the consumer, and are free from alcohol industry influence. They also propose that label content and design are based on best practice in relation to size, colour, and positioning.

Anne Doyle

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Review of alcohol marketing restrictions in seven European countries

Background

Based on recommendations by the World Health Organization (WHO), the Alcohol Framework 2018 in Scotland aims to reduce alcohol-related harm, including restricting alcohol marketing.^{1,2} A 2022 report by Public Health Scotland sought to examine alcohol marketing restrictions in seven European countries (Estonia, Finland, France, Ireland, Lithuania, Norway, and Sweden) in order to inform consideration of alcohol marketing policy in Scotland.³

Key findings

Justifications for restricting alcohol marketing

The introduction of alcohol marketing restrictions in the seven countries aims to reduce population-level alcohol use and harmful drinking but specifically focused on protecting children from exposure to alcohol advertising. Public support for such measures was common, especially for safeguarding children, although Finland and France identified a need to find a balance between promoting health and supporting local business and the economy.

Controlling the content of alcohol advertising

A total ban on alcohol advertising was noted in Lithuania and Norway, while the remaining countries restrict the content of alcohol advertising (e.g., product name, manufacturer name, country of origin, ethanol content). The report indicated that restrictions to alcohol marketing include the banning of advertising that exhibits alcohol use as 'healthy, normal, therapeutic or desirable; content that associates alcohol with driving; content that associates alcohol with sexual success; encouragements to buy or consume alcohol; and content that links alcohol with important dates or activities' (p. 5). The use of children and young people in alcohol marketing is prohibited as is content targeting them. Health warnings are also mandatory in Estonia, France, Ireland, and Sweden.

Alcohol advertising restrictions by medium

Alcohol marketing restrictions varied between the countries investigated, from restrictions on advertising in locations frequented by children and young people to complete bans.

- Under French law, all alcohol advertising is banned, except where permitted under the Évin Law.
- In Finland, alcohol marketing is restricted based on the alcohol by volume (ABV) of the product.
- In Lithuania, Sweden, and Norway, broadcast watersheds are in place. The remaining four countries have legislation for partial broadcast watersheds.
- Only Lithuania has an outright ban on alcohol marketing online and on social media, while there are partial bans in the remaining countries, with the exception of Ireland where no restrictions in alcohol marketing apply online or on social media.
- France, Lithuania, and Norway have a ban on sports and event sponsorship, while Estonia, Finland, and Ireland have partial bans, typically depending on the extent to which the event is attended or performed by children.
- Alcohol advertising in cinemas is prohibited in France, Lithuania, and Norway, while the remaining countries have partial bans, for example, for films certified for viewing by those aged less than 18 years in Ireland or for strong ABV products in Finland.
- All seven countries prohibit outdoor alcohol advertising to some extent, with complete bans in Estonia, Finland, Lithuania, and Norway.
- Only Lithuania has a complete ban on alcohol advertising in print media, while partial bans are in place in the remaining countries. For example, alcohol advertising is allowed in foreign magazines in Norway and only banned in children's magazines in France.

Restrictions on product packaging and sales practices

Estonia, France, Ireland, and Sweden have legislation that requires health warning messages to be displayed on alcohol products, including highlighting the association between alcohol use and cancer, the risks of drinking while pregnant, the calorie content, and an independent website providing impartial and factual information about alcohol-related harms. Structural separation is in place in Ireland and Estonia to reduce the visibility of alcohol to children, to discourage buying alcohol as part of regular grocery shopping, and to deter impulse buying of alcohol. In Norway, marketing of no alcohol and low alcohol products of the same brand as alcoholic products is banned and applies to food and clothing also.

Variation by product strength

The ABV of products dictates marketing restrictions in some countries. For example, in Ireland, Lithuania, and Estonia, advertising restrictions apply to products over 0.5% ABV and over 2.5% ABV in Norway and Sweden. In Finland, products over 22% ABV are subject to strict advertising bans, with products below this ABV permitted but with exceptions based on time of broadcast, audience, and content. Products over 15% ABV are governed by stricter restrictions in Sweden, while products with ABV of 2.25% or lower are not included in their legislation, with the exception that marketing of these products must not be able to be mistaken for stronger products.

Monitoring and enforcement

All countries reviewed in the report have statutory bodies monitoring and enforcing compliance with restrictions, with the exception of France and Ireland who have a combination of statutory and non-statutory bodies. In Ireland, the Environmental Health Service is the statutory body while the Advertising Standards Authority for Ireland (ASAI), which is funded by the advertising industry, acts as the non-statutory body.

Those countries with statutory bodies monitoring and enforcing adherence to the legislation involve issuing penalties for illegal marketing, including suspending licences and issuing fines or imprisonment. Non-statutory bodies provide guidance on advertising practices and can demand removal of unacceptable marketing and potentially issue fines or escalate issues to statutory bodies.

International collaboration to monitor and enforce marketing legislation was absent in the review and the authors note that this is relevant to online and broadcast marketing, as it can be accessed beyond the borders of their countries of origin.

Review of alcohol marketing restrictions continued

Evaluations of restrictions

An absence of comprehensive evaluations of alcohol marketing in the seven countries was noted. As marketing restrictions were often introduced as part of a suite of alcohol legislation measures, it is more often than not difficult to isolate the effects of a particular measure. The authors recommend that monitoring and evaluation plans be incorporated into new alcohol restriction legislation. The report outlines a number of studies that investigated the effects of the marketing restrictions introduced.

- In Norway, the evidence indicates that its legislation banning alcohol advertising resulted in a 7.4% reduction in alcohol sales.⁴
- In Lithuania, marketing restrictions are deemed responsible for a decline in alcohol-related mortality.⁵
- Research following the introduction of social media marketing restrictions in Finland found an initial decline in alcohol industry posts; however, user engagement increased, indicating that those advertising alcohol found ways to circumvent restrictions.⁶
- Awareness of alcohol marketing declined following the introduction of legislation restricting advertising in Ireland.⁷

Conclusion

The seven countries included in the review have incorporated alcohol policies restricting alcohol marketing based on WHO recommendations to reduce alcohol use and related harms.

Such policies receive public support, particularly to prevent alcohol marketing exposure to children and young people. There is limited evidence demonstrating the effectiveness of such legislation. However, where available, a banning or a reduction in alcohol marketing has resulted in reduced alcohol use, especially harmful and hazardous drinking, and consequently a reduction in alcohol-related harms.

Anne Doyle

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Psychosocial and psychiatric factors preceding death by suicide: a case-control psychological autopsy study

Background

Globally, suicide is a significant public health concern with over 700,000 people worldwide dying by suicide each year.¹ A range of factors, especially mental disorders, which include substance use disorders and adverse life events, can increase the risk of suicide.² A study examining psychosocial and psychiatric factors and service engagement among people who died by suicide compared with a living control group in the Cork region (Cork City and County) was published in 2022.³

Methods

A case-control study using multiple sources, including review of coronial files and structured interviews with family members and general practitioners (GPs), was conducted. Data on 132 consecutive cases of suicide or probable suicide were extracted from coronial files for deaths which occurred between June 2014 and September 2017. The control group included 53 living people who attended the same GP practices as the deceased. Interviews were conducted with 35 family informants and 53 living control participants. GPs completed questionnaires for 60 suicide deaths and 27 control participants.

Results

The 132 people who died by suicide and the 53 living control participants were predominantly male. A similar proportion of the people who died by suicide and the control participants had a history of physical, emotional, or sexual abuse reported. People who died by suicide were more likely than control participants to be single, living alone, and unemployed. People who died by suicide were significantly more likely than control participants to:

- Have a psychiatric diagnosis (60% vs 18.5%)
- Have a depressive illness (36.7% vs 14.8%)
- Have a history of violent behaviour (45.7% vs 22.6%)
- Experienced legal troubles (31.4% vs 11.3%).

Psychosocial and psychiatric factors in suicide continued

The majority of people who died by suicide and the majority of control participants had contacted a GP in the year prior to death; however, a higher proportion (23.3%) of people who died by suicide had 10 or more consultations during the year prior to death compared with control participants (3.7%). A higher proportion of people who died by suicide had a history of alcohol misuse (31.4%) compared with control participants (17%). Also, a higher proportion of people who died by suicide had a history of drug misuse (22.9%) compared with the control participants (9.4%).

While none of the control group had a history of previous self-harm, one-half (50%) of people who died by suicide had previously self-harmed. Over one-quarter (26.7%) of people who died by suicide had previously received treatment as a psychiatric inpatient compared with 3.7% of control participants. No psychiatric diagnosis was reported for 40% of people who died by suicide.

Conclusion

Referencing existing international research, the study reports that training primary care doctors in depression recognition and appropriate treatment, which may include pharmacotherapy in combination with psychosocial interventions, can help prevent suicide.

Primary care providers should be adequately resourced to deliver multidisciplinary interventions to engage, assess, and treat patients at risk of suicide, targeting those who present very frequently, those with a history of self-harm or substance misuse, and those with psychological presentations.

Ena Lynn

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Cost-effectiveness of mass screening for hepatitis C virus in Irish prisons

Background and methods

There is a high proportion of people who inject drugs (PWID) in Irish prisons and a high prevalence of hepatitis C virus (HCV), making prison a high priority setting for HCV testing and treatment. However, HCV screening in Irish prisons currently occurs intermittently. Although every prisoner undergoes a committal health screening on entering prison and information is gathered on drug use and blood-borne virus testing is offered, many prisoners initially refuse, but then return later and request screening.¹

A 2021 Irish study² evaluated the cost-effectiveness of a mass HCV screening intervention in Mountjoy Prison, Dublin, compared with the standard-of-care intermittent screening on committal. In this research, published in the *International Journal of Drug Policy*, primary cost data were collected from the intervention using an overall provider perspective. Standard-of-care costs were estimated through interview. All costs were inflated to 2020 euros. A HCV transmission and disease progression model among incarcerated and community PWID and ex-injectors was calibrated to the Dublin HCV epidemic, allowing inclusion of population-level health benefits. The model used intervention data suggesting 419 individuals were screened, 50 HCV infections diagnosed, and that 32 individuals underwent treatment.

Results

The study found that the total direct costs of the intervention (not including treatment drug costs) was €82,392, with most costs being due to staff (43%) and overhead or management costs (38%). Despite having little epidemiological impact due to the small numbers treated, over 50 years the incremental cost of the intervention was €36,592.

Conclusions

The authors noted that mass HCV screening in Dublin prisons is unlikely to have a large prevention impact on the overall HCV epidemic among PWID, with yearly screening only reducing the number of new HCV infections by 1.1%. This small impact is due to the low levels of incarceration among PWID in Dublin and negligible HCV risk in prison. Nevertheless, they suggest that this should not be seen as a reason for not doing screening and treatment in prison, as it is likely to be highly cost-effective (and possibly cost-saving) and may reach individuals not well reached by other testing initiatives.

Seán Millar

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PREVALENCE AND CURRENT SITUATION

Drug use among Probation Service clients in Ireland

Background and methods

Substance misuse has been highlighted as a key area of need among prisoners and a 2019 systematic review estimated that the pooled percentage of prisoners in Ireland reporting a substance use disorder was 50.9% (95% CI: 37.6–64.2%).¹ A history of substance misuse has also been identified as a strong predictor for reoffending. Therefore, on release from prison, engagement with the Probation Service is a critical juncture at which assessment, intervention, and appropriate referral for substance misuse issues can take place.

A 2021 Irish study² aimed to identify the prevalence of substance misuse among persons on probation supervision, examine the relationship between substance use behaviour and offending, and assess service user engagement. In this research, published in the *Irish Probation Journal*, a cross-sectional quantitative survey was carried out in 2019 among a representative sample of probation officers supervising people in the community. Participants were asked to complete an anonymised survey in respect of all clients (adults and young persons) who were subject to a probation order, supervision order, adjourned supervision, or supervised temporary release. In total, 3,096 surveys were completed by probation officers (male n=2566; female n=522; unknown n=8).

Results

A total of 2,074 (67%) persons were reported to misuse drugs; 84% (n=1765) of the sample were reported to misuse cannabis, while high rates of misuse were also identified for benzodiazepines (55%), cocaine (48%), heroin (41%), and ecstasy (27%). A link between drug misuse and current offending was reported for almost one-half of the research sample (48%), with comparable rates of drug-related offending across male (48%) and female (47%) clients. On referral to the Probation Service, a total of 2,169 offenders reported drug misuse to their probation officers with one-third (33%) engaging with some form of medical intervention when presenting to the Probation Service. Methadone treatment (18%) was the most frequently cited medical intervention.

Conclusions

The authors noted that the present study identified a high prevalence of drug misuse among people on probation supervision. However, a similar figure was reported in the Probation Service's 2011 Drugs and Alcohol Survey report,³ suggesting that substance misuse has remained relatively stable throughout the target population in the intervening eight years (2011–2019). Nevertheless, there is a need to increase service users' access to programmes and interventions that provide information and support that is relevant and appropriate.

Seán Millar

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Not-fatal drug-related hospital admissions in Ireland, 2020

The HIPE (Hospital In-Patient Enquiry) scheme is a computer-based health information system, managed by the Economic and Social Research Institute (ESRI) in association with the Department of Health and the Health Service Executive. It collects demographic, medical, and administrative data on all admissions, discharges, and deaths from acute general hospitals in Ireland. Each HIPE discharge record represents one episode of care; each discharge of a patient, whether from the same or a different hospital, with the same or a different diagnosis, gives rise to a separate HIPE record. The scheme therefore facilitates analysis of hospital activity rather than of the incidence of disease. HIPE does not record information on individuals who attend emergency departments but are not admitted as inpatients. Monitoring of drug-related acute emergencies in the Irish context refers to all admissions for non-fatal overdoses to acute general hospitals in Ireland.

Drug-related emergencies – non-fatal overdoses

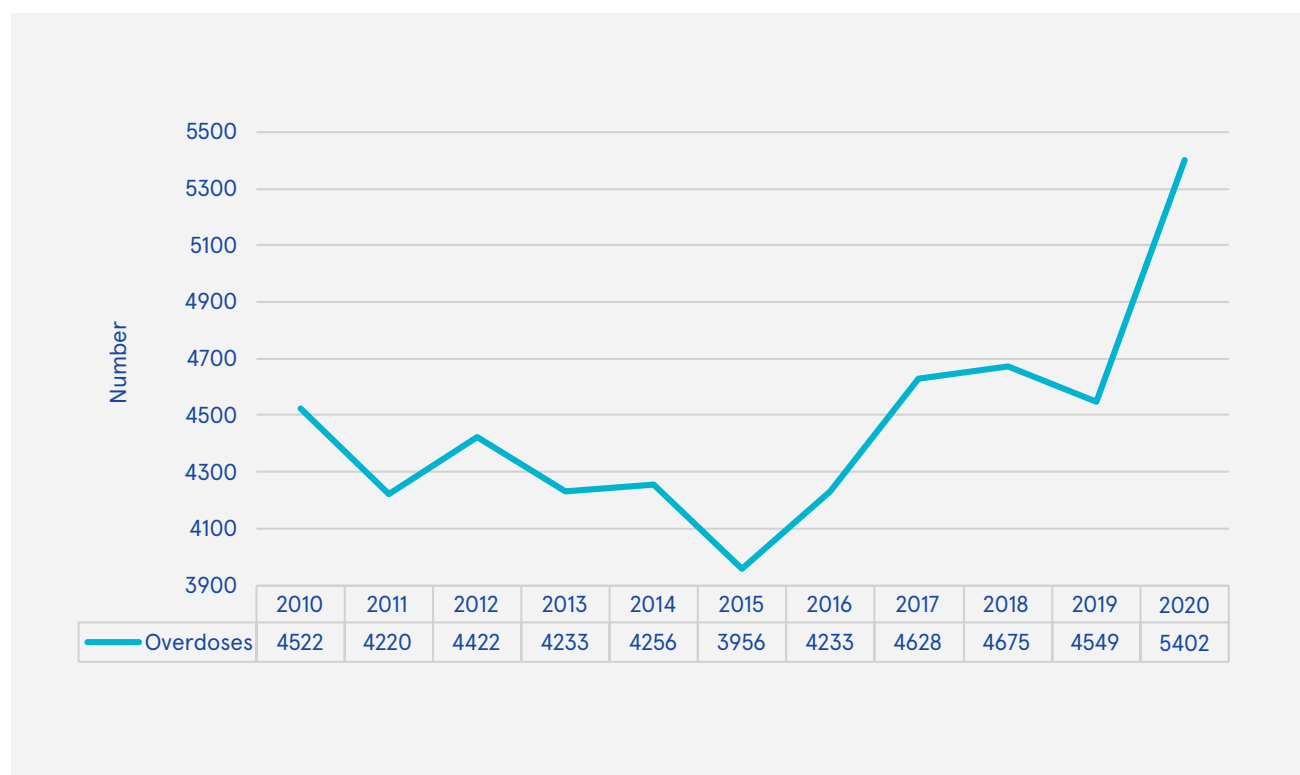
Data extracted from the HIPE scheme were analysed to determine trends in non-fatal overdoses in patients discharged from Irish hospitals in 2020.¹ There were 5,457 overdose cases in that year, of which 55 died in hospital. Only discharged cases are included in this analysis (n=5402). The number of discharged overdose cases in 2020 was the highest recorded in 10 years, with trends indicating a general increase since 2015 (see Figure 1).

Sex of overdose cases

Between 2010 and 2020, there were more overdose cases among women than men, with women accounting for 3,092 (57.2%) of all non-fatal overdose cases in 2020 (see Figure 2).

Age group

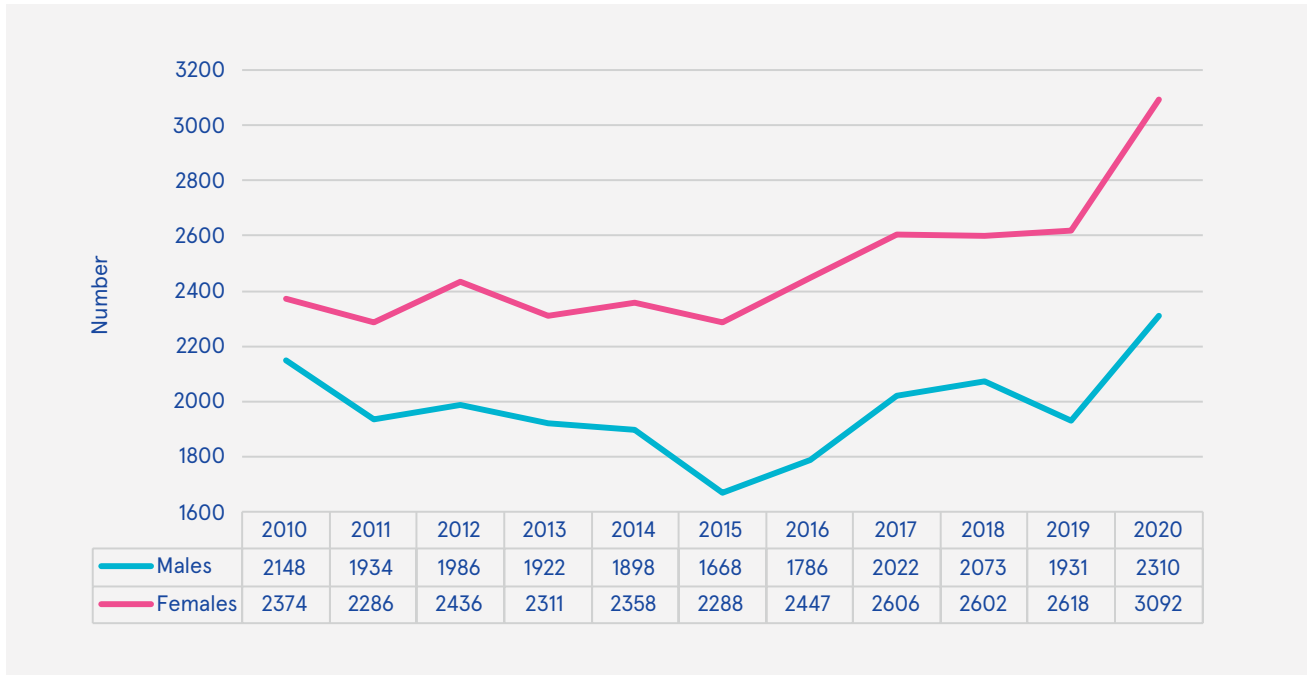
Between 2015 and 2020, there has been a general increase in the number of non-fatal overdose cases in all age groups. As noted in previous years, the incidence of overdose cases peaked in the 15–24-age group (see Figure 3). In 2020, some 34.7% of cases were under 25 years of age.



Source: HIPE, Healthcare Pricing Office (2022)

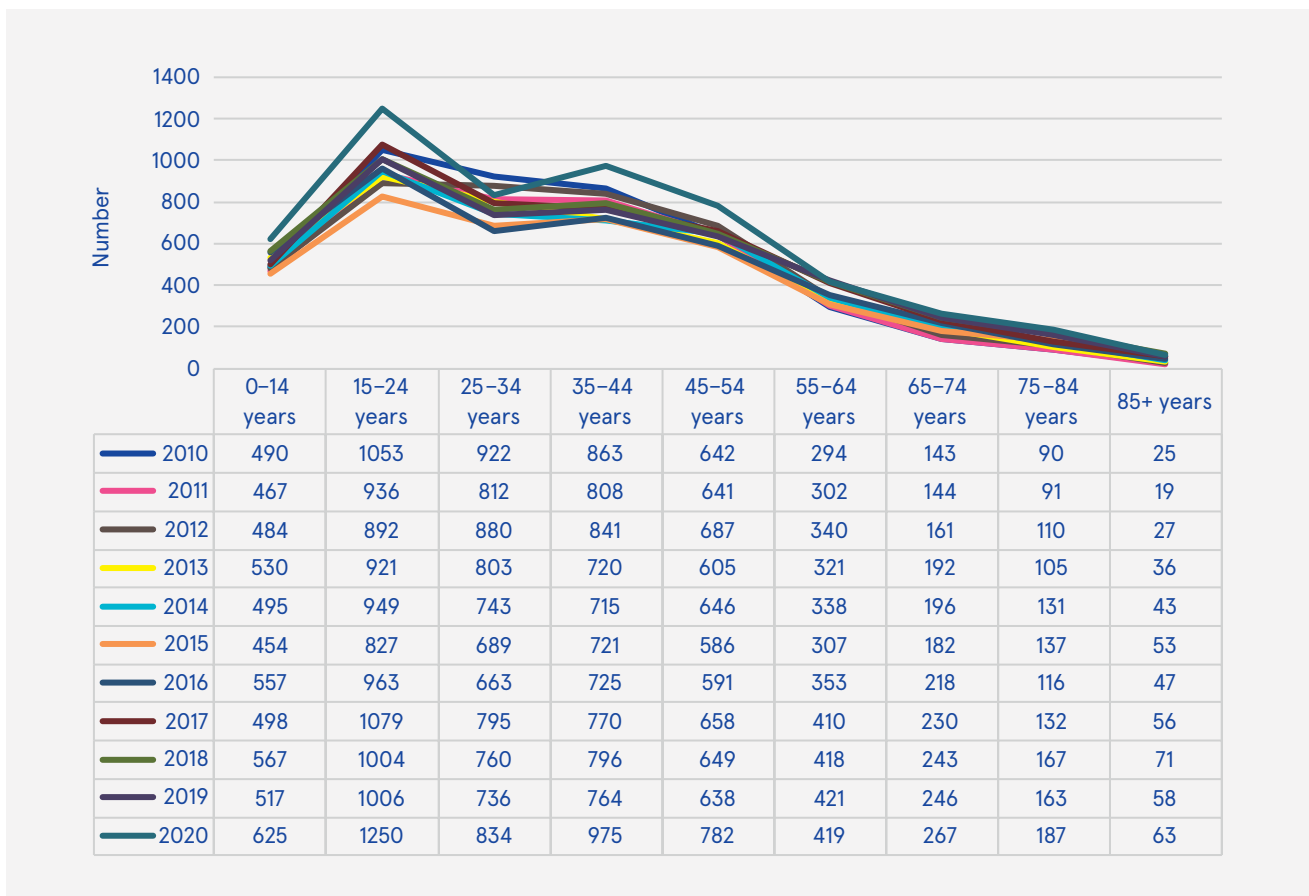
Figure 1: Number of non-fatal overdose cases admitted to Irish hospitals, by year, 2010–2020

Not-fatal drug-related hospital admissions in Ireland, 2020 continued



Source: HIPE, Healthcare Pricing Office (2022)

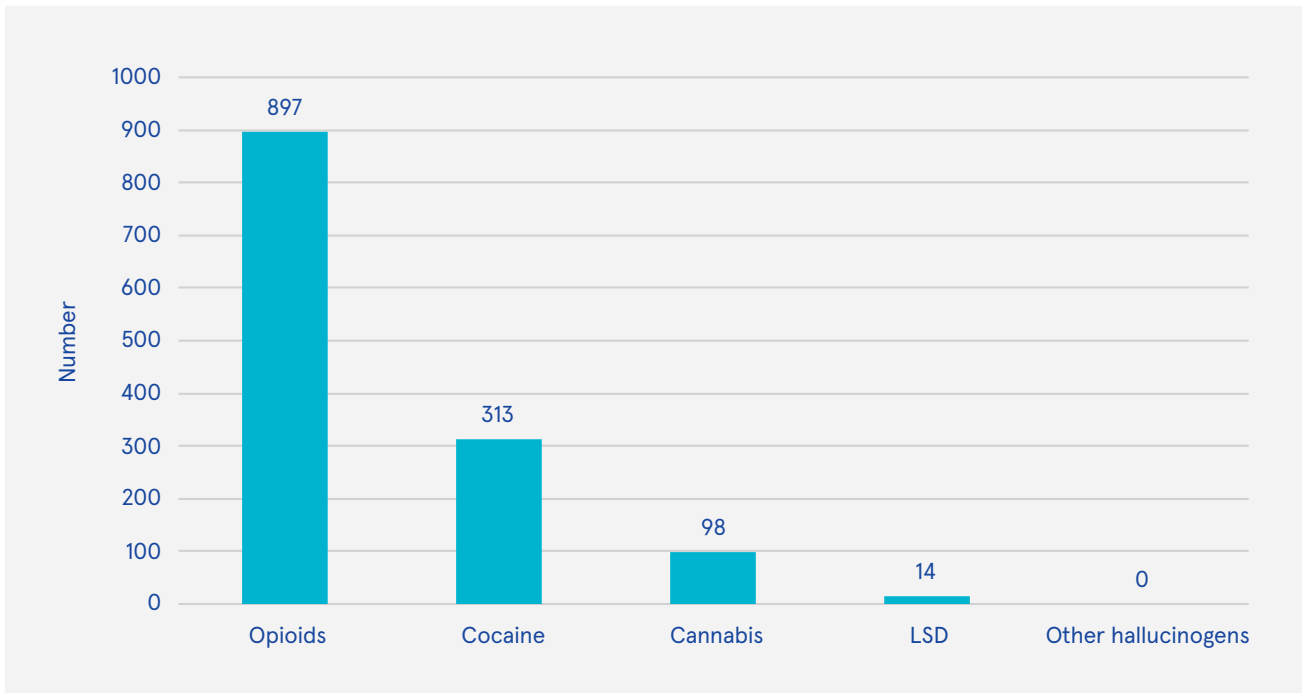
Figure 2: Number of non-fatal overdose cases admitted to Irish hospitals, by year and sex, 2010–2020



Source: HIPE, Healthcare Pricing Office (2022)

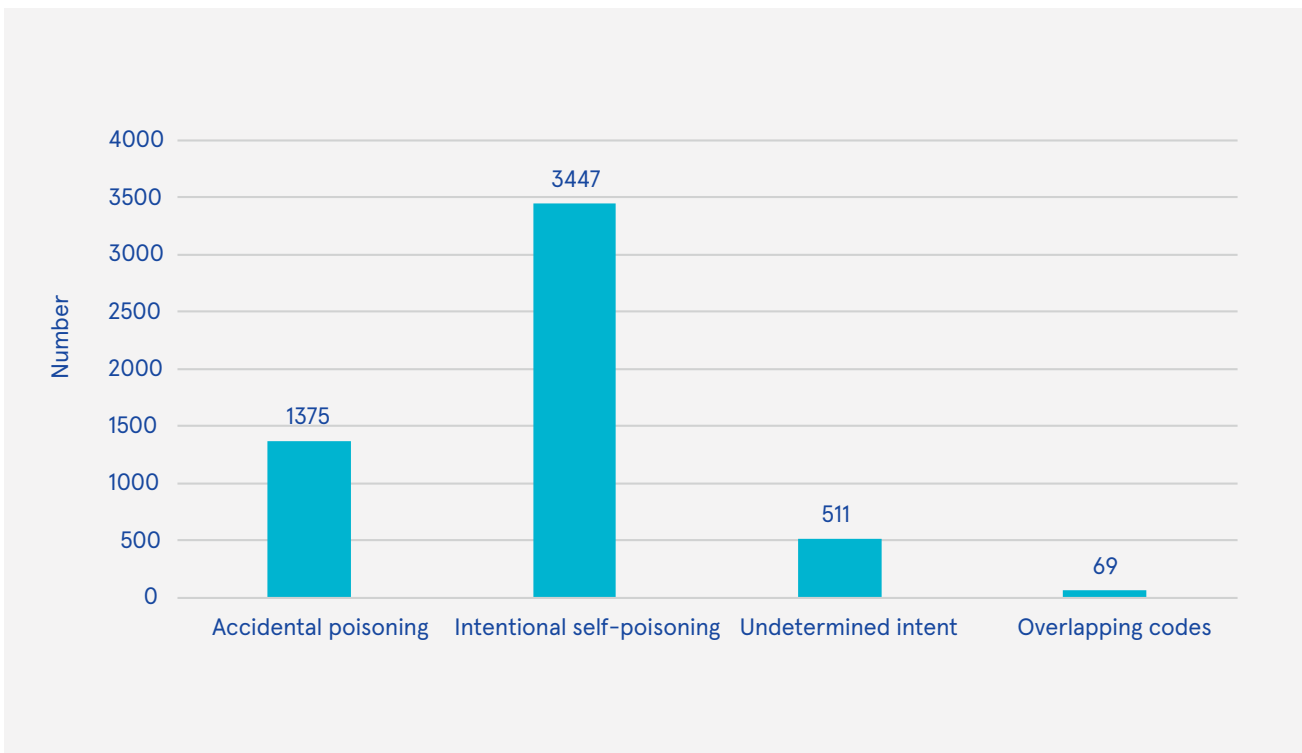
Figure 3: Non-fatal overdose cases admitted to Irish hospitals, by year and age group, 2010–2020

Not-fatal drug-related hospital admissions in Ireland, 2020 continued



Source: HIPE, Healthcare Pricing Office (2022)

Figure 4: Narcotics and hallucinogens involved in non-fatal overdose cases admitted to Irish hospitals, 2020



Source: HIPE, Healthcare Pricing Office (2022)

Figure 5: Non-fatal overdose cases admitted to Irish hospitals, classified by intent, 2020

Not-fatal drug-related hospital admissions in Ireland, 2020

continued

Table 1: Categories of drugs involved in non-fatal overdose cases admitted to Irish hospitals, 2020

Drug category	Count
Non-opioid analgesics	1880
<i>Paracetamol (4-Aminophenol derivatives)</i>	1580
Benzodiazepines	1111
Psychotropic agents	1416
Antiepileptic/sedative/antiparkinson agents	2536
Narcotics and hallucinogens	1168
Alcohol*	519
Systemic and haematological agents	247
Cardiovascular agents	163
Autonomic nervous system	170
Anaesthetics	45
Hormones	175
Systemic antibiotics	84
Gastrointestinal agents	105
Other chemicals and noxious substances	311
Diuretics	67
Muscle and respiratory agents	27
Topical agents	58
Anti-infectives/antiparasitics	32
Other gases and vapours	46
Other and unspecified drugs	1203

Source: HIPE, Healthcare Pricing Office (2022)

Note: The sum of positive findings is greater than the total number of cases, as some cases involved more than one drug or substance.

* Alcohol was only included for cases where any code from any of the other drug categories in this table was also reported.

Toxicology of drug-related acute emergencies

Table 1 presents the positive findings per category of drugs and other substances involved in all cases of overdose in 2020. Non-opioid analgesics were present in 1,880 of cases. Paracetamol is included in this drug category and was present in 1,580 of cases. Benzodiazepines and psychotropic agents were taken in 1,111 and 1,416 of cases, respectively. There was evidence of alcohol consumption in 519 of cases. Cases involving alcohol are included in this analysis only when alcohol was used in conjunction with another substance.

Overdoses involving narcotics or hallucinogens

Figure 4 shows positive findings of illicit substances among overdose cases in 2020. Opioids were used in 16.6% (n=897) of cases, cocaine in 5.8% (n=313), and cannabis in 1.8% (n=98) of cases. There were 14 overdose cases involving LSD.

Table 2: Categories of drugs involved in intentional self-poisoning cases admitted to Irish hospitals, 2020

Drug category	Count
Non-opioid analgesics	1590
Benzodiazepines	744
Psychotropic agents	1101
Antiepileptic/sedative/antiparkinson agents	1819
Narcotics and hallucinogens	588
Alcohol*	339
Systemic and haematological agents	162
Cardiovascular agents	101
Autonomic nervous system	111
Anaesthetics	14
Hormones	115
Systemic antibiotics	63
Gastrointestinal agents	79
Other chemicals and noxious substances	100
Diuretics	32
Muscle and respiratory agents	15
Topical agents	15
Anti-infectives/antiparasitics	21
Other gases and vapours	~
Other and unspecified drugs	705

Source: HIPE, Healthcare Pricing Office (2022)

Note: As some discharges may be included in more than one drug category, the total count in this table exceeds the total number of discharges.

* Alcohol was only included for cases where any code from any of the other drug categories in this table was also reported.

Overdoses classified by intent

In 2020, for 63.8% (n=3447) of cases, the overdose was classified as intentional (see Figure 5). For 9.4% (n=511) of cases, classification of intent was not clear.

Table 2 presents the positive findings per category of drugs and other substances involved in cases of intentional self-poisoning (n=3447) in 2020. Non-opioid analgesics were involved in 1,590 of cases, benzodiazepines in 744, and psychotropic agents in 1,101 of cases.

Seán Millar

1 For further information on HIPE data, visit the Healthcare Pricing Office website: <http://www.hpo.ie/>

RESPONSES

Alcohol consumption and attitudes to evidence-based alcohol policy in Donegal

Background

In 2018, following a protracted process, the Public Health (Alcohol) Act was enacted to address alcohol use and associated harm in Ireland. The Act includes legislation restricting alcohol availability, advertising and promotion, sales and pricing: it aims to reduce population-level alcohol use and related harm but particularly to delay or prevent alcohol use among children and young people.¹

With the second highest rate for treatment for alcohol in Donegal and its above average hospital admissions for mental and behaviour disorders due to alcohol, and due to the Border location, a study commissioned by the Alcohol Forum sought to examine support for the Act by residents of Donegal.^{2,3}

Methods

A sample of Donegal students (n=395, 38% male, mean age 23.3 years) and a sample of adult Donegal residents (n=536, 34% male, mean age 41.7 years) completed a survey that included questions about their alcohol use (quantity and frequency), how much they spend on alcohol, and attitudes to elements of the Act.

Table 1: Agreement with statements regarding alcohol use, public health interventions, alcohol availability, and evidence-based alcohol policies (%)

Statement	Student sample (%)	Adult sample (%)
Public health countermeasures – who should intervene		
Individuals are responsible enough to protect themselves from harm	26.7	24.5
Public health bodies should intervene to protect people from alcohol-related harm	58.1	52.5
Health professionals should ask about alcohol use	70.0	68.5
Alcohol availability		
The government should reduce the number of outlets selling alcohol	18.5	32.5
Alcohol should be sold in separate premises to food and other household items	20.6	36.6
The law on selling and serving alcohol to people under the age of 18 should be strictly enforced	79.8	85.8
It is not acceptable to allow a child aged 15 to drink alcohol in their own home	63.9	68.5
It is not acceptable to allow a child aged 16 or 17 to drink alcohol in their own home	34.3	37.6
Alcohol marketing		
Advertisements for alcohol should include the risks of drinking alcohol	81.2	81.8
Alcohol providers should not sponsor sporting teams	39.7	58.0
Alcohol advertisements should not be displayed at sports grounds	39.6	60.8
Alcohol advertisements should not be displayed at music events	17.4	33.2
Alcohol advertising should not be promoted on public transport or at bus stops, train stations, or other transport hubs	37.9	53.1
Television advertisements for alcohol should not be shown until after 9pm	60.5	77.0
Alcohol advertising targeting young people should be banned	58.8	85.9
Alcohol advertising should not be placed in or near a school or early years services	80.1	81.6
Alcohol providers should not sponsor children's sporting teams	84.8	89.7
Alcohol pricing		
Minimum unit pricing is a good idea	35.8	31.6
Price promotions on alcohol encourage excessive drinking	60.9	58.2
Price promotions in pubs, clubs and bars should be banned	19.1	32.8
I would be more likely to drink alcohol if it were free or sold at a discount price	67.1	36.8

Note that in the full report the percentage of those (student and adults) who reported hazardous patterns of drinking are also presented.

Alcohol consumption and attitudes continued

Results

Main findings

Of the student sample, 95% reported lifetime alcohol use and 59% had an AUDIT-C score ≥ 5 (indicating hazardous drinking), whereas 97% of the adult sample reported lifetime alcohol use, with 53% scoring ≥ 5 on the AUDIT-C. Almost one-half of the student sample and over one-third of the adult sample reported heavy episodic drinking on a single occasion monthly or more in the last year (46% vs 36%). Respondents were also asked how much money they spent weekly on alcohol both on-trade and off-trade.

As well as their own drinking patterns, the survey also asked respondents about their experiences of other people's drinking. Some 67% of the student sample and 59% of the adult sample reported that they considered an individual in their life to be a heavy drinker, while 9% of the student sample and 12% of the adult sample claimed that they considered themselves a harm to themselves or others when they were drinking.

Respondents were then asked whether they agreed or not with statements about alcohol use, health professional intervention, alcohol availability, alcohol marketing, and other statements about alcohol policies. Table 1 illustrates the percentage of student and adult respondents in agreement with the statements provided.

Support for evidence-based alcohol policy on perceived local characteristics

Respondents' perception of local issues influenced their support for evidence-based alcohol policy measures. For example, those who considered that teenagers drinking in parks, drinking in public places, underage drinking, drink-driving, alcohol-related violence, and public drunkenness were a problem in their local area were more likely to support alcohol policies.

Conclusion

The report found that respondents in Donegal differed to other parts of Ireland in their support for alcohol policy measures,⁴ with lower support for such measures reported among the sample in Donegal. The report also found differences between the student and the adult samples in their views on alcohol policies, with students more likely to support minimum unit pricing and banning alcohol advertising targeting young people, whereas all other measures were more likely to be supported by the adult sample. Findings also revealed that those who reported hazardous patterns of drinking were unsurprisingly less supportive of alcohol policy measures. The authors recommend that policymakers and community representatives consider the findings and next steps and highlight that geographical location can influence views on alcohol policies, which in turn may influence alcohol use and related harms.

Anne Doyle

- 1 Office of the Attorney General (2018) Public Health (Alcohol) Act 2018. Dublin: Irish Statute Book. <https://www.drugsandalcohol.ie/33698/>
- 2 Shorter GW, Leonard P, Bunting E, *et al.* (2022) Alcohol consumption and attitudes to evidenced-based alcohol policy in Donegal: findings from a student and general adult sample. Donegal: Alcohol Forum Ireland. <https://www.drugsandalcohol.ie/36325/>
- 3 Goggin D, Cullen L, O'Kane J, *et al.* (2019) Donegal alcohol related harm profile 2019. Dublin: Health Service Executive. <https://www.drugsandalcohol.ie/31168/>
- 4 Davoren MP, Lane D, Kirby J, *et al.* (2019) Support for evidence-based alcohol policy in Ireland: results from the Community Action on Alcohol Pilot Project. *J Public Health Policy*, 40: 76–90. <https://www.drugsandalcohol.ie/29899/>



Tabor Group annual report, 2021

The Tabor Group is a provider of residential addiction treatment services in Ireland. It aims to offer hope, healing, and recovery to clients suffering from addictions through integrated and caring services. In addition to two residential facilities, the organisation provides a continuing care programme to clients who have completed treatment in order to assist with their recovery as well as a community-based programme. Its family support programme offers counselling to families whose loved ones are struggling with an addiction. In 2022, the Tabor Group published its annual report for 2021.¹ This article highlights services provided by the Tabor Group to individuals with a substance use addiction in 2021.

Tabor Lodge: residential addiction treatment centre

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

A total of 127 clients (64% male) were admitted to Tabor Lodge for residential treatment of addiction in 2021; 32% were aged between 18 and 30 years. Sixty-four per cent of clients admitted to Tabor Lodge reported alcohol as their main reason for referral, 14% reported other drugs, while 20% reported addiction issues with both alcohol and other drugs.

Tabor Fellowship: integrated recovery programme

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

In 2021, some 82 clients (71% male) were admitted to Tabor Fellowship for extended treatment; 62% were under 32 years of age. The report observed that the just over one-half of clients (51%) reported addiction issues with both alcohol and other drugs.

Seán Millar

¹ Tabor Group (2022) *Tabor Group annual report 2021*. Cork: Tabor Group. <https://www.drugsandalcohol.ie/36458/>



Coolmine Therapeutic Community annual report, 2020

Coolmine Therapeutic Community is a drug and alcohol treatment centre providing community, day, and residential services to men and women with problematic substance use and to their families in Ireland. Established in 1973, Coolmine was founded on the philosophies of the therapeutic community approach to addiction treatment. This is primarily a self-help approach in which residents are responsible for their own recovery, with peers and staff acting as facilitators of change. Participants are expected to contribute to the general running of the community and to their own recovery by actively participating in educational activities and in group and individual therapy. This article highlights services provided by Coolmine in 2020.¹

Welcome/Stabilisation Programme

The Welcome/Stabilisation Programme is for people who are not yet drug-free and are seeking support to address their substance use. The programme runs Monday to Friday, from 10.30am to 3.30pm (to 1.00pm on Wednesdays). Clients engage in self-development workshops, one-to-one key working sessions, relapse prevention groups, and various other therapeutic/educational programmes. In 2020, some 30 clients were supported in Coolmine's Stabilisation Programme.

Drug-Free Day Programme

The Drug-Free Day Programme (DFDP) provides a supportive setting for clients to build self-confidence and the skills to maintain a drug-free life. The programme lasts a minimum of 10 months: 5 months of primary treatment and 5 months of aftercare. Clients engage in open therapy groups, self-development workshops, one-to-one key working sessions, relapse prevention groups, and various other therapeutic/educational programmes. In 2020, some 45 clients engaged in Coolmine's DFDP programme.

Contingency Management Programme

The Contingency Management (CM) Programme consists of the reinforcement of desired behaviours. These are rewarded in the form of vouchers awarded for a combination of group attendance and drug-free urine tests. The programme is 12 weeks long, with participants attending meetings three times per week. The content of the programme is three supervised urine tests per week, with a brief intervention at every meeting, and a weekly facilitated support group. In 2020, some 32 clients were supported by Coolmine's CM programme.

Community Addiction Team Dublin 15

The Community Addiction Team Dublin 15 (D15 CAT) service provides focused care pathways specifically to the local community in Dublin 15 impacted by problem substance use. It includes treatment and rehabilitation support for adult men and women with problem substance use; contact and interventions to young people and adolescents at risk of experiencing problematic substance use; tailored support

to members of ethnic and new communities impacted by problematic substance use; and integrated family work to deliver whole-family outcomes. Services include:

- Information and support
- Specific support for young people
- Cannabis programme
- Family support
- Alcohol programme
- Support for new community members
- Mindfulness-based stress reduction programme
- Support for all problematic substance use.

In 2020, some 185 individuals were supported by the D15 CAT team.

Coolmine residential services

Coolmine Lodge – men's residential

Coolmine Lodge is a therapeutic community that hosts a five-month residential treatment programme for men who are working towards an independent life, free from addiction. Coolmine Lodge provides a supportive, peer-led environment where clients can build confidence, strength, resilience, and hope for a positive future. The service can admit men who may be prescribed medication, or those detoxifying from methadone, following assessment. In 2020, some 72 men were supported in residential treatment at Coolmine Lodge, with a 78% retention rate. There were 19 residential detox admissions, with a 68% retention rate. Twenty-nine per cent of admissions to Coolmine Lodge in 2020 were referrals from the Probation Service or Irish Prison Service.

Ashleigh House – women and children's residential

Ashleigh House is a residential therapeutic community for women, expectant mothers, and mothers with young children. The service can admit women who may be prescribed medication, or those detoxifying from methadone, following assessment. Ashleigh House is designed to help women in recovery develop the skills they need to live a drug-free, independent life. In 2020, some 56 women were supported in residential treatment at Ashleigh House, with a 63% retention rate.

Seán Millar

¹ Coolmine (2021) *Coolmine annual report 2020: expanding possibilities*. Dublin: Coolmine.
<https://www.drugsandalcohol.ie/34580/>



Strategic plan for UISCE, 2022–2025

UISCE, the Union for Improved Services, Communication and Education for people who use drugs (PWUD), published its new strategy in July 2022 entitled *Peer partnership for change: UISCE's strategy to build inclusion and participation of people who use drugs 2022–2025*.¹

UISCE

UISCE was established in the 1990s as a service user group and is now an independent organisation that works with and for PWUD. It is funded by the North Inner City Drugs and Alcohol Task Force and the Health Service Executive. In his foreword to the report, UISCE chairperson, Padraig Ryan, notes that the organisation seeks to empower PWUD to 'advocate for themselves and to ensure that their civil liberties and human rights are realised' (p. 2). In line with this, UISCE's vision is 'that PWUD are treated equally in society, with dignity and respect, and that they participate fully and have their voices in all areas where decisions affecting their lives are made' (p. 5). The relationship between poverty, inequality, and drug use is well understood by UISCE. It sees part of its role as closing the gap between those most affected by drug use (PWUD, their families, and communities) and the policies that affect them and policymakers.

UISCE's strategy

The strategic objectives of UISCE have evolved since its inception in the 1990s, taking account of changes such as the drug preferences, demographics, and overall drug consumption of PWUD. As part of the process of developing the new strategy, UISCE consulted with PWUD to explore their views of UISCE and any issues of concern. Some examples of the findings are:

- People valued UISCE's services, including linking people with services, naloxone training, and harm reduction.
- PWUD want to be part of the decision-making processes that impact their lives; for example, in the development of care plans and policies on drugs.
- The risk of drug-related deaths for PWUD and their friends was of particular concern.
- The provision of safe injecting facilities is a priority.
- PWUD reported being discriminated against and having to go through the criminal justice system for health-related issues.
- PWUD spoke about being affected by social and health inequalities, which puts them in a position with less power due to economic, social, historical, and political conditions in society.

Strategic goals and actions

The strategy is structured around seven goals, each of which has a set of actions. It is beyond the scope of this article to include all actions, but two are selected for each goal for illustrative purposes.

Goal 1: To build a resilient organisation which promotes and develops a high level of participation, inclusion, and meaningful engagement with PWUD.

- To develop creative tools to engage PWUD in workshops/sessions that allow them to identify the issues and develop collective responses through their lived or living experience which values their role as experts.

- To advocate for, enable, and support greater participation of people with lived experience in all relevant matters and at all relevant spaces.

Goal 2: To continue to strengthen engagement with PWUD and relevant organisations locally, regionally, and nationally.

- To establish a peer-led National Drugs Network which will create a platform for local and regional task forces and other relevant organisations to promote the participation of PWUD and ensure stronger representation nationally.
- To continue to identify and engage with PWUD that experience intersectional discrimination (e.g. Travelling community, LGBTQ+ community, sex workers, homeless population, prison population, etc.).

Goal 3: To enhance and further develop our communications to challenge discrimination and stigmatisation and to foster a greater understanding of the rights of PWUD.

- To continue to challenge negative stereotypes that impact PWUD.
- To support PWUD to develop campaigns to highlight issues of concern and to challenge stereotypes that limit their full participation in society.

Goal 4: To maintain and further develop strong relationships with relevant services to ensure effective collaboration that seeks to address the inequalities experienced by PWUD.

- To continue to support services to improve participation of PWUD in decision-making processes.
- To continue to work collectively with community partners identified in the national drugs strategy.

Goal 5: To promote a health-led approach in partnership with PWUD and relevant stakeholders.

- To continue to work with identified partner organisations to advocate for the delivery of the national drugs strategy commitment to establish a pilot supervised injecting facility.
- To continue to facilitate naloxone training programmes and to advocate for peer-led overdose response initiatives.

Goal 6: To continue to work with PWUD to promote and support the decriminalisation of drug use and the people who use them.

- To advocate for the meaningful participation of the community of PWUD in all relevant discussions regarding decriminalisation.
- To develop submissions and recommendations on issues related to the decriminalisation of PWUD and wider drug policy.

Goal 7: To develop the organisation of UISCE to ensure that the systems, policies, and structures in place are effective and capable of delivering on this strategic plan.

- To work with our funders to ensure that UISCE is appropriately resourced to deliver initiatives arising from this strategy.
- To carry out a review of all UISCE policies to ensure that the organisation has clear governance arrangements in place and to ensure compliance with all relevant legislation.

Lucy Dillon

¹ UISCE (2022) *Peer partnership for change: UISCE's strategy to build inclusion and participation of people who use drugs 2022–2025*. Dublin: UISCE. <https://www.drugsandalcohol.ie/36558/>



National Drugs Library

UPDATES

Recent publications

PREVALENCE/CURRENT SITUATION

Structural gender inequality and gender differences in adolescent substance use: a multilevel study from 45 countries

Cosma A, Elgar FJ, de Looze M, Canale N, Lenzi M, Inchley J and Vieno A (2022) *SSM – Population Health*, 19: 101208. <https://www.drugsandalcohol.ie/37152/>

In summary, our study highlights that structural gender inequality is associated with gender differences in adolescent involvement in substance use. Considering the current large variations in the direction and magnitude of gender differences in adolescent substance use showed by our findings, when orienting the transition towards a more gender-equal society it is important to implement prevention programs focused on specific health behaviours and contexts. International health institutions and national health systems should adapt prevention policies to the specificity of local contexts, by using empirical evidence to inform programs and evaluating their effectiveness on the target outcomes.

An exploration of organizational characteristics and training adoption in Irish community drug treatment services

Kelly P, Hegarty J, Dyer KR, O'Donovan A (2022) *Journal of Addictions Nursing*, Early online. <https://www.drugsandalcohol.ie/36971/>

This study explores the impact that staff and service characteristics have on the process of training adoption in Irish opiate substitution therapy services, with a specific focus on the concept of organizational readiness to change.

Planners and service managers need to carefully consider the composition or dynamics of services when initiating change. Organizational readiness to change and staff characteristics as measured by instruments used in this study are important determinants of the process of innovation or training adoption and provide a good basis for developing further understanding of how treatment services work. This article expands on results from previous studies conducted in the United States to a European context.

Time of self-harm presentations to hospital emergency departments: a scoping review

McEvoy D, Clarke M and Joyce M (2022) *Social Psychiatry and Psychiatric Epidemiology*. Early online. <https://www.drugsandalcohol.ie/36953/>

This scoping review sought to identify studies that report on the peak time of day for self-harm presentations to hospital Emergency Departments (EDs). This could help hospital managers to properly allocate the appropriate services for self-harm patients when they are needed the most.

While this scoping review identified a satisfactory number of studies for data extraction, examination of time of day of presentation was a secondary outcome across most studies. Given that the majority of studies focused on adult samples, further research is necessary to investigate peak times for other age cohorts. More research on this topic is also needed in low- and middle-income countries. Consideration should be given to ensure that the necessary resources to treat hospital presenting self-harm are allocated outside of typical working hours.

Feigning corporate social responsibility (CSR) through health-washing: gambling industry conflicts of interest in health service provision and training in Ireland

Houghton F (2022) *Medicina Internacia Revuo (MIR)*, 30(118): 27–36. <https://www.drugsandalcohol.ie/36950/>

The gambling industry in Ireland feigns concern with corporate social responsibility (CSR) to camouflage its activities. Three particular aspects of the gambling industries' CSR activities may be referred to as health-washing. These are the funding of gambling related research, the funding of counselling programs for individuals and their families impacted by problematic gambling, and the funding of gambling related third-level courses.

This commentary focuses specifically on the last two of these which are funded by the Gambling Awareness Trust (GAT), a representative body of the Irish gambling industry.

Recent publications continued

Has the national fall in smoking rates in Ireland been replicated in cancer patients? A 5-year report

Fitzpatrick P, Bhardwaj N, Lyons A, Doherty K, Frazer, K McCann A, Niranjana V, Syed S and Fox P (2022) *International Journal of Environmental Research and Public Health*, 19(4): 2348. <https://www.drugsandalcohol.ie/36796/>

As part of a feasibility study of smoking cessation for cancer patients in Ireland, smoking rates were reviewed. Hospital In-Patient Enquiry (HIPE) data on the smoking status of discharges with a cancer diagnosis (overall, breast, lung, cervical and head and neck cancer) were used (2014-2018).

Rates remain high; therefore, robust documentation and smoking cessation referrals for cancer patients are important.

Connecting the person by removing the stigma: why Ireland should follow the Portuguese model of drug decriminalisation

Finucane A and Moran Stritch J (2022) *South Eastern European Journal of Public Health*, 6: 5768. <https://www.drugsandalcohol.ie/36795/>

The decriminalisation of drugs and how it can impact addiction, crime and mental health is a subject that inspires global interest and debate. Much has been written about the positive outcomes of decriminalisation from a public health perspective, including the elimination of aggressive policing and community oversight and the shift to offering treatment and social supports for those affected by addiction. Ireland has yet to move to a model of decriminalisation, although a system similar to the one employed in Portugal has been suggested. This article briefly outlines reasons why a paradigm shift is vital if progress is to be made in reducing addiction in contemporary Ireland. The potential benefits could include a reduction in the pervasive social stigma connected with substance abuse, leading to less social exclusion within the Irish population.

A process evaluation of 'We Can Quit': a community-based smoking cessation intervention targeting women from areas of socio-disadvantage in Ireland

Darker CD, Burke E, Castello S, O'Sullivan K, O'Connell N, Vance J, Reynolds C, Buggy A, Dougall N, Loudon K, Williams P, Dobbie F, Bauld L and Hayes CB (2022) *BMC Public Health*, 22(1): 1528. <https://www.drugsandalcohol.ie/36800/>

This paper reports on the 'We Can Quit 2' process evaluation which assessed feasibility and acceptability of the programme and trial processes.

Intervention and trial-related processes were generally feasible and acceptable to participants and CFs [community facilitators]. Any future DT [definitive trial] will need to take further steps to mitigate structural barriers to accessing free NRT [nicotine replacement therapy]; and the established problem of low literacy and low educational attainment in SED [socio-economic disadvantage] areas, while continuing to comply within the contemporary legislative research environment.

An examination of the diversity of beer and cider products sold in Irish supermarkets in the context of health promotion advice

Houghton F and O'Mahony C (2022) *South Eastern European Journal of Public Health*, XVIII: 5720. <https://www.drugsandalcohol.ie/36607/>

This study sought to determine if the assumed alcohol strength of beer and cider available in a sample of mainstream supermarkets was appropriate. This study also sought to examine if the assumed size of containers of beer and cider was accurate.

There is a substantial level of variation in the container size and alcohol content of beer available in mainstream supermarkets in Ireland.

Substance use and self-harm emergency department presentations during COVID-19: evidence from a National Clinical Programme for Self-Harm

Maguire E, Kavalivdou K, Bannan N, Doherty AM and Jeffers A (2022) *Irish Journal of Psychological Medicine*, Early online. <https://www.drugsandalcohol.ie/36724/>

This study aimed to examine any change in self-harm and suicide-related ideation presentations, together with any possible contribution made by alcohol or substance misuse, to Irish Emergency Departments in 2020, compared with 2018 and 2019.

An increase in suicide-related ideation and substance-related self-harm presentations may indicate longer term effects of the pandemic and its relevant restrictions. Future studies might explore whether those presenting with ideation will develop a risk of suicide in post-pandemic periods.

Ireland, the 2020 Tokyo Olympics, Guinness, and the Imagine One World Kimono Project

Houghton F and Houghton D (2022) *Medicina Internacia Revuo (MIR)*, 29(117): 176-181. <https://www.drugsandalcohol.ie/36658/>

A spin-off event building on the global focus on the 2020 Tokyo Olympic Games was the production of 213 kimonos as part of Imagine One World's Kimono Project. Problematically, the kimono produced for Ireland features both the word Guinness and the associated harp symbol. This serves to reinforce and legitimise links between alcohol, sport, culture, and Irish identity. As an artistic work, rather than paid advertising or sponsorship, the kimono would probably not be covered by alcohol advertising control legislation in most countries. National alcohol control advocacy groups should develop materials and linkages with national arts and cultural representative groups to ensure their health message is widely heard.

Recent publications continued

Cannabinoid use for pain relief among people with multiple sclerosis

Daly D and Sweeney BJ (2022) *Irish Medical Journal*, 115(6): 615.
<https://www.drugsandalcohol.ie/36550/>

This research aimed to determine the prevalence and patterns of use of cannabinoids for pain relief among a sample of Irish people with multiple sclerosis (PwMS).

Pain is a significant problem for people with PwMS. A substantial number of people used cannabinoids to manage their pain, however, further research into the efficacy and long-term side effects of this substance is necessary.

Risk factors for COVID-19-related stress among college-going students

Bhargav M and Swords L (2022) *Irish Journal of Psychological Medicine*, Early online.
<https://www.drugsandalcohol.ie/36564/>

This study aimed to explore the degree of COVID-19-related stress among college students enrolled in higher level institutions and identify socio-demographic and psychosocial factors that may predict, or be associated with, higher levels of pandemic-related distress.

Findings suggest that certain categories of college students may be at higher risk for experiencing poor mental health during a global pandemic. Higher level institutions should consider this when designing and delivering support services aiming to promote student mental health and alleviate mental distress.

RESPONSES

Posttraumatic growth following a drug-related death: a family perspective

O'Callaghan D, Lambert S, Conway N and Frost N (2022) *Death Studies*, Early online.
<https://www.drugsandalcohol.ie/36779/>

This paper explores the experience of posttraumatic growth in families who have lost a family member to a drug-related death. Seven family units (17 participants) were interviewed, and interviews were analyzed using reflexive thematic analysis. Analyses revealed themes that reflected positive adaptation and growth, including (a) reframing the loss, (b) open dialogue and social support, and (c) reclamation of purpose. Themes are presented in this paper for their pertinence in understanding how best to negotiate adaptation through complicated grief.

The paper concludes that posttraumatic growth can occur once families begin a process of acceptance and receive support through the journey.

Alcohol and psoriasis for the dermatologist: know, screen, intervene

Kearney N and Kirby B (2022) *American Journal of Clinical Dermatology*, 23: 881–890.
<https://www.drugsandalcohol.ie/36893/>

Dermatologists may be able to complete brief interventions encouraging alcohol reduction in psoriasis patients. Psoriasis patients may respond to messages of gain with reduced psoriasis severity and loss with reduced cardiovascular risk. It is important for dermatologists to discuss alcohol with all psoriasis patients, to be aware of the impact of alcohol in psoriasis and to familiarise themselves with screening tools, brief intervention and local services available to patients who require specialist input for harmful alcohol use or alcohol dependency.

POLICY

Understanding the political organization and tactics of the alcohol industry in Ireland 2009–2018

Lesch M and McCambridge J (2022) *Journal of Studies on Alcohol and Drugs*, 83(4): 574–581.
<https://www.drugsandalcohol.ie/36657/>

This study examines how the alcohol industry responded to developments in Irish alcohol policy leading to the 2018 Public Health (Alcohol) Act, a set of measures designed to reduce overall alcohol consumption in order to reduce harm to health and society. Previous research has emphasized the political and economic strengths of the alcohol industry in Ireland and elsewhere. This study examines the origins of and the debates over this legislation to better understand the political tactics of the alcohol industry.

Public health considerations withstood a range of challenges from alcohol industry interests in passing public health legislation in Ireland. The findings have important implications for the study of the alcohol industry's political tactics in Ireland and elsewhere, including the use of lobbying registry data as a potential data source.

