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Alcohol: availability, affordability, related harm, and policy in Ireland

Background

The Health Research Board (HRB) published its fifth alcohol overview in April 2024.[1] Using data from published Irish and international literature and information systems and surveys, the report examines how much people drink in Ireland, trends over time, and the consequences of their alcohol use. This report also examined alcohol availability and affordability, two key drivers of alcohol use.

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Health Research Board

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Alcohol: availability, affordability, related harm, and policy in Ireland continued

Alcohol use in Ireland

In 2023, per capita alcohol use per person aged 15 years and over in Ireland was 9.9 litres of pure alcohol, a decrease since 2022 (10.2 litres).

Patterns of alcohol use in Ireland

Survey data indicate that approximately one-half of drinkers in Ireland can be classified as hazardous drinkers, more common among males than females, and 32% of drinkers drink multiple times per week. There is a growing minority of young people choosing not to drink, from 18% in 2002 to 28.2% in 2019. However, it is important not to become complacent about alcohol use among young people as hazardous drinking is common in those that do drink.

Alcohol availability in Ireland

Despite an 8% decline in the number of pubs in Ireland since 2012, the country ranks third highest in the world for the number of pubs per 100,000 population. A geospatial analysis of the location of all licensed premises indicated that 73% of the population of Ireland live within 300 metres of a licensed premises and that they are more common in areas of higher deprivation.

Alcohol affordability and expenditure

Although the cost of alcohol in Ireland is the fourth highest in the European Union, in 2021, Ireland had the second most affordable alcohol of OECD (Organisation for Economic Co-operation and Development) members, and price increases have kept in line with inflation, meaning that alcohol remains as affordable now as it was in 2003. Irish households spent EUR 2.9 billion on off-trade alcohol in 2021, which is equivalent to 0.7% of Ireland's gross domestic product.

Alcohol-related harm

To understand alcohol-related harm to health, the number of alcohol-related hospitalisations were examined. There were 18,877 discharges from Irish hospitals in 2021 that were wholly attributable to alcohol use, a 16% increase compared with 2001. However, when population increases are factored in (which have been

In 2023, on average, the adult population of Ireland drank

9.9 litres of pure alcohol.

This corresponds to

37 bottles of vodka

or

104 bottles of wine

or

400 pints of beer

Alcohol: availability, affordability, related harm, and policy in Ireland continued

substantial in that time period), it represents a 17.1% decrease per 100,000 population. However, alcohol-related liver disease has continued to rise, even when population increases are considered, with 2021 seeing the highest ever number of hospitalisations for the condition, increasing by 80% in the 20-year period.

Alcohol use and mental health

The association between alcohol use and suicide and self-harm incidents in Ireland is evident, as one-third of self-harm hospital presentations in 2020 involved alcohol use. A study in the Cork area found that alcohol was present in the toxicology reports of 44% of suicide cases.

Alcohol-related crime in Ireland

Data from the PULSE system (Police Using Leading Systems Effectively) indicated that there were 5,527 incidents of drink driving in 2022; some 9,917 incidents of 'drunkenness'; and 237 liquor-licensing incidents.

Alcohol-related mortality in Ireland

The Global Burden of Disease (GBD) Study estimates that four people die in Ireland every day due to alcohol use and that alcohol use has risen from being the 13th leading cause of death in the population of Ireland in 1990 to the eighth leading cause of death in 2019.

Alcohol treatment

Data from the National Drug Treatment Reporting System (NDTRS) indicate that the number of cases receiving treatment for alcohol as the main problem drug decreased by 2.6% between 2015 and 2022. However, cases receiving treatment for cocaine as the main problem drug and alcohol as a secondary problem substance have increased substantially in the same time period. The most common treatment intervention received is brief intervention, followed by counselling and alcohol detoxification.

Alcohol policy in Ireland

The most important development in alcohol policy in Ireland in the last decade has been the enactment of the Public Health (Alcohol) Act in 2018. The legislation, based on the World Health Organization's 'best buys' recommendations, sees alcohol as a public health issue. Most of the components of the Act have been commenced and, in May 2026, Ireland will be the first country globally to have such detailed and comprehensive labelling on alcohol products. The report also considers the proposed Sale of Alcohol Bill 2022.

Conclusion

Despite a recorded decline, Ireland continues to have a high level of per capita alcohol use that remains above the Department of Health's reduction aim as well as the current Health Service Executive (HSE) low-risk drinking guidelines. The consequences of alcohol use in Ireland are outlined in the report, and future overviews will continue to observe alcohol use and related harms, providing evidence of any impact of legislation or policy changes.

Anne Doyle

1 Doyle A, Mongan D and Galvin B (2024) *Alcohol: availability, affordability, related harm, and policy in Ireland*. HRB Overview Series 13. Dublin: Health Research Board. Available from: https://www.drugsandalcohol.ie/40465/

Policy and legislation

Civil society involvement in the field of drug policy

The Correlation Network (Correlation–European Harm Reduction Network (C-EHRN)) published a report in 2023 entitled *Critical partners: level and quality of civil society involvement in the field of drug policy*.[1] It explores the experiences of decision-makers and civil society from working together in the field of drug policy. Case studies were carried out in four countries – Finland, Greece, Hungary, and Ireland. This article focuses on the findings as they relate to the Irish context. Overall, they suggest a situation in which the mechanisms and structures are in place for meaningful partnership, but it does not always follow through to implementation.

Context

C-EHRN advocates for more civil society involvement in drug policy and decision-making. This is grounded in a core belief:

> *[Doing so is] a sound investment and a core element of good governance. It allows governments at national, regional and local level to tap wider sources of information, perspectives and potential solutions, and improves the quality of the decisions reached. It also contributes to strengthening the capacity of civil society itself.*[2]

This position is widely recognised by international organisations, agreements, and national governments, such as the Pompidou Group of the Council of Europe and the *EU Drugs Strategy 2021–2025*.[3]

Methodology

Two focus group discussions (FGDs) were held in each of the four participating countries. One had civil society representatives (CS FGD) who had expert knowledge of the involvement of civil society in drug policy decision-making, while the other had decision-makers working in the field of drug policy (DM FGD). The groups were structured around the nine criteria of the *Quality standards of civil society involvement in drug policies*, which is an output of the Civil Society Forum on Drugs (see Figure 1).[4,5] In Ireland, representatives of the Ana Liffey Drug Project have been involved in both the current report and the quality standards.

Findings

The report outlines the findings for each participating country, first describing their structures and mechanisms for engaging civil society in drug policymaking, followed by the views and experiences discussed in the focus groups under the nine overarching quality criteria (see Figure 1). The findings as they relate to Ireland are outlined as follows.

Structures and mechanisms

The National Oversight Committee (NOC) is described as the 'head platform' (p. 24)[1] for civil society and Government to work together on Irish drug policy, as well as the six Strategic Implementation Groups, other national drugs strategy subcommittees, and the Citizens' Assembly on Drugs Use.

Civil society involvement in the field of drug policy continued

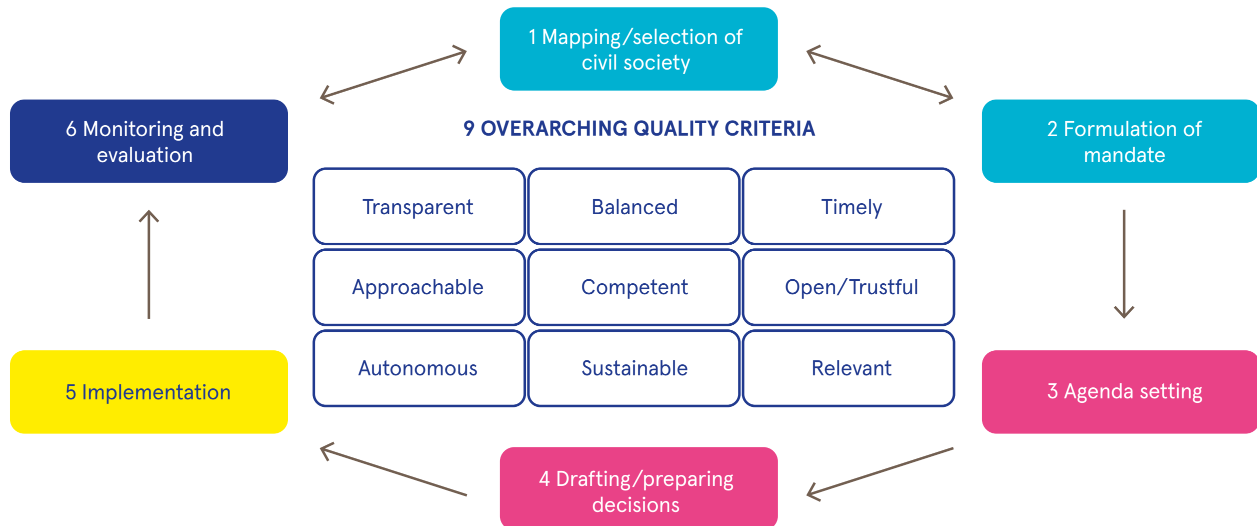


Figure 1: The planning–implementation–evaluation cycle of civil society involvement

Transparency and accountability

Participants in the DM FGD mentioned that the system through which civil society becomes involved at the national level is not particularly transparent. There was a perception that these organisations were 'pre-selected' (p. 28),[1] as there were organisations that had been members of the various groups over a number of Government lifetimes. When decision-makers tried to revise membership to allow for a broader representation of insights, this was met with resistance. The overall message from the CS FGD was that the involvement of civil society has been weakening since 2011.

Balance and inclusivity

There was a call from the DM FGD to broaden the involvement of civil society participation from just the organisations that have been involved historically to ensure the range of perspectives were included (i.e. all concerned citizens including those with lived experience, and not only organisations). This was seen to be less of an issue at the local rather than the national level. However, it was noted by the CS FGD that the role of civil society is often seen to be in the delivery of interventions rather than decisions about policy.

Timeliness

Timeliness was not seen to be problematic in either FGD.

Approachability

The focus groups differed in the extent to which they considered the others approachable. Civil society organisations were perceived by the decision-makers to be approachable and to engage in a professional way. However, civil society had a less favourable view of the approachability of the decision-makers. They were seen to be inconsistent in terms of responding to civil society requests.

Competency

The DM FGD suggested that civil society was not always competent in its ability within the policymaking process. In turn, in the CS

Civil society involvement in the field of drug policy continued

FGD, there was general agreement that the competence of civil society may not be valued and that where they provide their analysis of the drug situation, it was sometimes labelled as servicing a political agenda (p. 38).[1]

Openness and trust

The findings on the theme of openness and trust would suggest that there is not a common understanding on the role of civil society in policy decision-making and that trust can be lacking. There appeared to be differing views between the groups on this, however. Among civil society it was understood that the decision-makers trusted them to deliver services, but that their role in policymaking was diminishing.

Autonomy

The autonomy of civil society was 'one of the most heatedly discussed issues in both FGDs' (p. 43).[1] A decision-maker argued that civil society organisations sometimes go beyond their remit and enter the political realm. Examples of reasons given by decision-makers for why problems arise in this area included a lack of clarity about the role of civil society and its boundaries in policy decision-making and language used. In the CS FGD, there was a view that where civil society was critical of Government policies, they risked losing their funding. This resulted in them being hesitant to air their views publicly. It was argued in the CS FGD that when they air their views or their overall analysis of the situation, they are accused of being political.

Sustainability

The issues that arose on the question of sustainability related to insufficient funding for civil society and a lack of equality in how funding is distributed within civil society. It was noted that some organisations are better funded than others.

Relevance

The DM FGD recognised the importance of the civil society voice in decision-making but the overall findings would suggest a lack of meaningful involvement within the current system. For example, decisions are made by State players and civil society has no real chance to change those decisions.

Conclusion

The findings of this study highlight problems with the current situation in Ireland in terms of the involvement of civil society in drug policy. While formal and operational structures for civil society involvement are in place through the national drugs strategy (unlike in any of the other countries participating in the study), this does not necessarily follow through to implementation. As in other countries, overall, the DM FGD had more positive views about the quality of civil society involvement in policy decision-making than the CS FGD. There is a gap between the two groups in their understanding of the role and meaning of civil society in general and how it can best be involved in the development and implementation of drug policy. There appears to be conflict over airing views and providing analysis of the situation and it becoming 'political'. This leads to a situation where there can be mutual distrust and suspicion, which impacts negatively on partnership working.

What is described as 'a concerning trend' (p. 7)[1] by the authors across all four countries is 'the shrinking space for civil society: many representatives perceive an increasing hostility from governments towards civil society, exacerbated by decreasing funding and advocacy opportunities' (p. 7).[1] This was certainly seen to be the case from the perspective of the Irish CS FGD.

Civil society involvement in the field of drug policy continued

Lucy Dillon

1. Sarosi P (2023) *Critical partners: level and quality of civil society involvement in the field of drug policy. Case study research in Finland, Ireland, Greece and Hungary*. Amsterdam: Correlation –European Harm Reduction Network. Available from: https://www.drugsandalcohol.ie/40481/
2. Correlation Network (nd) Advocacy/civil society involvement. Available from: https://www.correlation-net.org/advocacy.csi/
3. Council of the European Union (2020) *EU Drugs Strategy 2021–2025*. Brussels: Council of the European Union. Available from: https://www.drugsandalcohol.ie/33750/
4. Sarosi P, Fulga V, de Boer Y and Keane M (2021) *Quality standards of civil society involvement in drug policies. Report of the Civil Society Forum on Drugs*. Amsterdam: Civil Society Forum on Drugs in the EU. Available from: https://www.drugsandalcohol.ie/34368/
5. Dillon L (2022) Quality standards and civil society. *Drugnet Ireland*, 80 (Winter): 29–30. Available from: https://www.drugsandalcohol.ie/35835/

The Harm Done: Community and Drugs in Dublin

The Harm Done: Community and Drugs in Dublin is a memoir by Dr Barry Cullen that is grounded in his career since the early 1980s in community work, social services (as a qualified social worker), and as a lecturer and researcher in third-level settings.[1] In his introduction, Cullen says that this 'personal narrative' (p. 15) is aimed at those whose lives have been impacted by drugs and those who study, work, and write about drug issues, community work, and related policy areas. The book culminates in a call for major reforms to Ireland's drug policies and for community development as an essential element of the country's response to the drugs issue.

Barry Cullen, author of *The Harm Done*

The Harm Done: Community and Drugs in Dublin continued

Community development

Underpinning the narrative of the book is Cullen's commitment to community development 'particularly in helping groups and communities to celebrate shared identities and to find solutions to social problems' (p. 16).[1] Based on his experiences in the field, he illustrates the strength and capacity of community groups to address the problems associated with drug use. He grew up in the Dublin suburb of Ballyfermot with parents involved in community work. From an early age he learnt of its value and the barriers faced by people active in this field. His training as a social worker took place in an era where community development and the field of social work were changing rapidly. The context was evolving from one in which the Catholic Church and its religious orders had dominated to one in which lay people were becoming increasingly involved. Furthermore, the individualistic approach of social work that focused on the individual's behaviour in isolation as the problem that had to change was being challenged. A broader understanding of how a person's environment and the systems within it impact on their experiences and outcomes was being taught.

Heroin use as an issue

When he qualified as a social worker in 1980, Cullen took up a role as a community social worker in St Teresa's Gardens (STG) in Dublin's south inner city. Heroin had become more widely available in the area and criminal gangs were involved in its importation and distribution. The impact of this was seen at the local level with an increasing number of young people injecting heroin. Cullen witnessed the escalating drug problem in STG and other parts of the city. He describes the 'catastrophic failure' (p. 48) of the Department of Health to listen to people working in the community who warned about the escalation of heroin use in the late 1970s and early 1980s. There was no formal mechanism in place to have these voices heard. He describes a systematic failure of the Government and State bodies throughout the 1980s to act, despite numerous calls to do so by local stakeholders. Cullen concludes that 'the extent of institutional denial was deeper than anything previously suspected' (p. 58).

Abstinence model for managing drug problems

In the 1970s and 1980s, and leading on from the ethos of alcohol treatment, the treatment for heroin use was dominated by the abstinence model to the exclusion of all others. While both alcohol and drug use were treated medically under a disease perspective, Cullen witnessed a distinct difference in the attitudes of service providers towards those seeking help – those who used drugs other than alcohol tended to be treated with a much more punitive approach. He argues that the National Drug Advisory and Treatment Centre and Coolmine, who both worked to an abstinence model, dominated the statutory treatment response to heroin at the start and did so for almost two decades. This occurred, despite no rigorous evidence base for a positive impact of their services. Cullen argues that the abstinence model continues to be represented as the ideal for treatment in Ireland today.

The communities respond

Chapter 5 describes how in the absence of an adequate State response, communities in the early 1980s began to organise themselves to address the issues they faced as a result of drug use and its trade. Their main concerns included the harms caused to individual residents who were using and their families, the extensive intimidation being experienced by residents from those involved in the trade, and the damage to the reputation of their communities. Cullen provides an in-depth account of how

The Harm Done: Community and Drugs in Dublin continued

members of the STG community held meetings in the early 1980s, which evolved to form the STG Concerned Parents Against Drugs (CPAD) group. He describes the meetings that took place, how they identified actions and initiatives to help address the issues faced, and how they started to take action. At the time, STG was a 'well-established central point of supply for most of South Dublin' (p. 75).[1] Among the first activities organised by the STG group was residents blocking access to the estate for those coming in to buy drugs. This resulted in a shortage of supply for users across the south inner-city area, which was seen to demonstrate the need and value of their local community-driven response. The focus of many of the activities was on discouraging dealers from selling drugs in their community.

Cullen's descriptions of efforts to keep boundaries on the meetings and activities of the local groups, as well as the threat to their safety from those involved in the trade, illustrate the challenges faced in community work. Tensions arose within the community on the best approach to be taken to address the issues arising. For example, some of the activities of a broader CPAD group (the eviction of dealers from their homes) caused division within the community. However, as Cullen sees it the core argument remained, which was that the State had not done enough to address the escalating problem, so the community had to take direct action.

A failed youth project

Between 1983 and 1985, Cullen was the project leader for the STG Youth Development Programme. The project that would work in prevention and treatment was welcomed by the community, but he experienced barriers to delivering on what the community needed. There are two recurring themes in this chapter that illustrate the challenging environment in which he was working. First, the Health Board (and its funding) remained wedded to the abstinence approach to treatment. Cullen was a strong advocate of services that would offer an alternative to abstinence for people who used drugs, but could not secure funding for this. Second, there was a lack of support for a community grassroots-up response to the drugs problem, which was indicated by the concentration of users from a small number of communities. While the link between drug use and these areas was documented, it was not widely acknowledged or discussed by service providers and policymakers: the Government 'favoured retention of the centralised system and squashed the community model before it could even get properly started' (p. 87).[1]

Community and political conflict

The chapter titled Community and Political Conflict deals with the complex relationships between the community and political entities. Direct action by communities against dealers between 1983 and 1985 was seen as largely successful in terms of removing dealers from some communities. However, politicians and authorities, especially the Health Board, were seen by Cullen to be stifling rather than supporting community activities. Furthermore, he recognised that the main political parties by and large were neglectful of the community initiatives. This was in part attributed to a perception that Sinn Féin and the IRA were supporting the 'anti-drugs' campaign. Cullen describes the complex nature of these relationships and the impacts on communities and their activities around responding to drug use and its trade. Media coverage was suggesting that 'anti-drugs community groups were superficially dealing with the problem and being manipulated' (p. 100).[1] This undermined the value of the work of community groups and what they had achieved. While there were elements of manipulation by Sinn Féin and the IRA of the broader 'anti-drugs' movement in the city at

The Harm Done: Community and Drugs in Dublin continued

the time, Cullen rejects the suggestion that they were in control of the community's activities in STG. Cullen argues that the community movement should have been supported by institutions to develop an appropriate infrastructure. Where this was lacking, it left groups vulnerable to others taking advantage for political or other purposes.

Community model for managing drug problems

Cullen joined the Ana Liffey Drug Project (ALDP) as director in 1989, at a time when HIV and AIDS were prevalent among injecting drug users in Ireland. He describes the 1990s as an era of great change, in which services beyond those driven by abstinence became more widely available and the role of the community model was formally recognised. ALDP supported people not only with their drug use but also to resolve other personal, social, and family issues. The wider infrastructure required to work in this way was not in place at the time, but ALDP used individual cases to try and change the system.

The community model gained traction in the 1990s with the establishment of initiatives across the city and has been part of Ireland's national drugs strategies ever since. The *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (better known as the Rabbitte Report) was published in 1996 and recognised the link between drug use and economic and social deprivation, recommending the establishment of what would become the Local Drug and Alcohol Task Forces in the areas most affected.[2] This constituted a major shift in Government policy, in part because it was accompanied by significant funding for the first time. Cullen argues that this approach was not new and that many elements had been outlined previously in 1983 in an unpublished Government report by the Special Government Task Force on Drug Abuse: 'The overall effort aimed to help deal, in a focused manner, with the close association between heroin use and socio-economic disadvantage, an approach so patently avoided and institutionally undermined in earlier decades' (p. 120).[1]

Not all plain sailing for task forces

Overall, Cullen highlights the value of the community model in addressing drug issues. He draws on his experience as coordinator of the Dún Laoghaire Rathdown Drug and Alcohol Task Force (2013–2021) to illustrate the array of activities and successes delivered through this community model. However, he also highlights the negative impact of the financial cutbacks experienced by task forces since 2008. The development of rehabilitation (as opposed to treatment) interventions has been particularly impacted by this lack of resources. The lack of adequate funding means that task forces are at risk of stagnation and cannot respond properly to existing and emerging trends. He sees the current national drugs strategy as placing responsibility for drug policy back in the Department of Health rather than at the community level.[3] He is heavily critical of the current structures, including Sláintecare, which he argues fails to take account of the uneven distribution of the drug problem in localities:

> *The new model appears as a return to doing business as previously during the 1980s, when the central structure was ascendant, and when the attitude of the health authorities, as the heroin problem emerged in inner city communities, was that they could not act until they had a single, universal plan for the whole country or region.* (p. 129)[1]

He recognises that the task force model needs renewal, but argues it is essential that a local partnership approach is adopted so that people have access to wraparound services.

The Harm Done: Community and Drugs in Dublin continued

Changing the unchangeable drug laws

Cullen argues for a major change in Ireland's drug laws, for a policy move that would legalise and regulate all drugs. A recurring theme in this chapter is the hypocrisy of how Ireland deals with alcohol when compared with other drugs, given the extensive harms it can cause. He supports an approach that acknowledges that people use drugs (legal and illegal) to get intoxicated and looks for a system in which that can be facilitated, while minimising the harms caused. As the situation currently stands, prohibition causes problems of violence, drug debt, and intimidation. For those living in communities affected by drug use, there is not necessarily a need for more treatment, rather ways to deal with 'the everyday fear and violence caused by drug criminality and its pervasive impact on young people's lives' (p. 136).[1] He advocates for a position in which Ireland would make a large rather than a gradual move to legalisation and regulation. The market would be under the control of the State. In contrast, a gradual approach would create an environment in which the drug industry would have time to develop a powerful position to influence policy – akin to what is currently the case with the alcohol industry.

Reimagining and strengthening community

In his final chapter, Cullen reiterates the importance and power of community work and how it can bring about small yet significant changes in everyday lives. Throughout his career he has seen the positive impact of community development and associated organisations or initiatives, and how these have been severely negatively impacted by the economic recession and various Government policies. He argues for community development to be more reliably funded, with proper structures to develop and support their work.

Concluding comment

Cullen's book provides a valuable overview from his perspective of the history of heroin use in the south inner city of Dublin and the community's response to the problems it has caused. His narrative reflects the frustration of working in an environment where the only formally accepted and funded approach to meeting the needs of people who use drugs (i.e. abstinence) was failing and the voices of those working in the communities calling for change were largely ignored. This, inevitably, resulted in more harms and loss of life. It was coupled with a political context, in which the concentration of drug use in areas experiencing economic and social deprivation was not acknowledged, despite the availability of data proving this link. Cullen illustrates not only the value of the community model in addressing these problems but also the barriers faced by communities in trying to do this work. His decades of experience have led him to the conclusion that the criminalisation of drugs and their users is adding to the problems and that Ireland needs to take a radical approach to drug laws, introducing legalisation and regulation.

Lucy Dillon

1. Cullen B (2023) *The Harm Done: Community and Drugs in Dublin*. Dublin: SethBrimmers.
2. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996) *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*. Dublin: Stationery Office. Available from: https://www.drugsandalcohol.ie/5058/
3. Department of Health (2017) *Reducing Harm, Supporting Recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. Available from: https://www.drugsandalcohol.ie/27603/

A spatial examination of alcohol availability and the level of disadvantage of schools in Ireland

Background

Among schoolchildren and young adults aged 10–24 years, alcohol use was the second leading risk factor attributable to deaths and disability-adjusted life years (DALYs) globally in 2019. Alcohol use is common among adolescents in Ireland. By 17 years of age, four in five adolescents have consumed alcohol, and Irish adolescent girls are ranked third highest (boys fourth highest) for rates of heavy episodic drinking (HED) in a *Lancet* study examining 195 countries. The Public Health (Alcohol) Act 2018 has children at its core, as not only does it aim to reduce population-level alcohol use and related harms, but it also specifically aims to prevent and delay alcohol use among children. This is why Section 14 of the Act prohibits alcohol advertising within 200 metres of the perimeter of schools, playgrounds, and child service locations. However, not included in the legislation is signage or sponsored awnings, partitions, umbrellas, etc. with logos of alcohol products on premises selling alcohol (e.g. shops and pubs, etc.).

The presence of licensed premises in a community (including the school community) normalises alcohol use, and their exposure to schoolchildren in the form of proximity and density has been found to be associated with early alcohol initiation, higher rates of adolescent drinking, truancy, lower academic achievement, and disruptive behaviour in class.

The Sale of Alcohol Bill 2022 proposes to increase alcohol availability in an attempt to revive the night-time economy following the Covid-19 pandemic. Considering this proposed legislation and the alcohol harm paradox (i.e. those living in more deprived communities are more susceptible to the negative consequences of alcohol use, despite drinking the same or less than those from more affluent areas), this study sought to examine the density and proximity of liquor licences in relation to schools in Ireland. It specifically sought to establish if this differs depending on the level of disadvantage of the school based on DEIS (Delivering Equality of Opportunity in Schools) status versus non-DEIS school status.

Methods

The addresses of all 3,958 schools, including 966 DEIS primary schools and 235 DEIS secondary schools, and all licensed premises (n=14840) in Ireland were geocoded and analysed using Geographic Information System (GIS) software. The number of licensed premises within 300 metres of each school type was examined. Mann–Whitney U tests, Kruskal–Wallis tests, and Dunn–Bonferroni tests were conducted to specifically examine the significance between DEIS and non-DEIS levels of disadvantage and primary schools compared with secondary schools.

Results

The mean number of licensed premises within 300 metres of all Irish schools was 2.01: it was 1.75 for non-DEIS schools and 2.61 for DEIS schools. The higher number of licensed premises in close proximity to disadvantaged schools compared with non-disadvantaged schools was statistically significant ($p<0.001$).

Alcohol availability and level of disadvantage of schools in Ireland continued

DEIS primary schools were further classified according to their level of disadvantage and the results indicated that those schools classified as the most disadvantaged had a significantly greater number of liquor licences within 300 metres ($p<0.001$). However, there was no significant difference in density of licensed premises when comparing disadvantaged secondary schools with non-disadvantaged secondary schools ($p=0.705$).

Conclusion

This examination of licensed premises and their proximity to schools is the first of its kind in Ireland and is important in light of proposed legislation to increase alcohol availability. The findings from this study indicating higher alcohol availability in areas of deprivation align with those from studies in other jurisdictions. This is also an important factor to consider given that those in more deprived areas are more likely to experience alcohol-related harms. Further research is warranted to understand the drinking behaviours of the schoolchildren attending schools with a higher density of licensed premises within the school's vicinity.

Anne Doyle

1 Doyle A, Foley R and Houghton F (2024) A spatial examination of alcohol availability and the level of disadvantage of schools in Ireland. *BMC Public Health*, 24: 795. Available from: https://www.drugsandalcohol.ie/40641/

New Minister for National Drugs Strategy

Colm Burke TD, Minister of State with responsibility for Public Health, Wellbeing and the National Drugs Strategy

In April 2024, Colm Burke TD was appointed as the new Minister of State at the Department of Health with responsibility for Public Health, Wellbeing and the National Drugs Strategy.[1] Minister Burke has been a TD serving Cork North-Central since 2020. Prior to that he was a Senator (2011–2020), a member of the European Parliament for the Ireland South constituency (2007–2009), and a member of Cork City Council (1999–2007). Among his first tasks as Minister will be to coordinate a response to the 36 recommendations of the Citizens' Assembly on Drugs Use, which will be the subject of a forthcoming Oireachtas Joint Committee on Drugs Use.[2]

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

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

Recent research

Trends in gabapentinoid prescribing, law enforcement, drug seizures, and postmortem toxicology in Ireland, 2010–2020

Gabapentin and pregabalin are collectively known as gabapentinoids.[1] They are licensed as an anti-epileptic, for neuropathic pain and generalised anxiety disorder.[2] Since their market introduction (gabapentin 1993; pregabalin 2004) they have risen to become one of the most commonly prescribed medications in a number of countries. One of the theories for the rise in prescribing is the increase in off-label prescribing, i.e. being prescribed for conditions other than that licensed for, such as other pain disorders.

Of concern is that when gabapentinoids are used alongside opioids, there may be an increased risk of respiratory depression, overdose, and death. When first released onto the market, these medications were thought to have a low risk of misuse or dependence; however, ever since there has been a growing recognition of those associated risks. There has been an increased reporting of misuse or dependence to various agencies, and an increase in the number of overdose deaths where they are implicated often in combination with opioids, specifically heroin and methadone. In 2019, the United Kingdom (UK) authorities reclassified gabapentinoids as Schedule 3 (Class C) controlled drugs.

In this context, a 2024 retrospective observational study in Ireland[3] aimed to:

1. Describe trends in gabapentinoid prescribing (2010–2020) using General Medical Services (GMS) data from the Primary Care Reimbursement Services (PCRS)
2. Examine trends in the illicit supply of gabapentinoids (2012–2020) using law enforcement data from Forensic Science Ireland and the Health Products Regulatory Authority (HPRA)
3. Describe trends in the detection of gabapentinoids in a national postmortem population (2013–2020) using data from the State Laboratory, and
4. Estimate rates among individuals with opioid use disorder (OUD) where gabapentinoids were found with benzodiazepines and prescription opioids using data from the State Laboratory (2013–2020).

Trends in gabapentinoids in Ireland, 2010–2020 continued

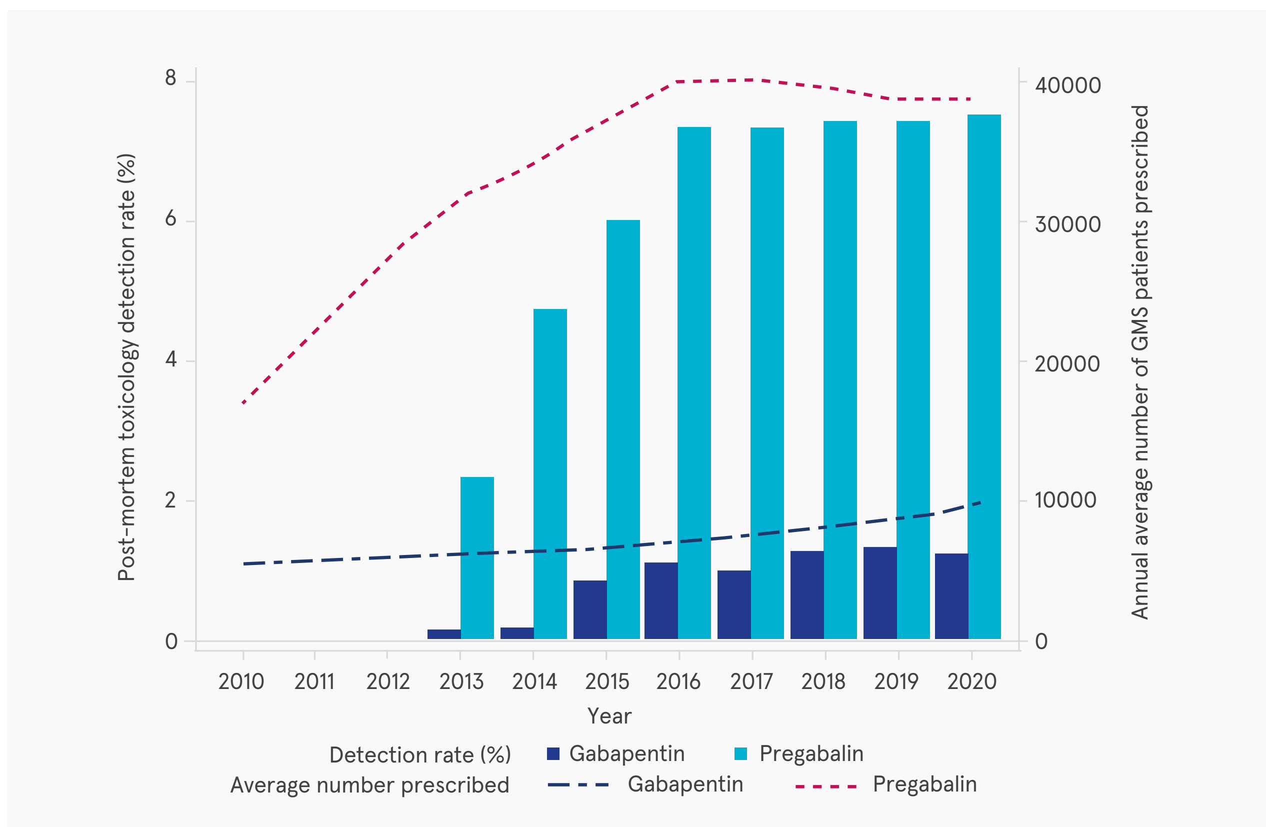
Results

Prescribing data (2010–2020)

The prescription data include those aged 17 years and older. The analysis showed that gabapentin prescribing, after accounting for age and sex, increased every year by 6% (adjusted rate ratio (ARR) 1.06, 95% CI: 1.05–1.06, $p<0.001$). Gabapentin prescribing increased from 454 per 100,000 (GMS population) in December 2010, rising to a high of 823 per 100,000 in December 2020. Prescribing rates for pregabalin were greater than gabapentin for every year. In relation to demographics, women were more likely to be prescribed gabapentinoids than men. Additionally, those aged 46 years or older were more likely to be prescribed these drugs.

Drug seizure data (2012–2020)

Compared with the annual number of all drug seizures, the number of seizures of gabapentinoids is low. Gabapentin seizure numbers rarely numbered above a handful, with the highest number recorded in 2013 (n=14). Since 2016, the number of seizures of pregabalin, again while relatively low compared with the overall number of drug seizures, has been consistently higher than gabapentin, with the highest number in the study period (n=61) recorded in 2019.



Source: Durand *et al*. (2024)[3]

The secondary *y*-axis shows the annual average number of patients prescribed gabapentinoids in Ireland between 2010 and 2020.

Figure 1: Postmortem toxicology detection rate for gabapentin and pregabalin in Ireland, 2013–2020

Trends in gabapentinoids in Ireland, 2010–2020 continued

Postmortem toxicology (2013–2020)

Of the total postmortem toxicology analyses done in the study period, 1,881 (7.14%) cases tested positive for a gabapentinoid: 243 cases were positive for gabapentin (0.92%) and 1,679 (6.37%) positive for pregabalin. Both drugs were detected in a small number of cases (0.16%, n=41) (see Figure 1). There was a statistically significant increase of 28% over the 8 years in positive results, driven by the increasing numbers of pregabalin-positive results.

Rates among individuals with OUD in postmortem toxicology (2013–2020)

An individual was defined as having OUD if they tested positive for heroin or methadone in postmortem toxicology. For the period, 5.2% (n=1379) individuals tested positive for methadone and 3.2% (n=852) tested positive for heroin; in total 7.2% were classified as OUD. Of this group, 27.8% (n=528) tested positive for pregabalin compared with only 4.7% in the non-OUD group. Similar to other results, a lower number tested positive for gabapentin (n=41, 2.2%) in the OUD (compared with 0.8% in the non-OUD group). In almost 1 in 10 (8.2%) of OUD cases, benzodiazepines were found along with pregabalin, which increased over the study period, peaking at 37.3% in 2018, and then decreasing slightly to 31.3% in 2020. The proportion of OUD where benzodiazepines were found along with gabapentin was lower, but also peaked in 2018, at 3.3% before dropping to 2% in 2020.

Limitations

The study has a number of limitations. The prescription data are estimated to represent one-third of the Irish population and does not include private prescriptions or from specialist secondary care. It is likely to over-represent people with a lower socioeconomic status, women, and older people. It does not include any information about what conditions the drugs were prescribed for or other drugs prescribed along with the gabapentinoids. The number of individuals identified as OUD is likely to be underestimated due to the short half-life of heroin and its metabolite.

Discussion

The authors concluded that similar to other countries there has been an increase in gabapentinoid prescribing, in particular pregabalin, in Ireland over the last number of years. Of concern is the finding of the higher rates of pregabalin in the OUD population compared with the non-OUD population. Concurrent use of an opioid along with pregabalin can increase the risk of overdose, with some research showing that pregabalin can hinder the effectiveness of naloxone in reversing an opioid overdose.[4] A number of counties have implemented regulatory measures. However, a 2023 UK study suggests that the immediate impact of reclassification of pregabalin in April 2019 in that country has been limited, particularly on prescribing for existing users of the drug,[5] and had no discernible impact on English drug-related deaths for 2020.[6] In September 2019, the Irish Medical Council issued an advisory notice to doctors in Ireland when prescribing pregabalin to follow best practice guidelines and only prescribe when unequivocally necessary. The authors note that this advice had no impact on pregabalin prescribing in Ireland. However, the authors also sound a note of caution, in the context of the unintended consequences in Scotland, following implementation restrictions on benzodiazepine prescribing in that jurisdiction, which resulted ultimately in an increase in drug-related deaths.[7]

The authors conclude that their findings raise concerns about the risk of ubiquitous prescribing of pregabalin in Ireland, associated street supply, and in particular the potential serious harmful consequences to people who are also using opioids.

Trends in gabapentinoids in Ireland, 2010–2020 continued

Suzi Lyons

1 Neurontin is a common brand name for gabapentin, while Lyrica is a common brand name for pregabalin.

2 Pregabalin is licensed for fibromyalgia in the United States only.

3 Durand L, O'Kane A, Tierney J, *et al*. (2024) Gabapentinoids in Ireland 2010 to 2020: an observational study of trends in gabapentinoid prescribing, law enforcement drug seizures and postmortem toxicology. *Br J Clin Pharmacol*, 90(4): 987–995. Available from: https://www.drugsandalcohol.ie/40133/

4 Lyndon A, Audrey S, Wells C, *et al*. (2017) Risk to heroin users of polydrug use of pregabalin or gabapentin. *Addiction*, 112(9): 1580–1589. Available from: https://www.drugsandalcohol.ie/34645/

5 Ashworth J, Bajpai R, Muller S, *et al*. (2023). Trends in gabapentinoid prescribing in UK primary care using the Clinical Practice Research Datalink: an observational study. *Lancet Reg Health Eur*, 27: 100579.

6 Kalk NJ, Chiu CT, Sadoughi R, *et al*. (2022) Fatalities associated with gabapentinoids in England (2004–2020). *Br J Clin Pharmacol*, 88(8): 3911–3917.

7 McAuley A, Matheson C and Robertson JR (2022). From the clinic to the street: the changing role of benzodiazepines in the Scottish overdose epidemic. *Int J Drug Policy*, 100: 103512.

Suicide risk following hospital attendance with self-harm: a national cohort study in Ireland

An Irish study by Griffin *et al*.[1] assessed suicide risk following hospital attendance with self-harm. This is an important Irish study as it calculated the risk of suicide among those with a history of hospital-presenting self-harm using national-level data.

Background

Self-harm can be defined as intentional self-injury or poisoning, irrespective of motive.[1] There are many ways people can intentionally harm themselves, including poisoning with tablets or toxic chemicals, misusing alcohol or drugs, or cutting or burning their skin.

History of self-harm is the strongest predictor of suicide. It is estimated that the risk of suicide is up to 100 times higher in those that attempted self-harm within the last year.[2] Within 10 years, it is estimated that between 5% and 10% of adults who have self-harmed will have died by suicide. Several studies and a systematic review have reported that the 1-year of risk of suicide after previous self-harm episodes is between 0.5% and 2.0%.[3,4,5]

Several different factors have been shown to play a role in the risk profile among those who presented to hospital with self-harm, including age, sex, and violent self-harm. Though the findings have shown that the highest suicide

Suicide risk following hospital attendance with self-harm
continued

risk is among men, the highest relative risk was among women.[1,2] This means that women with a history of self-harm were more likely to die by suicide than women with no history of self-harm, whereas men overall had a higher risk of suicide. A violent self-harm method (such as hanging and other self-injury methods) was also found to be the strongest examined risk factor of suicide in those aged 20 years or older.[2]

Suicide prevention strategies and interventions can benefit from a greater understanding of suicide risk after self-harm and thereby offer a more tailored approach in mitigating factors that can influence suicide risk.

Methods

The study used data from National Self-Harm Registry Ireland (NSHRI) from the period 1 January 2015 to 31 December 2017. The NSHRI is one of the only dedicated national self-harm registries worldwide, and it records all self-harm presentations to emergency departments in Ireland. The main aim of the study was to examine suicide risk among those who presented to emergency departments in Ireland. The study also sought to identify subgroups that were at an elevated risk of suicide using individual characteristics such as age, sex, self-harm method, and previous history of self-harm. Data collected during this period were also validated using the Irish Probable Suicide Deaths Study (IPSDS). The IPSDS collects national coronial data on probable suicides.

Results

In total, 23,764 individuals attended emergency services after self-harm during the study period. Over one-half (54.4%) of these were female. More than one-third (37.3%) of these presentations were in individuals aged under 25 years. Poisoning or drug overdose only was the most common method (59.5%) of self-harm in those that presented to emergency services. Additionally, 17.6% of individuals presented with self-cutting only. A combination of methods, including drug overdose and self-cutting, or drug overdose and hanging, were used by a minority of individuals. Nearly one-third (31.4%) of individuals had consumed alcohol as part of the self-harm episode. A minority of individuals (17.1%, n=4066) had a history of presentation to hospital having self-harmed in the 12-months preceding their most recent presentation.

The study found that the 1-year risk of suicide in this cohort was 0.9%, with a total of 217 individuals dying by suicide during the study follow-up. The 12-month cumulative incidence of suicide for male, female, and all persons was 1.3%, 0.6%, and 0.9%, respectively. Overall, the 12-month risk of suicide was more than 80 times higher in the hospital-presenting self-harm cohort relative to the general population. Nearly 38.7% of these suicides occurred within the first month following a self-harm episode. Factors such as increasing age, male sex, prior self-harm history, and previous hanging as a method of self-harm were all linked to an elevated suicide risk.

Discussion

Overall, nearly 24,000 individuals presented to emergency services with self-harm during the 2-year study period. In total, 217 individuals died by suicide during the follow-up period. The 1-year risk of suicide was 0.9% for this cohort. These findings are in line with previously reported international figures.

The study highlights the critical need for safety planning and timely follow-up after hospital-presenting self-harm episodes. Suitable interventions are also needed during the first month after the period of self-harm, where the risk of suicide is greatest. Timely and targeted interventions are needed particularly among the youngest and oldest age categories.

Suicide risk following hospital attendance with self-harm

continued

Conclusion

The risk of suicide is elevated after the period of self-harm. Several factors associated with an elevated suicide risk have been identified, including male sex, older age, and hanging as a self-harm method. However, prediction of suicide risk remains very difficult, and all patients should receive appropriate after-care to reduce mortality.

Erica Keegan

1 Griffin E, Corcoran P, Arensman E, *et al*. (2023) Suicide risk following hospital attendance with self-harm: a national cohort study in Ireland. *Nat Mental Health*, 1: 982–989. Available from: https://www.drugsandalcohol.ie/39829/

2 Tidemalm D, Beckman K, Dahlin M, *et al*. (2015) Age-specific suicide mortality following non-fatal self-harm: national cohort study in Sweden. *Psychol Med*, 45(8): 1699–1707.

3 Gibb SJ, Beautrais AL and Fergusson DM (2005) Mortality and further suicidal behaviour after an index suicide attempt: a 10-year study. *Aust NZ J Psychiatry*, 39(1–2): 95–100.

4 Owens D, Horrocks J and House A (2002) Fatal and non-fatal repetition of self-harm. Systematic review. *Br J Psychiatry*, 181: 193–199.

5 Carroll R, Metcalfe C and Gunnell D (2014) Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. *PLoS One*, 9(2): e89944.

Prevalence and current situation

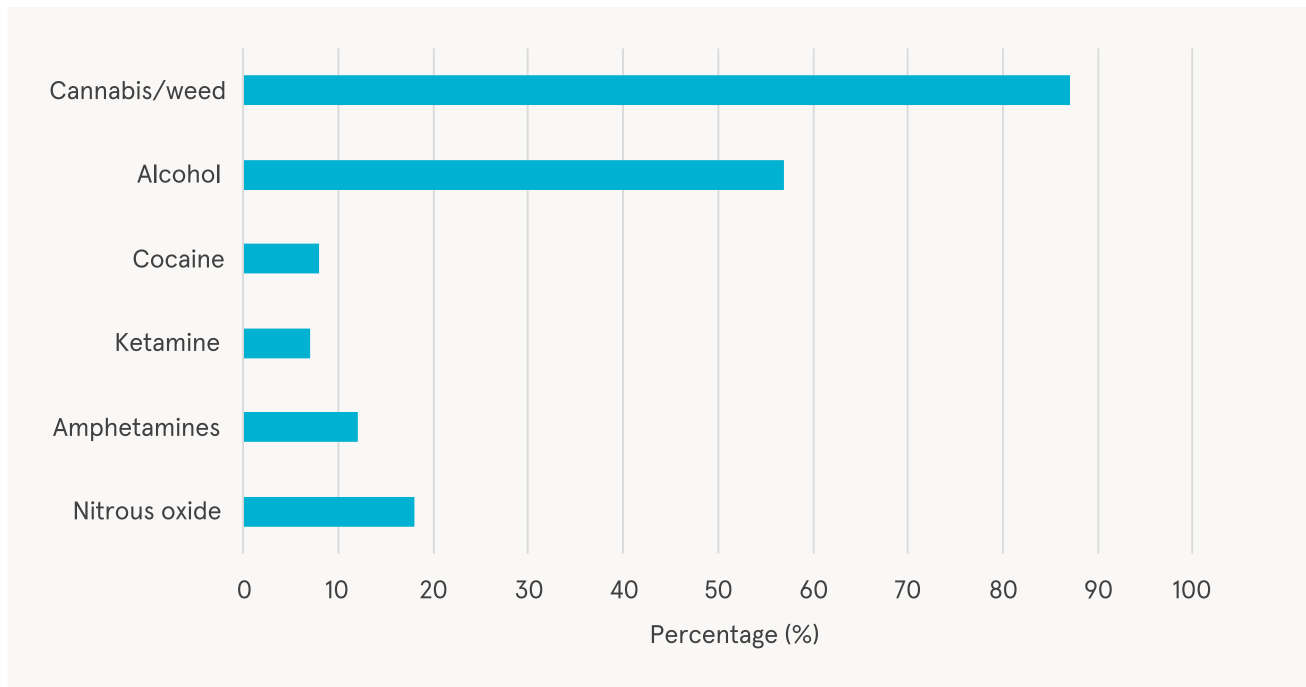
Adolescent Addiction Service report, 2024

The Adolescent Addiction Service (AAS) of the Health Service Executive (HSE) provides support and treatment in relation to alcohol and drug use for young people and families from the Dublin suburbs of Ballyfermot, Clondalkin, Palmerstown, Lucan, and Inchicore. Services provided include advice, assessment, counselling, family therapy, professional consultations, and medications if required. In 2024, the AAS published a report detailing referrals for 2023.[1]

Referrals

In 2023, AAS worked with 60 young people and their families, with a mean age of 15 years (range: 13–18 years). This figure includes new referrals, re-referrals, and continuances. The majority of young people were male (71%), which reflects a 5% reduction on 2022. In terms of referral areas, the greatest numbers of referrals were from Clondalkin, followed by Lucan, Ballyfermot, Palmerstown, and Inchicore. In comparison with

Adolescent Addiction Service report, 2024 continued



Source: HSE AAS (2024)[1]

Figure 1: Main substances used by AAS clients, 2023

2022, referrals were up by 13%. However, 6% of referrals were from outside the catchment area; hence, 3% were referred to services within their own area.

Drug and alcohol use

Cannabis (weed) continued to be the main substance used by clients, with an overall use rate at 87%, while alcohol use was at 57% (see Figure 1). Other substances of use included cocaine (8%), ketamine (7%), and amphetamines (12%). In addition, 18% admitted to taking nitrous oxide on occasion.

Other issues

As in previous years, most young people had established patterns of substance use prior to referral, with an average of 17 months (range: 1–60 months). The extent to which substance misuse featured within families was 48%, compared with 42% in 2022. The incidence of parental separation was also higher in 2023 at 56%, compared with 28% in 2022. Additionally, some young people had one parent who was deceased, while others had experienced domestic violence or sexual abuse. Although the majority of young people lived with their family, 10% were in residential care or foster care.

The report also noted that in addition to co-occurring mental health issues, other issues presented included school refusal, absconding, drug dealing, joy riding, issues around sexual/gender identity as well as unsafe sexual practices. Issues affecting some families included poverty, accommodation insecurity, multiple moves, and overcrowding, with three or four siblings sharing a bedroom or parents having to share with their children. The AAS notes that these circumstances place added

Adolescent Addiction Service report, 2024 continued

stress on all family members, especially where substance use and domestic violence are both features of family life.

Seán Millar

1 Adolescent Addiction Service (AAS) (2024) *Adolescent Addiction Service report 2024*. Dublin: Health Service Executive. Available from: https://www.drugsandalcohol.ie/40526/

National Self-Harm Registry Ireland annual report, 2021

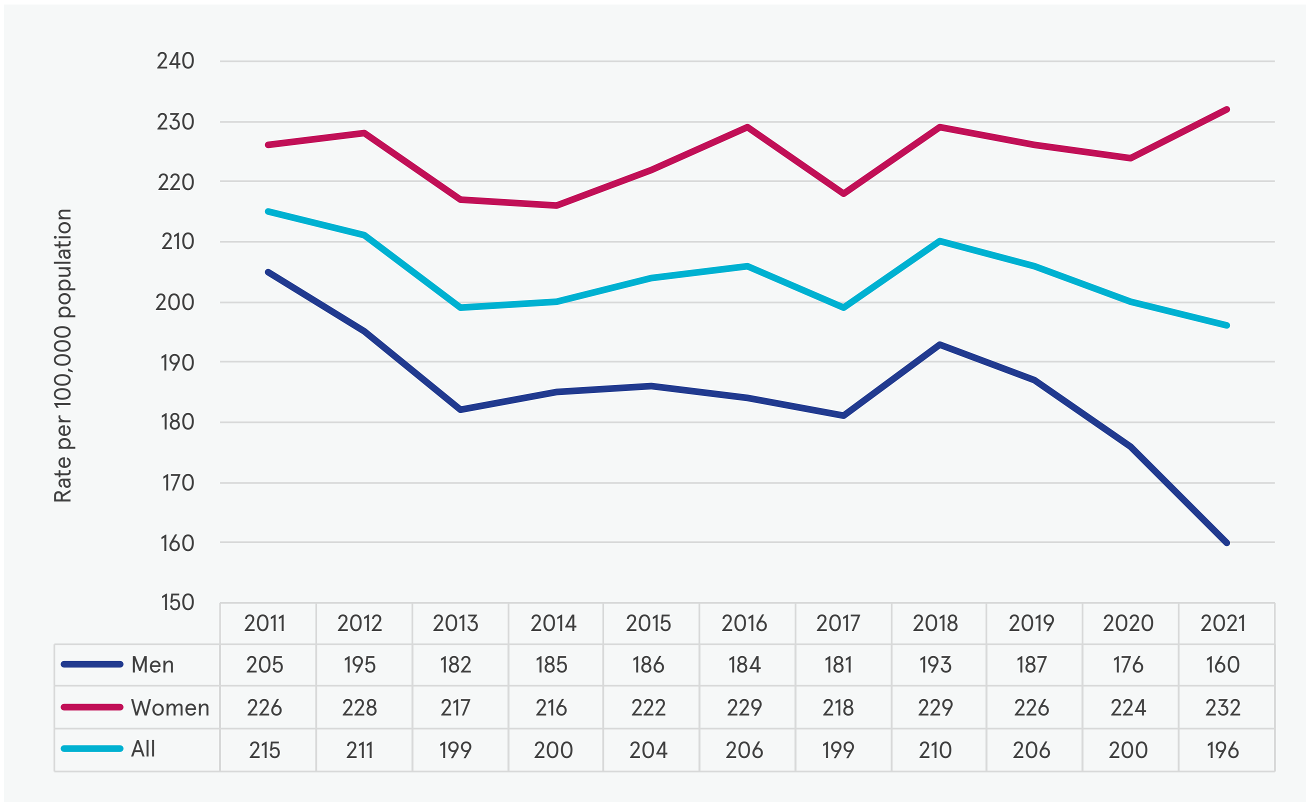
The 2021 annual report from National Self-Harm Registry Ireland was published in February 2024.[1] The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in Ireland in 2021 and complete national coverage of cases treated. All individuals who were alive on admission to hospital following deliberate self-harm were included, along with the methods of deliberate self-harm that were used. Accidental overdoses of medication, street drugs, or alcohol were not included.

Rates of self-harm

In 2021, National Self-Harm Registry Ireland recorded 11,415 presentations to hospitals as a result of self-harm, involving 8,595 individuals. Adjusting for the absence of data from two hospitals, it was estimated that there was a total of 12,661 self-harm presentations made by 9,533 individuals in 2021. Taking the population into account, the age-standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm was 196 per 100,000 population (see Figure 1). This was a decrease of 2% compared with the rate recorded in 2020 (200 per 100,000) and 12% lower than the peak rate recorded by the registry in 2010 (223 per 100,000).

In 2021, the national male rate of self-harm was 160 per 100,000 population, 9% lower than in 2020, and the lowest ever-recorded by the registry. The female rate was 232 per 100,000 population, which was 4% higher than in 2020. With regard to age, the peak rate for men was in the 20—24-age group, at 387 per 100,000 population. As seen in previous years, the peak rate for women was among 15—19-year-olds, at 888 per 100,000 population.

National Self-Harm Registry Ireland annual report, 2021 continued



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Men	205	195	182	185	186	184	181	193	187	176	160
Women	226	228	217	216	222	229	218	229	226	224	232
All	215	211	199	200	204	206	199	210	206	200	196

Source: National Suicide Research Foundation (2024)[1]
'All' in the legend refers to the rate for both men and women per 100,000 population.

Figure 1: Person-based rate of deliberate self-harm from 2011 to 2021, by sex

Self-harm and drug and alcohol use

Intentional drug overdose (IDO) was the most common form of deliberate self-harm reported in 2021, occurring in 6,956 (60.9%) of episodes. As observed in 2020, overdose rates were higher among women (65.1%) than among men (54.9%). Minor tranquillisers and major tranquillisers were involved in 28% and 10% of drug overdose acts, respectively. In total, 35% of male and 50% of female overdose cases involved analgesic drugs, most commonly paracetamol, which was involved in 33% of all drug overdose acts. In 67% of cases, the total number of tablets taken was known, with an average of 27 tablets taken in episodes of self-harm that involved a drug overdose.

Although the proportion of self-harm presentations to hospital involving IDO in 2021 was similar to that recorded in 2020, there was a reduction in self-harm presentations involving street/illegal drugs in 2021, specifically for men. While the female rate remains similar to that reported in 2020, the male rate was reduced by almost one-third. Between 2007 and 2021, the rate per 100,000 of IDO involving illegal drugs increased by 31% for men, while the female rate has almost doubled.

Cocaine and cannabis were the most common street drugs recorded by the registry in 2021, present in 7% and 3% of overdose acts, respectively. Cocaine was more common among men than women and was involved in 20% of overdose acts by 25—34-year-olds. Cannabis

National Self-Harm Registry Ireland annual report, 2021
continued

was most common among men aged 15–24 years and was present in 7% of overdose acts. Alcohol was involved in 30% of presentations. It was more likely to be involved in male compared with female presentations (36% vs 26% respectively).

Recommendations

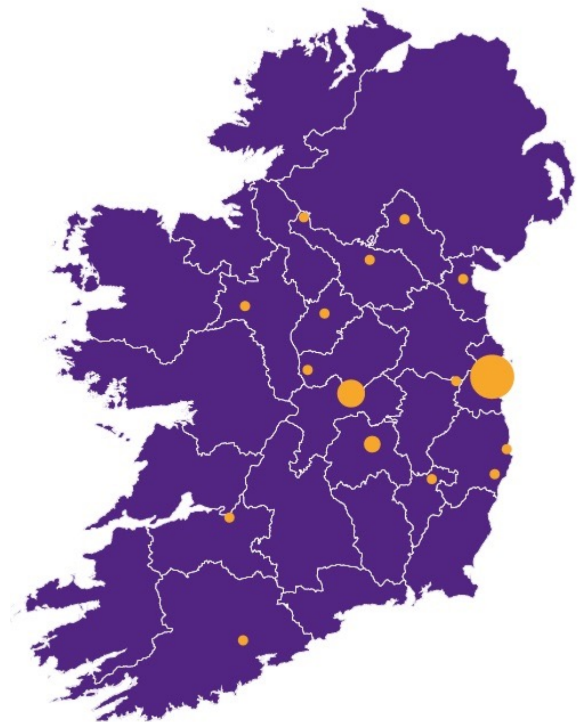
The authors noted that over the past 20 years, the highest rates of self-harm have consistently been observed among young people, underlining the need for upstream and preventative interventions such as school-based universal mental health programmes that have been found to be effective in preventing suicide attempts in young adolescents.

Seán Millar

1 Joyce M, Chakraborty S, Hursztyn P, *et al.* (2024) *National Self-Harm Registry Ireland annual report 2021.* Cork: National Suicide Research Foundation. Available from: https://www.drugsandalcohol.ie/40475/

Merchants Quay Ireland annual review, 2022

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and those that use drugs. There are 27 MQI locations in 14 counties in the Republic of Ireland (see Figure 1). MQI aims to offer accessible, high-quality, and effective services to people dealing with homelessness and addiction to meet their complex needs in a non-judgemental and compassionate way. This article highlights services provided by MQI to people who use drugs in Ireland in 2022.[1]



Source: *MQI annual review 2022*, p. 40[1]
The 14 counties are Dublin, Wicklow, Carlow, Cork, Limerick, Offaly, Westmeath, Laois, Louth, Longford, Roscommon, Cavan, Monaghan, Kildare.

Figure 1: MQI locations in the Republic of Ireland

Merchants Quay Ireland annual review, 2022 continued

Harm reduction services

The aim of harm reduction is to minimise the risks stemming from sharing drug-use paraphernalia. In 2022, MQI facilitated 35,787 interventions in its needle exchange and harm reduction services; 3,808 of these clients were unique.

Community Detox and opioid substitution therapy

In 2022, some 82 clients accessed the Community Detox service in the Riverbank Centre, Dublin, with 60 clients accessing benzodiazepine detox and 12 clients accessing alcohol detox; 144 clients accessed opioid substitution therapy.

Assertive In-Reach Service and community engagement

MQI has an Assertive In-Reach Service which supports and empowers clients to link in with different services to access appropriate and specialist supports. In 2022, the Assertive In-Reach worker supported 82 unique clients and provided 197 interventions.

A Community Engagement Team operates in the neighbourhood around Riverbank in Dublin 8 to strengthen relationships with the local community and stakeholders and proactively engage with clients and people sleeping rough in the area. The team also responds to calls and queries from the general public in relation to the local area as well as collecting drug litter. The team carried out 687 patrols in 2022, engaged with residents and local businesses, and collected 3,200 items of drug litter.

Hepatitis C treatment

The hepatitis C worker is the member of the MQI team who liaises with the primary healthcare team to ensure clients who use drugs intravenously are screened for blood-borne viruses. This worker advocates for testing; if a client is positive, a general practitioner refers the client to a specialist nurse. The hepatitis C worker continues to regularly check in with clients in these situations, ensuring that they are attending appointments and receiving care where required. In 2022, some 176 unique clients engaged with the worker.

Midlands services

Drug and Alcohol Treatment Supports project

MQI's Drug and Alcohol Treatment Supports team provides a community-based drug and alcohol treatment support service for individuals over 18 years of age and their families in the Midlands area (Counties Longford, Westmeath, Laois, and Offaly). Services provided include an outreach-based crisis support service, mobile harm reduction, needle and syringe exchange, rehabilitation and aftercare supports, and support for families affected by substance use. In 2022, some 725 unique individuals were supported through 9,008 interventions.

Recovery services

St Francis Farm and High Park

The St Francis Farm (SFF) Rehabilitation Service offers a 13-bed therapeutic facility with a 14-week rehabilitation programme set on a working farm in Tullow, Co. Carlow. At SFF, MQI provides a safe environment where service users can explore the reasons for their drug use, adjust to life without drugs, learn effective coping mechanisms, make positive choices about their future, and gain hands-on experience in animal care and vegetable production. In 2022, there were 173 referrals to the service, which was an increase of 4% compared with 2021 figures.

Merchants Quay Ireland annual review, 2022 continued

There were 40 individuals admitted to SFF in 2022, and 27 people completed the programme.

At High Park in Drumcondra, Dublin, MQI operates a 14-week residential programme in a 13-bed facility. The emphasis is on assisting clients to gain insight into the issues that underpin their problematic drug use and on developing practical measures to prevent relapse, remain drug-free, and sustain recovery. In 2022, the service received 235 referrals; of these, 205 people completed assessments, 39 were admitted, and 27 completed treatment.

Prison-based services

Addiction Counselling Service and Mountjoy Drug Treatment Programme

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

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

In 2022, MQI counselling staff saw a total of 2,126 unique clients, an increase of 10% on the previous year. In addition, MQI continued to operate a national phoneline where prisoners could access phone support; the service received 6,943 calls in 2022.

Seán Millar

1 Merchants Quay Ireland (MQI) (2023) *Merchants Quay Ireland annual review 2022*. Dublin: Merchants Quay Ireland. Available from: https://www.drugsandalcohol.ie/39781/

Irish Prison Service drugs strategy, 2023–2026

A new strategy document published by the Irish Prison Service (IPS), entitled *Irish Prison Service drugs strategy 2023–2026*, proposes to tackle the use of illicit drugs in Irish prisons by focusing on education, detection, reduction, support, and treatment.[1] The purpose of the IPS strategy is primarily to update the commitments of the IPS in its previous strategy, *Keeping drugs out of prison*,[2] and to set out clear measures to be taken by the IPS to tackle the problem of substance abuse in prisons over the next three years.

There are 12 institutions in the IPS, comprising 10 traditional 'closed' institutions and two open centres that operate with minimal internal and perimeter security. The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy Prison in Dublin, while the remainder are located in a separate wing of Limerick Prison. Despite a lack of published data, interviews conducted with prisoners indicate that there is a readily available supply of drugs in some Irish prisons. Reports suggest that visits by friends and family and the throwing of drugs over perimeter walls are among the supply routes used in Irish prisons.[3]

The IPS recognises that the best way to reduce the demand for drugs in prison is by providing a range of evidence-based options. It has outlined three core tasks to support drug treatment and rehabilitation:

- Inform and educate
- Detect and reduce, and
- Support and treat.

Inform and educate

The IPS will seek to broaden information and education to all people interacting with and living and working within Irish prisons to increase awareness of the devastating effects of bringing drugs into prisons. Measures will include:

- Increasing and improving media presence on all IPS media platforms regarding drug-related harm
- Improving the messaging in prison visiting areas to address harm reduction practices
- Increasing publicity for a confidential phoneline service via website and targeted messaging for visitors and service providers
- Maintaining membership of established international networks to continuously evaluate and develop new health approaches to manage the health impact of drugs in prisons, and
- Enhancing information-sharing networks with criminal justice partners and other State agencies to share learning regarding deterrent and detection advances in drug supply management.

Detect and reduce

The IPS will work to further develop security measures to enhance the detection and prevention of the smuggling of drugs into prisons and to improve retrieval rates of drugs that make their way into prisons. This will include:

- Continued research to inform the ongoing development and enhancement of security measures for exercise yards as significant incursion risk points for illicit substances

Irish Prison Service drugs strategy, 2023–2026 continued

- An increase in the number of screened visit areas
- Implementation of a mandatory process to present recognised photo IDs for all adult visitors
- Consideration of new methodologies and investment in security-scanning technology that more efficiently identifies contraband located in supplies and deliveries entering Irish prisons
- Establishment of formal operating procedures for general search practices and weekly targets for random and intelligence-led operational drug screening for prisoners in each prison, and
- Development of a mechanism to record operational drug screening results and enable sharing of information on detection trends with IPS Healthcare.

Support and treat

The IPS will continue to grow and improve medical and therapeutic interventions and services for people in prison living with addiction. In doing so, the IPS will recognise the overlapping presentations of addiction and mental health conditions and pursue an integrated approach to protect and maintain good health. Specifically, the IPS will:

- Appoint a national clinical lead for Mental Health and Addiction Services
- Engage with the Health Service Executive to implement a dual diagnosis programme in prisons to tackle the challenges of mental health and addiction in line with the national drugs strategy, Reducing Harm, Supporting Recovery[4]
- Evaluate the drug treatment programme available in Mountjoy Prison with a focus on improving the physical environment and operating procedures to achieve good clinical outcomes
- Review addiction counselling allocations with the supplier across all Irish prisons, and
- Increase collaboration with community-based agencies to audit the effectiveness of treatment post-release.

The IPS notes that the new drugs strategy seeks to reaffirm work already underway across the prison estate to interrupt the pathway of substances of abuse and to support those in active addiction when committed to the care of the IPS. It is hoped that with the support of sufficient resources, the IPS will continue to set targets to research, review, and enhance methods to tackle the problem of substance abuse and the prevailing demand for harmful drugs in the Irish prison environment.

Seán Millar

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Responses

Alcohol Liaison Service at Beaumont Hospital, Dublin

Background

In 2022, there were 17,512 discharges from Irish hospitals for wholly alcohol-related diagnoses, according to the Hospital In-Patient Enquiry (HIPE) scheme, indicating that alcohol is a common reason for hospital admission.[1] The mean length of stay for alcohol-related hospitalisations nationally is 9.9 days, increasing from 6.1 days in 2001, and almost double that of non-alcohol-related conditions (5.7 days), and representing 5.2% of all inpatient bed days.[2] This does not include emergency department (ED) presentations as they are not routinely collected in Ireland. However, a study carried out in Beaumont Hospital in Dublin found that 19.4% of ED presentations were alcohol-related.[3]

Alcohol-related hospitalisations only account for some of the societal costs of alcohol harm in Ireland. A 2021 systematic review estimated the costs in high income countries such as Ireland to be 2.6% of gross domestic product, the equivalent of approximately EUR 12 billion.[4] Alcohol use places a considerable burden on Ireland's healthcare system and alcohol liaison specialist nurses play a crucial role within a hospital environment in supporting patients to address their harmful drinking patterns or alcohol dependence. The ultimate aim of the service is to reduce repeat admissions to hospital due to alcohol and consequently reduce the resource burden (both financially and staffing) on the hospital as well as help the patient to manage their alcohol use, promoting a healthier lifestyle, physically and mentally.

Role of alcohol liaison nurse

The alcohol liaison nurse (ALN) is part of a multidisciplinary team engaging with inpatients with alcohol-related health problems. The role includes conducting comprehensive assessments to understand the patient's alcohol use history, physical and mental health, and social circumstances to determine the severity of the problem and inform treatment plans. The ALN provides specialist advice and guidance to the patient in the form of brief interventions, which are delivered to patients to help address their alcohol use and/or consider treatment options. The ALN may provide pharmacology for safe detoxification; vitamin therapy; alcohol education and training to other hospital staff; and onward referral to support services.

Alcohol Liaison Service, Beaumont Hospital, 2023

The Beaumont Alcohol Care Initiative is a cross-disciplinary group set up to tackle the issue of alcohol in Beaumont Hospital and within its catchment area. Clinical nurse manager (CNM2) Elizabeth Gilligan is an ALN on the team, in post since 2008. In 2008, when working part-time, 175 inpatients with alcohol problems were referred to her. In 2023, this had increased to 781 inpatient referrals, representing a 346% increase in the 15-year period and the highest number of referrals recorded since the creation of the post. Some 139 (17.8%) inpatients referred were not seen due to resource constraints. Of the referrals, 642 inpatients were reviewed a

Alcohol Liaison Service at Beaumont Hospital continued

minimum of four times during their hospital stay, ensuring a rapport was developed and a detox regime supervised, where applicable.

Referred patients were provided with an assessment and individual counselling for their alcohol use, and those willing to engage were referred to an appropriate addiction service available in their area of residence. This includes local services, such as Áit Linn outreach service in Ballymun, Dublin (closed since April 2024), and the North Dublin and Ballymun Drug and Alcohol Task Force, as vital interventions following hospital discharge for both patients and their families. Patients outside the Dublin area are referred to their local taskforce teams via a network of services. Patients from ethnic minorities and non-English-speaking patients are linked with appropriate services, wherever available.

The ALN does not have the capacity to cover the ED, despite the recognised need. However, patients with an urgent requirement are seen wherever possible.

Conclusion

There is evidence that the provision of hospital-based-specialist ALN services can reduce hospital readmissions and improve patient outcomes.[5,6] Many patients referred to the ALN have never approached their general practitioner (GP) or any alcohol service for help. Many are unaware of the harm caused by alcohol use or the impact their drinking has on their family members.

Brief interventions in a hospital setting are relatively inexpensive, but can achieve health gains for the population as well as potential cost savings for the hospital by reducing readmissions.[7]

Anne Doyle

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Seeing in the years – alcohol attitudes and behaviours in Ballymun, 2011–2023

Background

The Ballymun Community Alcohol Strategy, part of the Ballymun Local Drugs and Alcohol Task Force (LDATF), aims to use a public health approach to reduce alcohol-related risk to the community's health, safety, and well-being. One of the objectives of the strategy is to monitor alcohol use, behaviours, and attitudes through surveys. The most recent survey was conducted by IPSOS B&A in 2023 and updates those carried out in 2011, 2015, and 2019, and examines what, if anything, has changed.[1]

Methods

A representative sample of the adult population (aged 15 years or greater) of Ballymun in Dublin was surveyed in August–September 2023 to examine alcohol use trends, relevant community issues, and the policy context.

Findings

Alcohol use in Ballymun

Last-year alcohol use was reported by 77% of respondents in Ballymun (80% males vs 74% females), a decrease from 83% in 2011 and 78% in 2019, but it is higher than that reported by the nationally representative sample in the 2023 Healthy Ireland Survey (70%).[2]

Almost one in five of the Ballymun sample reported drinking alcohol 2–3 times per week (19%) and 2% reported drinking on a daily basis. An increase in heavy episodic drinking (HED) was noted in 2023 (46%) compared with 2019 (36%), substantially higher than the national average reported in the 2023 Healthy Ireland survey (24%).

In 2023, over one-third of drinkers reported alcohol initiation (beyond sips and tastes) before 16 years of age (34%). In 2011, the equivalent figure was 26%.

The majority of drinkers reported typically drinking with friends (64%) followed by a spouse, partner or other family members (23%). The number of respondents who reported drinking on their own typically has increased from 3% in 2015 to 10% in 2023. A person's own home is the most common location for alcohol use in 2023 (38%) followed by a pub, bar or club in the local area (33%).

Approximately one in 10 respondents reported using a drink delivery service (9%) compared with 19% in 2019.

Impact of own alcohol use

Respondents were asked to indicate if they perceived that their alcohol use was having an impact on their life:

- 24% said that their family or friends told them about things they said or did while drinking that they could not remember.
- 24% said that they had a feeling of guilt or remorse after drinking.
- 19% said that they failed to do what was normally expected of them because of their drinking.
- 6% said that they sometimes drink alcohol when first getting up in the morning.
- 23% felt that their drinking harmed their health.
- 19% felt that they should cut down on their drinking.

Alcohol attitudes and behaviours in Ballymun, 2011–2023 continued

- 12% felt that their drinking harmed their home life or marriage.
- 10% felt that their drinking harmed their friendships or social life.
- 9% used other drugs while drinking (most commonly cannabis and/or cocaine).
- 8% got into a physical fight when they had been drinking.
- 7% felt that their drinking harmed their work or studies.
- 2% had been in an accident when they had been drinking.

In Ballymun, there was a higher percentage reporting having been in a fight (8%) compared with the national figure (3%). Similarly, 12% of respondents in Ballymun reported harm to their home life or marriage compared with 3% nationally. This may be evidence of the alcohol harm paradox, which is the observation that people living in areas of higher deprivation experience greater alcohol-related harm than those in more affluent areas, even when drinking the same amount of alcohol.[3,4]

Impact of others' alcohol use

Respondents in Ballymun experienced a greater level of negative consequences from other people's alcohol use compared with the national average. For example, 19% of respondents in Ballymun experienced family problems due to someone else's drinking compared with 11% nationally. In Ballymun, 12% had been hit or assaulted by someone who had been drinking, whereas this figure was 5% nationally. Some 15% had property vandalised by someone who had been drinking compared with 4% nationally, and 12% had financial trouble because of someone else's drinking compared with 3% nationally.

Attitudes towards alcohol

Compared with the 2019 survey (51%), the percentage of respondents who felt that it is acceptable for parents, relations or family friends to let children aged 16–17 years drink alcohol in the child's home has fallen in 2023 to 37%; 12% felt that it is acceptable to let children aged 15 years drink alcohol in the child's home. Also declining is the percentage of respondents who felt that it is acceptable to buy alcohol for a 16–17-year-old (from 38% in 2019 to 20% in 2023), and 4% felt that it is acceptable to buy alcohol for a 15-year-old.

Perception of alcohol in the Ballymun community

The percentage of respondents who considered that the following alcohol-related situations were a 'very big problem' or a 'fairly big problem' in their local community of Ballymun were as follows:

- Underage drinking – 57%
- Teenagers drinking on the streets or in parks – 51%
- Alcohol-related violence (fights or assaults) – 48%
- Adults drinking in public – 45%
- Drink driving – 28%.

Alcohol policy perception

Support for alcohol legislation and policies was high. Some 91% agreed (ranging from a little to strongly) that advertising of alcohol on television and radio should be confined to after 9pm to protect children. To gauge support for the proposed legislation in the form of the Sale of Alcohol Bill 2022, some 64% felt that extending the hours at which alcohol can be sold will have a negative effect on public health, public safety, and public order.

Alcohol attitudes and behaviours in Ballymun, 2011–2023 continued

Pictured at the survey launch on 27 February 2024 (L to R): Lionel Duffy (Ballymun Youthreach); Calvin Kearney (Ballymun Athletic Club); Roisin Byrne (Ballymun LDATF); Niamh Ní Chonchubhair (Axis Ballymun); Angela Birch (STAR Ballymun, Easy Street Project); Andrew Montague (chair of Ballymun LDATF); Marie Lawless (Ballymun LDATF); Hugh Greaves (Ballymun LDATF); Orla Fagan (Alcohol Forum/Irish Community Action on Alcohol); Dr Aisling Sheehan (Health Service Executive Alcohol and Mental Health and Wellbeing Programmes); Anne Doyle (Health Research Board), and Rachel Mulcahy (Ipsos)

Conclusion

The data from Ballymun indicate that alcohol use is commonplace, as are hazardous and harmful drinking patterns. Of concern is the increase in HED since the last survey as well as the substantially higher than nationally reported incidence of HED in Ballymun. As valuable and necessary as the national picture is, it is also important to understand alcohol use and related harms in smaller communities, especially those susceptible to alcohol-related harms such as Ballymun. The data highlight the importance of continued focus and where specific responses need to be strengthened.

Anne Doyle

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National Drugs Library

Updates

Recent publications

Responses

Advancing early detection of suicide? A national study examining socio-demographic factors, antecedent stressors and long-term history of self-harm

McMahon EM, Cully G, Corcoran P, Arensman E and Griffin E (2024) *J Affect Disord*, 350: 372–378.

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Prevalence/current situation

Male patient attendances at Sexual Assault Treatment Units in Ireland: an analysis of 381 cases and a comparison with female patients

Kane D, Kennedy KM, Flood K and Eogan M (2024) *J Forensic Leg Med*, 102: 102643.

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Examining the relationship between adversity and suicidality and self-harm in Irish adolescents from 2020 to 2022

Silke C, Heary C, Bunting B, Devaney C, Groarke AM, Major E, *et al.* (2024) *J Affect Disord*, 349: 234–243.

https://www.drugsandalcohol.ie/40281/

A comparison of rate and methods of probable suicide for 2 years pre and post the onset of the COVID-19 pandemic

Mannix D, Holleran L, Cevikel P, McMorrow C, Nerney D, Phelan S, *et al.* (2024) *Ir J Psychol Med*, Early online.

https://www.drugsandalcohol.ie/40341/

Alcohol-related emergency department presentations and hospital admissions around the time of minimum unit pricing in Ireland

Maharaj T, Fitzgerald N, Gilligan E, Quirke M, MacHale S and Ryan JD (2024) *Public Health*, 227: 38–41.

https://www.drugsandalcohol.ie/40186/

Evaluation of a national clinical programme for the management of self-harm in hospital emergency departments: impact on patient outcomes and the provision of care

Cully G, Corcoran P, Gunnell D, Chang SS, McElroy B, O'Connell S, *et al.* (2023) *BMC Psychiatry*, 23: 917.

https://www.drugsandalcohol.ie/40111/

Recent Publications continued

Priority healthcare needs amongst people experiencing homelessness in Dublin, Ireland: a qualitative evaluation of community expert experiences and opinions

Ingram C, MacNamara I, Buggy C and Perrotta C (2023) *PLoS ONE*, 18(12): e0290599.

https://www.drugsandalcohol.ie/40160/

Public health responses to homelessness during COVID-19 in Ireland: implications for health reform

Parker S, Siersbaek R, Mac Conghail L and Burke S (2023) *Int J Homelessness*, 3(3): 36–52.

https://www.drugsandalcohol.ie/39969/

The experience of drug-related client loss for healthcare professionals who support people in addiction

O'Callaghan D and Lambert S (2023) *J Subst Use Addict Treat*, 158: 209236.

https://www.drugsandalcohol.ie/40128/

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