Review of Prevention Systems (RePS) in Ireland: Based on the UNODC/WHO International Standards on Drug Use Prevention

Ross Macmillan, Lucy Dillon and Brian Galvin

Published by:
Health Research Board, Dublin
An Bord Taighde Sláinte

ISBN: 978-1-903669-39-6

Copies of this report can be obtained from the HRB website at www.hrb.ie and from the HRB National Drugs Library at https://www.drugsandalcohol.ie/46461

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

t + 353 1 234 5000
f + 353 1 661 1856
e hrb@hrb.ie
w www.hrb.ie

Review of Prevention Systems (RePS) in Ireland: Based on the UNODC/WHO International Standards on Drug Use Prevention

Ross Macmillan, Lucy Dillon and Brian Galvin

Acknowledgements

The authors would like to acknowledge and thank the following for their contributions in making the realisation and publication of this report possible:

- the Government of Ireland, particularly the Department of Health
- the experts at the United Nations Office on Drugs and Crime who provided guidance on the development of the Review of Prevention Systems (RePS) tool and in analysing the data, particularly Dr Wadhi Maalouf and Ms Hanna Heikkilä
- The RePS Research Advisory Group in Ireland, including Trevor Bissett (Clondalkin Local Drug and Alcohol Task Force), Michéal Durcan (Western Region Drug and Alcohol Task Force), Yvonne Larsen (KORUS, Norway), Richie Stafford (Department of Health), Aisling Sheehan (Health Service Executive), Alexander Sollie Hvaring (KORUS, Norway), Hanna Heikkilä (UNODC), and Dr Wadhi Maalouf (UNODC).
- the network of Drug and Alcohol Task Force coordinators, who were pivotal in distributing information about the project and links to the core survey, as well as responding to the systems element
- all the many project leads and coordinators who contributed their valuable time and expertise in responding to the survey
- members of the Drug and Alcohol Education Workers Forum, who gave their time so generously.
- Dr Gregor Burkhart (formerly of the European Union Drugs Agency), Ms Triin Vilms (Estonian National Institute for Health Development), and Ms Renate K Vesterbekkmo (KORUS, Norway) who peer reviewed the report, and Brenda O'Hanlon for editing services
- the training staff at the European Union Drugs Agency, who provided training in prevention to one of the authors over the course of the work.

Table of contents

Table of figures

Table of tables

Executive summary

Prevention has been a pillar of successive Irish national drugs strategies, with several actions aimed at improving the well-being of young people through delaying the initiation of substance use and providing resources to encourage protective behaviour. In preparation for a new national drugs strategy in 2026, the Department of Health considered how Ireland might develop a more consistent, professionally administered, and knowledge-informed national prevention programme. An important step in developing a national prevention programme will be to establish a baseline for prevention practice in Ireland.

In 2018, the United Nations Office on Drugs and Crime (UNODC), in collaboration with the World Health Organization (WHO), published the International Standards on Drug Use Prevention. Based on these Standards, the UNODC developed the Review of Prevention Systems (RePS), a standardised tool to assess a national prevention system. RePS assesses the extent to which the drug prevention system of a country or region is in line with the Standards. This assessment helps to identify areas of strength and to prepare a plan for improvement. The RePS tool involves two components, each assessing a dimension of the country's prevention system. The first component focuses on the quality of interventions and assesses their concordance with best practices for effective prevention. The second component assesses the system as a whole and the degree to which the system is coherent and logical for delivering effective prevention interventions.

Data collection for the prevention interventions assessment part of the RePS in Ireland commenced in March 2025 and continued to February 2026. Ninety-six submissions generated information on 261 unique activities or programmes, of which 222 were deemed to be relevant to prevention and contained enough information for assessment. The evidence used to assess the prevention system was an analysis of key policy documents, a focus group with members of the Drug and Alcohol Education Workers Forum, and a survey with Drug and Alcohol Task Force (DATF) coordinators. Data collected from these sources were analysed thematically and used to make the assessment.

The report found that, while Ireland's drug and alcohol prevention system has many strengths – including strong public health legislation around alcohol and drugs, a network of dedicated local practitioners and community-based organisations, and a significant proportion (41%) of quality prevention interventions that are evidence based or strongly evidence informed – the country does not yet have a coherent and fully effective prevention system. The delivery of prevention interventions is fragmented and variable. Prevention interventions are largely organised and delivered by local organisations, resulting in uneven access and inconsistent quality across regions, with good practices often isolated or sparse within the local ecology of prevention activities.

Geographic and demographic coverage is good, at least in terms of there being some distribution throughout the country. However, there is imbalance in delivery in large urban areas, with the majority of interventions located in Dublin and quite a few in surrounding areas. There are also gaps in population coverage. The majority of prevention interventions target adolescents, with much fewer interventions targeting early life and at-risk families. Intervention quality and delivery is ultimately quite variable. Many interventions rely on short-term engagement and information sharing despite empirical evidence showing that effective prevention involves multiple sessions, is interactive, focuses on skill enhancement and decision-making, and connects to existing structures and institutions.

There is weak infrastructure for programme evaluation and the use of empirical evidence in designing and executing prevention interventions. While many interventions reviewed in the report were described as evidence informed, few provided evidence of this and none had undergone a local outcome evaluation. Existing evaluations focused on organisation and process outcomes rather than substance use-related outcomes. While prevention practitioners show a strong commitment to their work, training is often informal, self-directed, and resource dependent.

There is a lack of consistency in understanding among those working in the sector around the terms 'universal', 'selective', and 'indicated' risk, and the differences between them. This could undermine policy and planning coherence and programme efficacy, and could result in the inconsistent implementation of responses and monitoring of progress. For example, interventions that fit under the 'universal' risk category are often designated as 'selective' based on the profile of the community where they are being implemented. This is based on a deep knowledge of the difficulties young people face in particular communities, but incorrectly classifying interventions in terms of risk may result in inconsistency in their application and the use of inappropriate outcomes measures.

The national coordination of prevention activities in Ireland needs to be strengthened. At the time the RePS data were collected, Ireland was in a transitional period in terms of its national drugs strategy and associated structures. A new national drugs strategy was being drafted, and the prevention Strategic Implementation Group had not met in over 12 months. Policy should prioritise developing a national strategic approach to effectively support a prevention system in Ireland. This should include the expansion of prevention interventions in order to capture under-represented groups and areas of delivery, as well as support for the wider delivery of existing interventions that have been found to be effective. There is a need to develop a culture and infrastructure (including funding opportunities) for evaluation training and expertise, stronger professional supports for training in prevention, and opportunities for communities of learning. There is also a need to develop a shared national framework organised around a common terminology of risk.

In conclusion, the report found that Ireland has many features that are the foundation of an effective prevention system. However, current prevention efforts are fragmented, insufficiently coordinated, unevenly distributed, and often isolated from key institutions that could support their efficacy. The system as a whole would benefit from better coordination, stronger investment, coherent pathways for training and development, and an infrastructure prioritising outcome evaluations and the use of empirical evidence.

01

Introduction

In 2025, the European Union (EU) presented a new EU Drugs Strategy and Action Plan that updated the procedures and rules for monitoring and controlling drug consumption (1). The strategy reflects the EU's commitment to a balanced and multidisciplinary approach, with a strategy that is grounded in scientific evidence and that aims to curb drug use by reinforcing health and well-being, social connectedness, and security.

The strategy is an integrated approach that involves coordination at EU, national, regional, and local levels and mobilises health and social responses in order to protect against drug use and its negative consequences. The strategy emphasises a 'whole-of-society' approach based on strong sectoral and partner cooperation and an active and engaged civil society. The strategy aims to shape drug policy at both the EU and national levels and includes five strands or pillars:

1. **preparedness and response:** strengthening situational awareness by improving monitoring, substance identification, and response capacities
2. **public health:** stepping up prevention activities, raising awareness about the impact of drug use, promoting integration and social inclusion, and using evidence-based preventive approaches and treatment
3. **security:** stepping up the fight against illicit drug production, trafficking, and criminal infiltration, and implementing stricter rules against organised crime
4. **harm reduction:** addressing drug-related harm in order to protect individuals and society with measures that address individual health as well as social and environmental damages
5. **stronger partnerships:** building strong partnerships in order to address the drug situation, in particular with third countries and regions.

The strategy is anchored in EU values and reflects the rights enshrined in the Charter of Fundamental Rights of the European Union.

Drug policy in Ireland reflects many of the core principles of the EU framework. In general, it is 'health led', with an emphasis on harm reduction, rehabilitation, and social inclusion. The contours of the Irish approach were outlined in the national drugs strategy, titled *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* (2). Key aspects of the approach include:

- the treatment of alcohol and illicit drug misuse as a public health issue that focuses on reducing demand, minimising harm, and supporting recovery
- a strong emphasis on the prevention of alcohol and drug use, particularly among children and adolescents, that is evidence based and operating in all social settings (e.g. schools)
- efforts to reduce the health risks of drug and alcohol use, which include the coordination of multiple Government agencies
- a health diversion approach that diverts people found in possession of illicit drugs for personal use from the criminal justice system and into health services for screening and intervention.

There are important features of the prevention policy context in Ireland that shape the need for assessment. First, prevention policy is set at a national level, and the situation in 2025 (when data were collected for this review) was that the country was between national drugs strategies. Second, prevention occurs in multiple settings and involves the activities of multiple Government agencies. These include the Department of Health; the Department of Children, Disability and Equality; the Department of Education and Youth; the Department of Justice, Home Affairs and Migration; and the Department of Social Protection.

Each department operates independently but can also collaborate with others on prevention initiatives. Third, the departments are seldom involved in the delivery of prevention activities; instead, these are the responsibility of a wide array of actors. One such group is the network of Drug and Alcohol Task Forces (DATFs), which have specific jurisdictions and responsibilities. Importantly, the DATFs are reasonably independent and they have limited day-to-day oversight of their activities. Even when prevention is developed for the nation as a whole, as is the case where the Health Service Executive (HSE) has coordinated with the Department of Education and Youth to develop curricula for secondary schools, it is still the responsibility of individual schools (and even specific teachers in individual schools) to determine whether and how the curriculum is offered. There are also myriad local agencies – city and county based, philanthropic, or corporate – that have assumed responsibility for prevention work. Ultimately, prevention is a very localised activity in Ireland, with national Government Departments providing funding and leadership and local agencies actually delivering interventions. This has led to a wide diversity of practices and approaches.

To date, there has not been a formal assessment of the prevention system in Ireland, and, given the structure described above, a review of current practices and the system as a whole is needed. Moreover, the Government and many stakeholders are – at the time of writing in Q2 2026 – crafting a new national drugs strategy that builds upon lessons learned from current practices and innovation around all the core elements of the earlier strategy. Given this, a review of prevention – both in terms of interventions and the system as a whole – is particularly timely. This report outlines the results of a comprehensive Review of Prevention Systems (RePS) to inform the next national drugs strategy and its implementation.

02

Background

The last 40 years have seen a dramatic increase in efforts to evaluate the quality of public policies and social interventions. This includes both technological innovations and the development of evaluation protocols (e.g. innovative estimation approaches or meta-analyses). It also includes increased scientific and policy interest in quality assessments. The field of drug and alcohol prevention is no exception. Multiple agencies both emphasise the importance of quality assessment and have developed important assessment tools.

An early effort to outline both the importance of and approaches to quality assessment in prevention is seen in the 2007 publication, A manual in quality standards in substance use education, from the Drug Education Workers Forum in Ireland (3). Work at the European level is seen in the 2011 European drug prevention quality standards: A manual for prevention professionals, developed by the European Monitoring Centre for Drugs and Drug Addiction (4). The manual states:

> Information, advice, and guidance are offered to professionals and practitioners [that] will help its users as they progress from a first needs assessment to the delivery of an intervention and its final evaluation [through] implementation of prevention measures with evidence-based components and anchoring them within existing structures and services. (4 p. 11)

In 2015, the United Nations Office on Drugs and Crime (UNODC) took leadership in prevention science by publishing the first International Standards on Drug Use Prevention (5). This was followed in 2018 by a second edition of the Standards that updated the earlier version with more recent research (6). In the Standards, drug use is defined as the use of psychoactive substances outside the framework of legitimate use for medical or scientific purposes. This includes psychoactive substances regardless of their controlled status, and hence includes the use of illicit drugs, as well as tobacco, alcohol, and inhalants. The focus of the Standards on prevention includes any organised effort to avoid or delay the initiation of the use of psychoactive substances or prevent the development of substance use disorders, with particular (but not exclusive) focus on young people. As the introduction to the Standards articulates, "the overall aim of substance use prevention is much broader: to ensure the healthy and safe development of children and youth so that they can realize their talents and potential and become contributing members of their community and society" (6 p. 2).

Like its predecessor, the 2018 Standards document is a qualitative meta-analysis. Its purpose is to:

> [Describe] the interventions and policies that have been found to result in positive prevention outcomes by the scientific evidence and could serve as the foundation of an effective health-centred national drug prevention system. The International Standards also provide an indication as to how interventions and policies should be implemented, drawing on the common characteristics of interventions and policies that have been found to yield positive outcomes. Finally, the document discusses how interventions and policies should exist in the context of national prevention systems supporting and sustaining their development, implementation, monitoring and evaluation on the basis of data and evidence. (5 p. 1)

In order to facilitate the use of the Standards to develop and enhance prevention systems, the UNODC further developed the RePS that was first piloted in Norway in 2023 (7). The RePS is a survey-based tool that was created in order to assess the extent to which the drug prevention system within a country or other jurisdiction is consistent with the Standards. The tool involves two dimensions. The first dimension focuses on the quality of interventions within a country or jurisdiction and assesses their concordance with best practices for effective prevention. This is based on both the review and articulation of best practices found in Chapter I and, to some extent, Chapter II of the Standards. Quality evaluations in the Standards are organised around life stage, type of intervention, and setting, and include research from several dozen countries and five of six continents.

The second dimension assesses the system as a whole and the degree to which the system is coherent and logical for delivering effective prevention interventions. This explores the elements that make for an effective national prevention system, as identified in Chapter III of the Standards. The Standards argue that to "deliver an integrated range of interventions and policies, a system requires strong structural foundations" (6 p. 41), including: (1) a range of interventions and policies based on evidence; (2) supportive policy and regulatory frameworks; (3) evidence-based planning and use of research; (4) coordination among different sectors and levels; (5) a strong delivery system; and (6) sustainability. Collectively, the two dimensions of assessment are crucial in identifying areas of strength and weakness that form the basis of targeted improvements.

This report presents the results of the RePS assessment in Ireland that was carried out in 2025. The report will support the implementation of the next national drugs strategy. The introduction (Section 1) and background to the work (Section 2) are followed by the process and methodology of the data collection (Section 3). This is followed by a summary of the overall information collected about prevention interventions in Ireland (Section 4). Section 5 assesses the quality of interventions in relation to the UNODC/World Health Organization (WHO) Standards, both at a general level and with respect to setting and target group and to organisational features. Section 6 reports the system-level analyses. Collectively, these lead to the conclusions (Section 7), which identify areas of strength and weakness as well as opportunities for improvement. The specific objectives of this report are to:

- identify and catalogue the drug and alcohol prevention interventions operating in Ireland in 2025
- assess each intervention's consistency with the UNODC/WHO Standards
- rate the overall efficacy of the system of prevention in Ireland in relation to 22 criteria across the 6 domains, as identified by the UNODC
- identify specific strengths, gaps, and opportunities for improvement that will ultimately inform the implementation of the next national drugs strategy.

03

Process and methodology

The UNODC developed the RePS tool in 2022 on the basis of the 2018 *International Standards on Drug Use Prevention* and piloted the tool in Norway in 2023. Historically, there has been very little oversight of prevention activities, with most operations existing at national and subnational levels. The UNODC developed the RePS tool with the intent of having a standardised instrument for assessing strengths and weaknesses in prevention interventions and prevention systems within countries and subnational regions with the aim of improving them.

The RePS tool exists within a broad array of activities used to support "governments in implementing a balanced, health- and evidence-based approach to the world drug problem that addresses both supply and demand and is guided by human rights and the agreed international drug control framework" (8).

The RePS tool was developed with guidance from an international panel of experts and practitioners. It is a survey that collects information about the nature of prevention activities in a country or subregion that allows for assessment against evidence-based, effective practices. Following the UNODC/WHO Standards, the original RePS tool involved two components. The first component focuses on the assessment of the extent to which existing interventions are evidence based, while the second component assesses the quality and coherence of the system as a whole. With respect to the first component, the UNODC/WHO classifies prevention interventions as falling into one of five categories: (1) not evidence based; (2) weakly evidence informed; (3) strongly evidence informed; (4) evidence based; and (5) innovative. With respect to the second component, the UNODC/WHO provides a 5-level rating system for each of the 22 system criteria. The five levels are: (1) fully implemented; (2) almost fully implemented; (3) partially implemented; (4) implemented in a limited manner; and (5) not implemented at all. The definitions of each criteria are described in their respective sections. The goal of both components is to identify areas of strength and weakness, and thus highlight areas for improvement.

A. The RePS intervention survey

The RePS intervention survey was launched on AidaForm in March 2025, and survey submissions were received through to February 2026. Given the task of collecting data from operators and coordinators of intervention activities whose experience with online surveys was not known, AidaForm was deemed to be particularly user-friendly and allowed respondents to enter text manually or to record audio in their submissions, which permitted longer or shorter responses depending upon the nature and complexity of the intervention being described. It also had a comparatively sophisticated set of protocols for skipping sections that were not relevant to the survey respondent (e.g. if they indicated that they did not work in the health sector, they were not asked what type of interventions they were involved in that were specific to the health sector). The survey began with an orientation to the survey:

> The purpose of this survey is to gain knowledge about the overall nature of drug and alcohol prevention in Ireland in order to help develop the next National Drugs Strategy... This survey is directed toward practitioners - those who actually deliver or help deliver - prevention interventions in Ireland. By prevention interventions, we mean those that:
>
> > ...have as their primary objective "to help people—especially, but not only, young people—to avoid or delay the initiation of the use of psychoactive substances, or, if they have already initiated use, to avert the development of substance use disorders (harmful substance use or dependence)." (6), p.2

> RePS will map out what is and is not offered in Ireland and the degree to which interventions reflect empirical research on effective prevention at a system level... By contributing to this survey, you are helping shape the future of prevention activities in Ireland and efforts to develop better and more effective prevention.

It consisted of seven blocks of questions. The first focused on the organisation providing the intervention and contact information for the person responding to the survey. The second focused on the sector in which the intervention was provided (i.e. health, education, social care, and/or criminal justice) and the type of intervention. Here, respondents were provided with a set of prevention activities developed by the UNODC and used in the earlier Norwegian Pilot Study, and tailored to each sector. Respondents were asked to indicate which one(s) their organisation provided. There was also the option of simply writing in a prevention activity if it was not covered by the options provided. In addition to this, the RePS survey asked respondents to provide an open-ended description of the prevention activities in which they were involved. Most RePS survey respondents indicated multiple intervention activities. We differentiated between distinct prevention interventions by reviewing and comparing the two sets of responses. Figure 1 is a screenshot of the reporting protocol for the type of intervention based on sector.

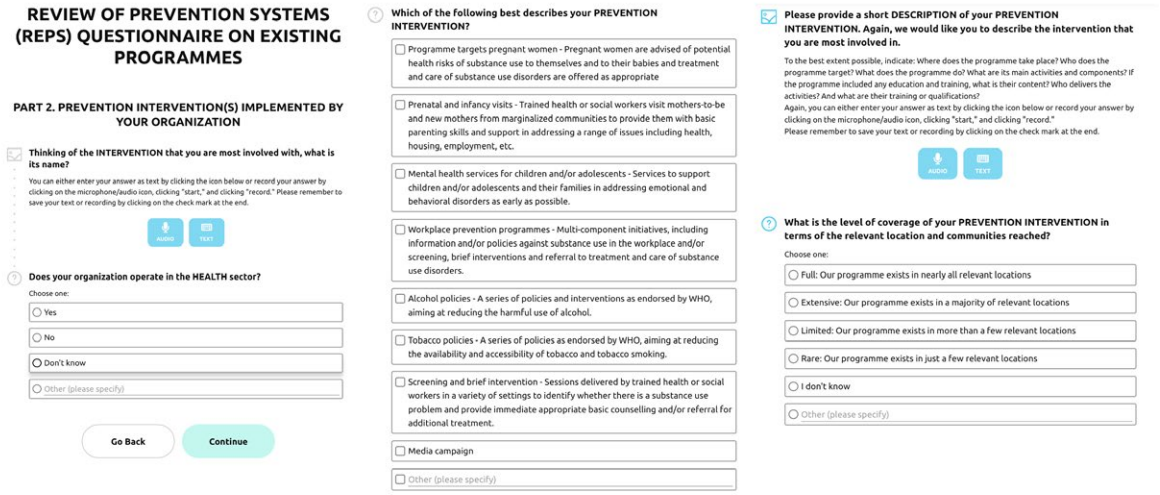

Figure 1: Sample questionnaire section, RePS intervention survey

The third block of questions focused on the demographics of prevention activities, with a specific focus on the age range and the risk type (differentiating between universal, selective, and indicated, with the latter typically indicating treatment rather than prevention) targeted by the prevention activity. The fourth block focused on the perceived evidence – if any – supporting the approach of a particular prevention activity. This included a simple indication of whether the respondent felt that there was research supporting their approach, an opportunity to describe such research in either text or audio, and an opportunity to upload any supporting documentation.

Participants were further asked whether their approach had ever been evaluated – either locally or in another location – and were again given opportunities to provide supporting documentation. The fifth block sought information about training, asking if practitioners had specific training and, if so, what it involved. There were no constraints or guidance given on what 'training' covered. The sixth block focused on the integrity of the interventions and asked if any mechanisms existed that ensured consistency in the delivery of the prevention activities and, if so, what these involved. Again, respondents could both describe the mechanisms and/or upload supporting materials. In a seventh block, respondents were provided an opportunity to name other prevention activities that operated outside of their immediate organisation as a way of both cross-checking the RePS submissions and seeing if any specific activities were missed and needed to be followed up on.

It should be noted that the categorisation of risk applied in the RePS methodology focuses on life stage/age rather than other assessments of risk groups. However, it is recognised that certain groups within Irish society are particularly vulnerable to drug use and its harms, for example members of the Lesbian, Gay, Bisexual, Transgender and Queer + (LGBTQ+) community, Traveller and Roma communities, or those affected by homelessness.

For the most part, the RePS intervention survey used in Ireland mimicked the tool developed by the UNODC/WHO and piloted in Norway. There were only two deviations. First, in some cases, the language was altered to better align with English-language grammar, spelling, and sentence structure. Second, some of the concepts used in the earlier pilot were not consistent with the Irish context. For example, the earlier pilot used the term 'municipality' in its categorisation of geography. Consultation with knowledgeable informants suggested that 'city, suburb, town, or village' was a more appropriate label for the Irish context. Still, such changes were minimal, and the final tool was very similar to that designed by the UNODC/WHO.

A1. Data collection for interventions

In prevention work in Ireland, there is neither a database of all available interventions to target nor a coherent universe of prevention activities. As a result, the effort to identify, survey, and assess prevention activities in Ireland was iterative and multifaceted, with the goal of having as many practitioners or project leads as possible complete the RePS intervention survey. This frames the target sample for the study as all lead practitioners or project leads delivering discrete prevention interventions in Ireland, specifically those connected to the DATFs and those funded by the Department of Health. Equally important, the interventions needed to be operating in the summer of 2025. The overall scope of the data collection covers prevention interventions across multiple age groups (i.e. from prenatal to adulthood), multiple risk groups (i.e. universal, selected, and indicated), and multiple settings (i.e. community, criminal justice, family, healthcare, schools, and workplaces) operating in any of the six HSE health regions.

The project was supported by three groups. The first was the RePS Research Advisory Group, composed of representatives from the UNODC, the Department of Health, the Health Research Board (HRB), the network of DATFs, the Health Services Executive and KORUS, Norway, which provided recommendations on strategy, helped troubleshoot issues arising in the process of data collection, and provided oversight on the overall direction of the project. The second was a smaller assessment committee composed of members of the UNODC, and the lead researcher reviewed all of the RePS submissions; identified discrete interventions; allocated said interventions to appropriate age groups, risk categories, and settings; and determined the final assessment based on the *International Standards on Drug Use Prevention*. The third was a review committee composed of members of the HRB, and the lead researcher provided direction on policy framing, scope of analysis, and the presentation of the key findings.

The approach used for the intervention aspect of this research was a mixed method national assessment using a non-probability approach. The first step involved making contact with coordinators or administrators of all Local and Regional DATFs. The DATF coordinators and administrators were chosen because they play a major role in the provision of prevention activities for a given jurisdiction, and the network of DATFs ultimately covers the entire country. In addition, DATFs provide funding for many prevention initiatives and, at least in theory, are responsible for governance and assessment.

Following the initial contact, the DATF coordinators were provided with a link to the online RePS intervention survey and asked to forward the link to anyone in their organisation involved in prevention activities. They could also fill out the survey themselves, and many did. DATF coordinators further assisted by including the RePS intervention survey on the agendas of their weekly meetings and coordinating among themselves to publicise the survey. This aspect of the research combined strategic sampling with respondent-driven sampling approaches.

A second round of activities targeted organisations or individuals that had received funding for drug and alcohol prevention work from the Department of Health. The relevant contact person was provided an invitation and link to the survey. Members of the Department of Health assisted by directly following up over the study period. A third round of activities used Internet searches to identify interventions that had not been captured in the earlier RePS submissions, and invitations and links were sent to identified contact persons. On average, there were four follow-up emails sent with a link to the survey for each RePS invitation. Following this, a fourth round of activities explicitly sought information on the existence of prevention interventions not previously captured in the first three rounds. One aspect of this capitalised on the network relationships among practitioners and asked for information about other interventions (i.e. those not reported in their RePS submission), and these were checked against the roster of submissions. When a unique submission was identified, the relevant coordinator or project lead was contacted directly in order to solicit their participation. A second aspect involved Internet searches focused on age groups, settings, and areas that appeared under-represented in the RePS submissions to that point. Both strategies had limited success in identifying additional interventions.

Given the iterative nature of the research and the lack of any true universe of prevention interventions in Ireland, it was not possible to determine the typically reported response rate for survey research. That said, there are good reasons to believe that the research protocol was reasonably successful in identifying both existing prevention activities and gaps in prevention services. On the former point, at least one, but typically, multiple, submissions were ultimately received from a coordinator or project lead connected to all entities contacted through the first two rounds of the research. On the latter point, both the intervention analyses and the system analyses were very consistent in identifying activities outside the scope of the intervention survey. This increases confidence that the intervention survey adequately captured the types of prevention interventions that it was designed to capture.

Ultimately, 96 RePS submissions generated information on 261 unique activities or programmes, of which 222 were deemed to be relevant to prevention and contained enough information for assessment. Programmes relevant to prevention included interventions, infrastructure projects (e.g. funding agencies and training programmes), and support services. When infrastructure programmes and support services were removed, the final list consisted of 121 prevention interventions. The criteria for inclusion in the study were based on a consensus of the assessment committee that: (1) the reported intervention was prevention focused (as opposed to being focused on harm reduction or treatment); (2) the primary activities included enough content around substance use (as opposed to programmes emphasising out-of-school activities without substance use as a core theme); and (3) the reported intervention included enough information to be evaluated.

However, interventions are assessed age-specifically in the *International Standards on Drug Use Prevention*. In other words, interventions apply to specific age groups, and their efficacy is determined based on that age group (e.g. early childhood, older adolescence, and adulthood). Given that in practice, interventions typically target at least two (e.g. early and older adolescents) and sometimes three or more (e.g. families) age groups, the 121 unique interventions were classified as age-specific interventions for the purpose of analysis of targeted age groups and for all assessments. This resulted in 272 age-specific interventions.[1] The overall triage process that generated the final samples is shown in Figure 2. The total number of submissions compares favourably with the documentation of prevention activities in Norway (a country whose population is similar in size to Ireland), where the RePS submissions identified 187 interventions, of which 130 were deemed to be prevention interventions and were therefore included in their analyses.[2]

1. Some analyses may have slightly fewer cases due to item-specific missing data.
2. The significantly greater percentage of submissions that were deemed to be prevention related in Norway's assessment likely reflects two factors. First, the earlier pilot informed thinking about prevention and identified the importance of 'infrastructure' and 'support services', with the former added as a category of activity and the latter expanded in scope and content for the Irish RePS. Second, the process of soliciting submissions involved: (1) a very explicit definition that would likely have screened out non-prevention activities; and (2) targeted coordinators of Local and Regional DATFs who administratively are the frontline of prevention in Ireland. As a result, the Irish RePS survey was very targeted in terms of who it sought information from and what it sought information about.

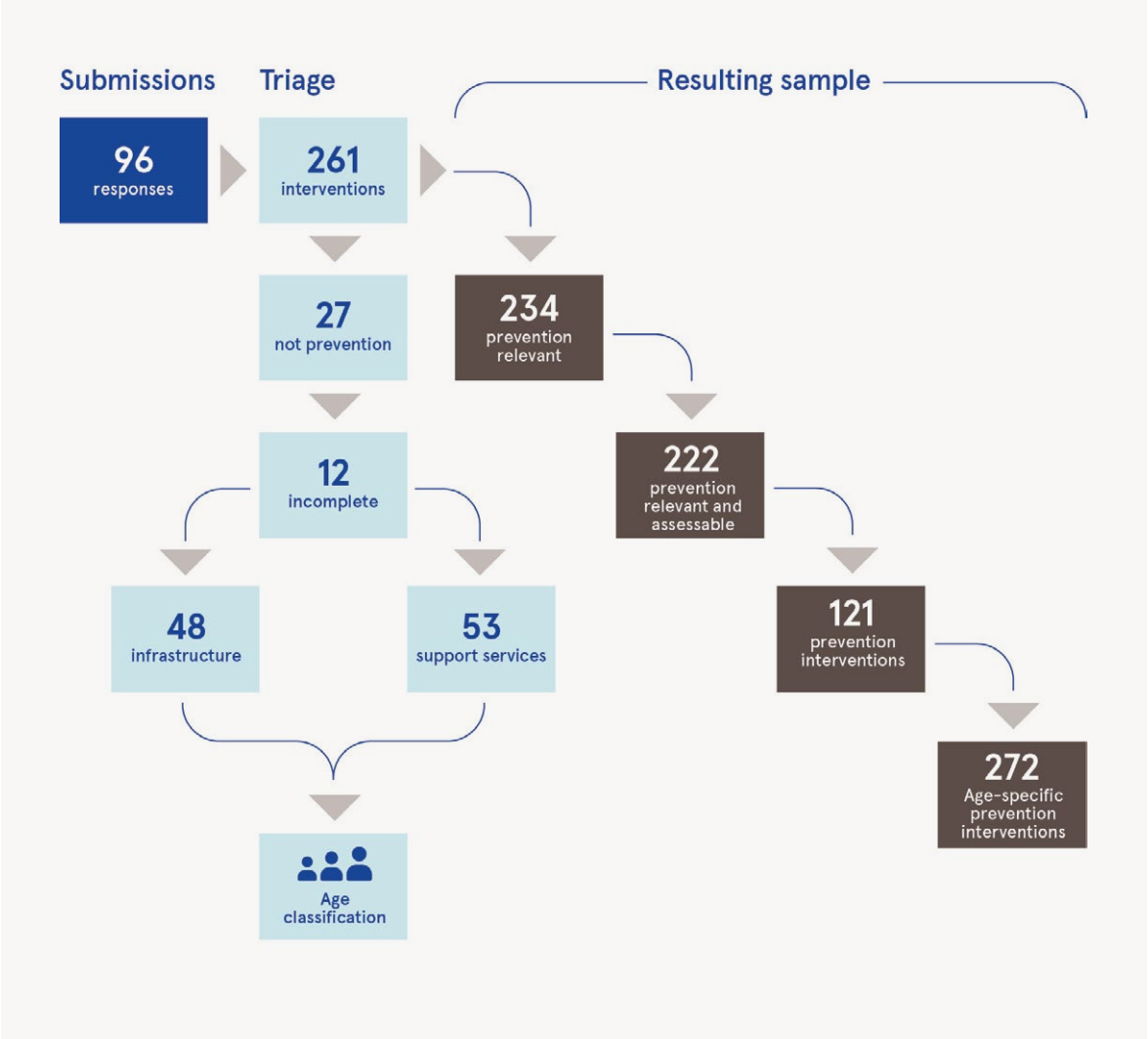

Figure 2: Triage protocol and resulting sample of prevention interventions

A1.1 Screening

The assessment of prevention interventions with respect to consistency with the UNODC/WHO *International Standards on Drug Use Prevention* involved the assessment group that consisted of the lead researcher and two members of the UNODC. On two occasions, researchers who contributed to the development and delivery of the Norwegian pilot joined meetings. Prior to meeting online, all attendees were provided with a file that included the raw RePS data, a cleaned version of the RePS data, and a list of all identified prevention activities (to date). The assessment group operated on a consensus model. Each intervention was assessed by two raters, and the group discussed each case in order to reach a consensus on the evaluation. Although there was no formal assessment of inter-rater reliability, there were very few instances where the initial raters had radically different assessments, and most discrepancies were easily resolved by further examination of the RePS submission.

Specifically, the group had two tasks. First, the submissions were assessed with respect to whether or not they were prevention interventions. This led to the elimination of 27 indicated activities. Twenty-five of these were eliminated after it was determined that they were not actually prevention interventions. The vast majority were interventions deemed to be more focused on treatment or harm reduction. The distinction between prevention and treatment, although often unclear in practice, is critical for drug use policy (9). A further 12 activities simply did not provide enough information for assessment (e.g. only a title or vague description was provided). For those without sufficient information, the majority appeared to be some form of media activity, one-off information provision, or public engagement activity. In cases where there was insufficient information, a follow-up request was sent to the original respondent. In most cases, further information was not forthcoming. One submission appeared to be a duplicate of an earlier submission, and these two submissions were merged.

Another aspect of the screening process differentiated submissions with respect to whether they were prevention interventions or activities that supported prevention interventions. With respect to the latter, there were two types: infrastructure and support services.

The RePS submissions identified activities that were not prevention activities but were the infrastructure necessary for prevention (e.g. training in prevention) and were designated as such. Infrastructure activities are those that provide the organisational and financial support for prevention interventions. A particularly clear example of this in the Irish context is the existence of Regional and Local DATFs. These DATFs have considerable autonomy and broad mandates and almost universally engage in a very broad range of activities within and beyond prevention. These sit alongside the Department of Health and the HSE, both of which fund and coordinate a range of prevention activities. Other types of infrastructure include organisations, training programmes, data collection, and projects that direct or oversee a range of prevention activities.

In addition to infrastructure, other activities were not prevention activities themselves but were supportive of prevention. Here, the designation of 'support services' was applied. Activities classified as support services are very diverse and are outlined in Annex 1 of the *Review of National Prevention Systems based on the UNODC/WHO International Standards on Drug Use Prevention: Final report of the pilot in Norway* (7). In many cases, an intervention targets multiple age groups, yet the *International Standards on Drug Use Prevention* indicate support for some age groups but not others. In such instances, the activity that is not age-consistent would be deemed a support service. The majority of support services involved three types of activities. The first type are interventions that engage young people in prosocial activities. These predominantly involved either sports or arts. The second type are interventions – typically trauma informed and emphasising mental health – focused on young people and families. One common service in this group is drop-in centres or 'safe spaces' that generally involve places that are free from alcohol, tobacco, or other drugs; that typically have trained adults as mentors; and where positive relationships and inclusion are promoted in order to encourage healthy choices and better decision-making.

Here, there is a critical distinction in that the UNODC/WHO Standards acknowledge that mental health supports can be important for drug and alcohol prevention, but the evidence is only strong when the targets are older children or young adolescents and when the intervention specifically incorporates substance use. In contrast, many mental health services are very open-ended with respect to age and focus. The third group of services are variable supports for families and young people, including educational supports, vocational training, information technology training, or childcare. In the end, support services as viewed in the UNODC/WHO Standards are critical activities in drug and alcohol prevention in that they help build a foundation for stronger institutions, more positive relationships, and increased socio-emotional well-being that lead to better decision-making around alcohol and drug use.

The final determinations for inclusion and categorisation are shown in Figure 3. Forty-six percent (121) of all submissions were deemed prevention interventions, and another 20% (53) were deemed support services. The latter were excluded from the later analyses. Nineteen percent (48) of unique activities were deemed to be infrastructure and were therefore excluded. A further 10% (27) were deemed not to be prevention activities, and 5% (12) did not provide enough information for assessment. The latter were excluded from analysis as well. In the end, 121 interventions were included that form the basis of the analysis.[3]

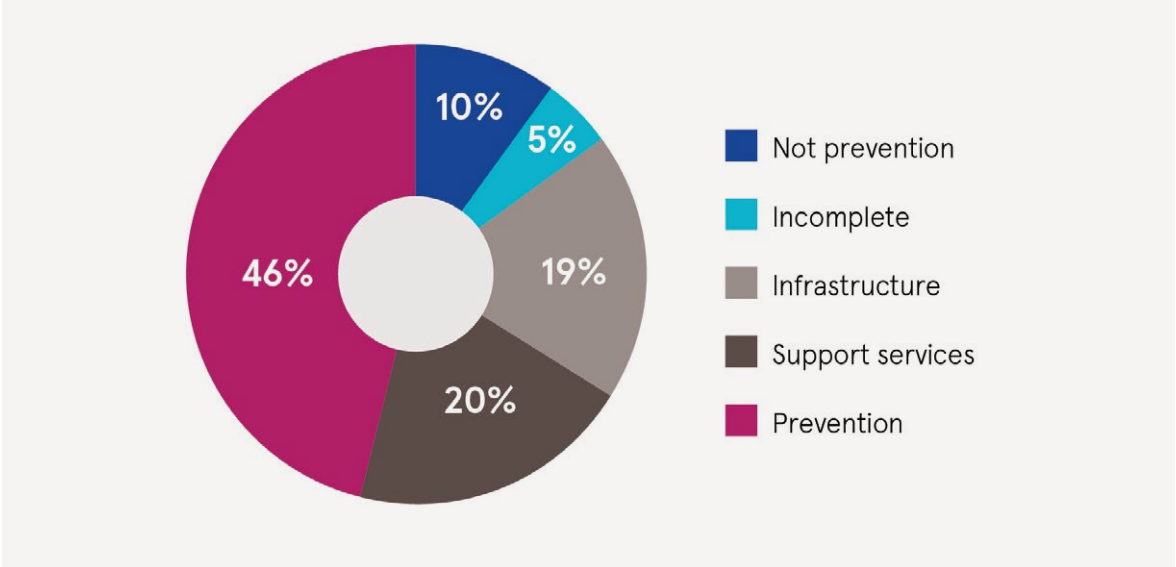

Figure 3: Percentage of programmes by final determination

The second task for the assessment group was generating a summary evaluation indicating how consistent each reported prevention intervention was with the *International Standards on Drug Use Prevention*. The decision tree for making determinations is shown in Figure 4. The first stage of this involved identifying whether the intervention had been evaluated or not. If the intervention had been evaluated and deemed to be sufficiently consistent with prior approaches, it was categorised as either 'evidence based – locally evaluated' or 'evidence based – not locally evaluated'. Here, evaluations needed to be outcome (rather than process) focused, be organised around a strong scientific methodology (case control or stronger), and consider outcomes such as a decrease in substance initiation, use, or progression. For interventions targeting children aged under 10 years, evaluations could focus on more intermediate factors (10).

3. Specific analyses may have fewer cases given missing data on specific questions.

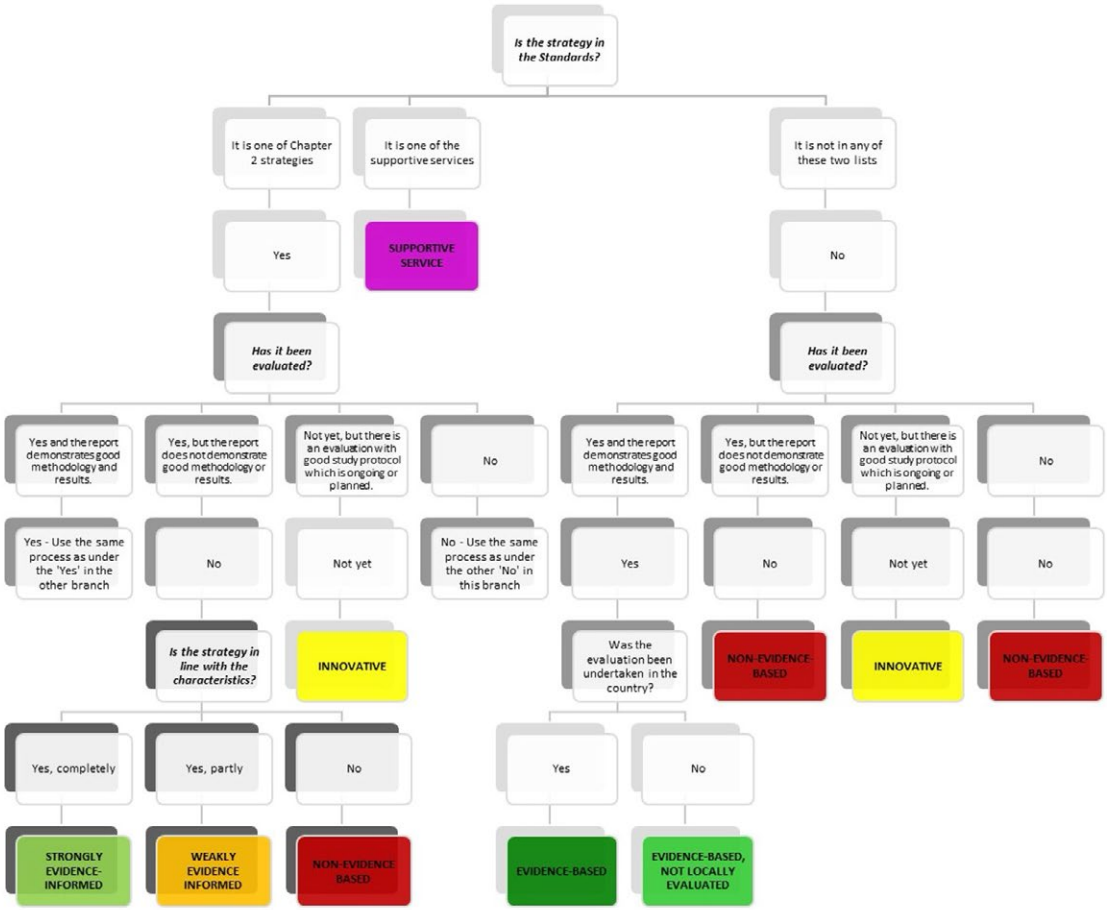

Figure 4: Decision tree for RePS assessment

Source: United Nations Office on Drugs and Crime, KORUS Oslo, 2023 (10)

If an intervention had not been evaluated, the content of the information provided was then assessed in relation to the description of interventions and best practices outlined in Chapter II of the UNODC/WHO Standards. This resulted in one of five designations. If an intervention type was not described in the Standards, it was deemed to be 'not evidence based'. If an intervention type was included in the Standards, then the characteristics of the intervention determined whether it had a positive, negative, or no effect on relative outcomes. An intervention was categorised as 'innovative' if there was no research to either support or challenge a particular approach, but where an evaluation with a strong methodology was planned or in process. The third and fourth categories were 'strongly evidence informed' and 'weakly evidence informed', with the distinction between the two lying largely in the overall extent or consistency of the information provided with criteria outlined in the Standards. The default when information was lacking was to designate an intervention as 'weakly evidence informed'. The final designation was 'evidence based' for interventions where an outcome evaluation, regardless of whether it occurred in the local context, indicated positive support for the efficacy of the intervention.

Throughout the process, the overall project received valuable input and strong support from a RePS Research Advisory Group that consisted of the authors, members of the HRB, members of the Department of Health, members of the UNODC, researchers who contributed to the development of the RePS tool and protocol, and two DATF coordinators.

A2. Categorisation of interventions

To give structure to the assessment process, each intervention was categorised based on seven dimensions: HSE health region, target age group, target risk level, setting, empirical basis for design and implementation, extent of training, and presence of mechanisms to ensure consistency.

A2.1 Geography

The first dimension was geographic location, which aligned with the current HSE health regions. Figure 5 is a map of the boundaries for the six regions, namely HSE West and North West, which comprises the counties of Donegal, Galway, Leitrim, Mayo, Roscommon, and Sligo; HSE Dublin and North East, which includes the northern part of Dublin, Cavan, Louth, Meath, and Monaghan; HSE Dublin and Midlands, which includes the western part of Dublin, Kildare, Laois, Longford, Offaly, and Westmeath; HSE Mid West, which includes Clare, Limerick, and Tipperary North; HSE Dublin and South East, which includes Carlow, the southern part of Dublin, Kilkenny, Tipperary South, Waterford, Wexford, and Wicklow; and HSE South West, which includes Kerry and Cork. Interventions were allocated to HSE health regions based on the location (e.g. region, city, town, or village) where the intervention was delivered.

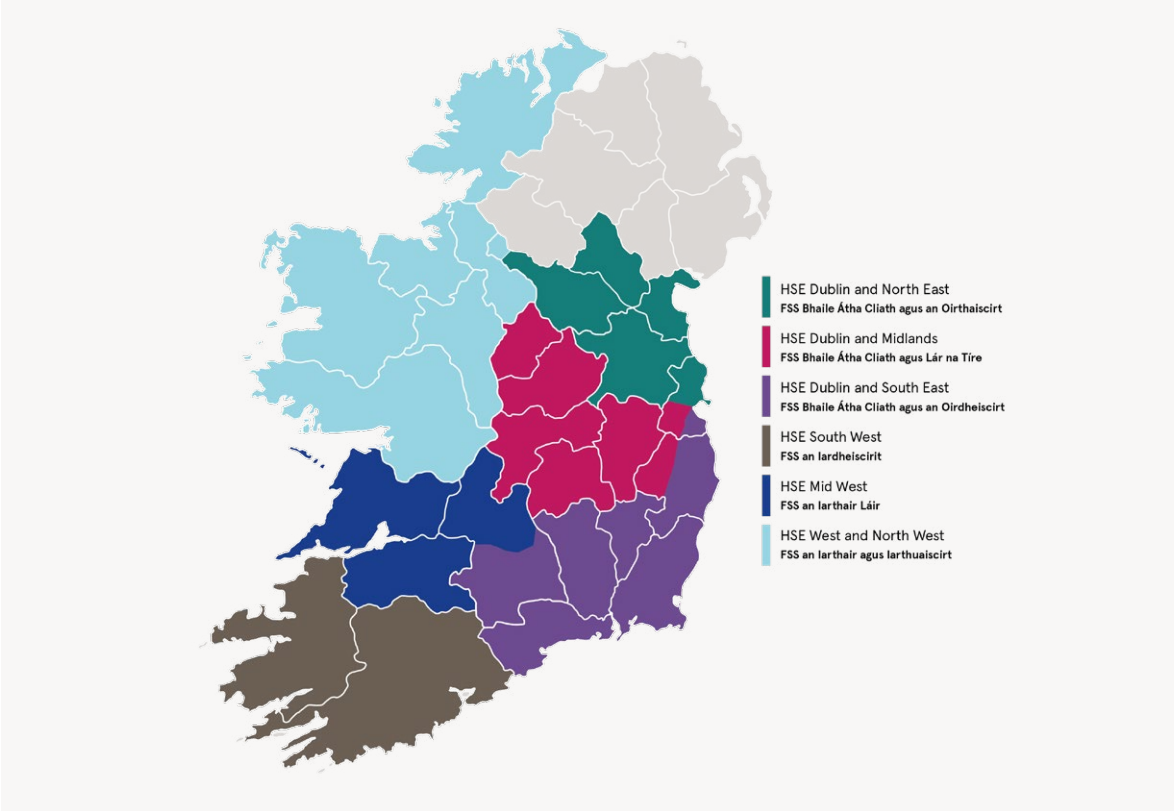

Figure 5: Geographic boundaries and county composition for HSE health regions (11)

A2.2 Age

The second dimension is target age group. The UNODC/WHO Standards organise interventions in terms of age group, and the assessment of interventions is typically age dependent. In other words, research may support a particular intervention for one age group, while not supporting the exact same type of intervention for another age group. In the RePS intervention survey, respondents were asked to indicate the age group or groups that the reported intervention(s) targeted. Respondents were provided with the instruction "Please use the age of the population among which the intervention intends to prevent substance use. For example, a parenting intervention for parents of early adolescents should indicate 'from 11 to 15' as the intervention seeks to prevent substance use among this age group (even if the participants are parents)" and then provided with the options of "no specific age group", "up to age 5", "from age 6 to 10", "from age 11 to age 15", "from age 16 to 18", "age 18 or older", and "I don't know". Respondents could indicate as many age groups as applied to the intervention(s) being reported, and they also had the option of "Other, please specify" where they could write in their response.[4] Based on these categories, this report has used age groups in accordance with the UNODC/WHO Standards' categories of 'infancy and early childhood', 'middle childhood', 'early adolescence', 'older adolescence', and 'adulthood'.

As mentioned in in subsection A1.1 on screening, interventions are assessed age-specifically in the *International Standards on Drug Use Prevention*, while in practice, interventions typically target multiple age groups. Given this, the classification by age group results in a larger number of age-specific interventions, as this is necessary for quality assessment (as well as better conforming to the reality of prevention work).

A2.3 Level of risk

Each intervention was also categorised according to the level of risk of the target group. This aligns with the Standards in that different types of interventions are more or less effective depending upon whether substance use has been initiated and, if so, the extent and pattern of use. The categorisation of risk includes three groups: (1) 'universal' targets the population at large (e.g. all families or all students); (2) 'selective' focuses on groups that have significantly higher risk than the typical person (e.g. children in socially deprived areas, or families exposed to alcohol and drug use); and (3) 'indicated' targets individuals who have a particularly high risk of substance use. This latter group typically includes individuals who are already using alcohol and drugs and hence are at particular risk of progressing to substance use disorders. For both the selective and indicated risk groups, there were follow-up questions that asked respondents to indicate who the risk group was. In practice, an intervention could target or encounter multiple risk groups, and the categorisation allows for this. This and its implications are discussed further in Sections 4 and 5.

4. In the Norwegian pilot study report, the categories included "pregnancy", "infancy (zero to two/three years of age)", "early childhood (two/three to five/six years of age)", "middle childhood (six to nine/ten years of age)", "early adolescence (10/11 to 13/14 years of age)", "older adolescence (14/15 to 18/19 years of age)", "youth (sic) adulthood (19/20 to 25 years of age)", "adulthood (25 to 65 years of age)", and "senior citizens (more than 65 years of age)".

A2.4 Setting

Each intervention was categorised according to the setting in which it was reported to be implemented. Settings included 'family,' 'health,' 'criminal justice,' 'school,' and 'multiple.' This was based on a number of different submission elements in the RePS intervention survey, including sector, type of intervention, and the qualitative description of the intervention(s). In line with the UNODC/WHO Standards, the 'community' category was a bit of a catch-all that reflected a wide array of locations and circumstances. Importantly, targeted risk groups (such as students and families) can be accessed in a variety of settings, and it was often a judgement call as to which setting best captured the different interventions. Interventions are sometimes implemented in multiple settings and, if so, were categorised as such.

A2.5 Perceived empirical basis for intervention effectiveness

Each intervention was also categorised according to whether the respondent making the submission indicated that there was research supporting their approach. Specifically, they were asked, "Is there any research or studies that provide support for the way in which your programme is designed and implemented and support its effectiveness as a prevention intervention?" Respondents were also provided the opportunity to describe such research or upload any relevant materials, although very few respondents did so. An important caveat is that most respondents reported on at least two and sometimes more interventions, yet were only able to provide a global assessment of whether their work as a whole was empirically backed. Still, it is useful to know whether people think their work is empirically supported given the assessment of quality that frames the second part of this report.

A2.6 Training of staff

In addition, the RePS intervention survey asked about the training of staff. Specifically, respondents were asked, "Have the people delivering your prevention intervention activities been provided with relevant training?" There was also a follow-up question asking about the duration and content of such training if respondents indicated that staff were provided with training, as well as an opportunity to describe and/or upload any relevant documentation.

A2.7 Quality control mechanisms

The final aspect of the RePS categorisation process focused on mechanisms that ensured that each intervention was delivered in a consistent manner. Specifically, respondents were asked, "Does your prevention intervention include a mechanism or procedure to ensure that it is always implemented in a similar manner?" and, if they answered 'yes', they were prompted to describe such mechanisms and/or provide any relevant documentation. Consistency of delivery is often ensured by a codified set of instructions or protocols that are part of the training of prevention practitioners. Although this is not always the case and likely varies based on the type of intervention and its complexity, the idea that interventions are 'manualised' is a key element that ensures consistency.

A3. Limitations and challenges of the RePS intervention survey

There are several limitations and challenges for the intervention analysis. First, and like all survey research, the quality of the data is entirely dependent upon the responses received. And while the overall picture of the submissions was extremely positive – in terms of the number of submissions, their breadth, and their quality – the analyses can only reflect what information was submitted or what data we could identify through external sources in order to augment what was submitted.

Second, and related to the first limitation, the assessment had to rely on the amount of information provided. The UNODC/WHO Standards begin with published research and then categorise the components associated with better prevention outcomes. In contrast, the RePS intervention survey respondents typically reported on more than one intervention and provided general information about the type of intervention, who the target group was, and some operational characteristics of the intervention and its providers. In many cases, there simply was not enough information to make a fully informed judgement. Given this, two strategies were pursued. First, follow-up enquiries were sent directly to the RePS survey respondents asking for clarification. Unfortunately, there were very few responses to these enquiries. Second, the researchers were deliberately conservative when information was lacking and classified interventions as 'weakly evidence informed' rather than 'strongly evidence informed', or as 'not evidence based' rather than as 'weakly evidence informed'.[5,6]

Third, there is no real universe of prevention interventions, and hence no sampling frame to draw upon or assess the submissions against. In one respect, the lack of a sampling frame is conceptual and definitional. Most prevention takes place behind closed doors in the routine activities of families and schools, and is part of the normative socialisation of young people, and most organised prevention takes place when there is a perceived failure on the part of families, schools, and communities. In another respect, there is no question that some prevention activities were not accounted for in the research. And while we did go to significant lengths to identify as many interventions as possible, some interventions will have been missed. It is unknown whether there was something systematic in our research methodology that skews the results.

Fourth, the organisation of interventions and their assessment in relation to research does not always reflect clear definitions that can easily be matched. For example, almost all RePS intervention survey submissions indicated multiple age groups, and the interventions reported almost never conformed to one specific age category. In some cases, interventions targeted multiple age groups. Particularly common target age groups were early adolescents, older adolescents, and young adults. This is not surprising given the widely reported delay in the onset of historically recognised 'adult social roles', such as the termination of schooling, movement into full-time work, marriage or partnering, parenthood, and exit from the home of origin (12).

5. It was typically not difficult to determine whether outcome evaluations had been carried out locally or existed for other contexts.
6. One of the main criteria that differentiated weakly and strongly evidence informed interventions was the extent of contact inherent in a prevention intervention, and the evaluators were usually able to infer this from the submissions, particularly the qualitative descriptions.

As the lack of involvement in such roles is itself a key risk factor for alcohol and drug use (e.g. not being in education, employment, or training), it is not surprising that interventions do not conform to clearly defined age groups and that people who are legally adults are often targeted simultaneously with adolescents. Another important issue is the focus on families, which, by definition, include people of different ages. Even though the RePS intervention survey instructions asked respondents to focus on the age of the focal target of the intervention, more often than not, interventions focused on multiple family members – for example, parents and children – and hence involved multiple age groups.

If an intervention targeted more than one age group, it was accounted for in each of the age groups targeted. When a specific age range was provided, it was converted into the relevant age group. For example, one intervention specified the age range of "5 to 24". For categorisation, this would have resulted in the UNODC/WHO categories of 'infancy and early childhood', 'middle childhood', 'early adolescence', 'older adolescence', and 'adulthood'. This categorisation was then assessed against the type of intervention (e.g. based in secondary schools), and the data were recategorised accordingly if the weight of the evidence supported such a change. Analytically, a count of the number of age-specific interventions is necessary in order to capture the quality of interventions, as they are age-based in the International Standards on Drug Use Prevention. Given this, the age-specific analyses and the quality assessments are based on a target age group sample that is much larger than that based on the interventions alone. This results in a sample of 272 distinct interventions targeting distinct age groups. Specific analyses may have fewer cases due to missing data for specific questions.

A similar situation exists for targeted level of risk. Here, definitions of risk blend together in terms of, for example, issues of age, vulnerability, and exposure, which have different expressions in different contexts. One RePS intervention survey submission provided the following summary of risk: "The reality of life in 2025 is that every area of the country reports substance use episodes as noted in the 2024 HRB report. The prevention strategy in [area] acknowledges that every young person will encounter or be offered MACs at some stage as they go through the teen years".

Likewise, definitions of settings seldom map onto the domains of prevention interventions that assume multiple risk factors in multiple contexts. A school-based intervention could still involve parents, and a health intervention could target families with young children. Similarly, the forthcoming national health diversion scheme involves activities in both the criminal justice setting and in community and healthcare settings. In the end, we have done our best to limit any ambiguity and highlight problematic areas, but any such effort will fall short of matching standards drawn from scientific research, which almost universally focuses on a specific group in a specific context in a specific place.

As a final limitation, the RePS intervention survey is much better at capturing some aspects of prevention than others. In particular, it captures prevention interventions that are discrete in nature, that are organised in a local context, and that are the responsibility of a particular entity. Other prevention activities that operate at a more system level and are more generalised or diffuse (e.g. national policies or advertising restrictions) are not captured well by the survey. Still, the combination of the survey and the system-level focus groups should mitigate the negative implications of this for understanding and assessing drug and alcohol prevention in Ireland.

B. The RePS system research

As with the intervention aspect of RePS, the UNODC's assessment tool lays out the elements and the criteria to assess the extent to which a national drug prevention system is considered to be supportive of evidence-based prevention, and in line with the UNODC/WHO's *International Standards on Drug Use Prevention*. Each criterion provides guidance in order to assess how well it is met. There is a description of when a system might be considered to meet the criteria fully, almost fully, partially, only in a limited manner, or not at all. The UNODC acknowledges that the rating of these criteria will require local interpretation and, in some cases, adaptation.

B1. Data collection for the system analysis

Evidence to inform this assessment process was guided by a system-focused questionnaire designed by the UNODC as part of the RePS tool. A pragmatic approach was taken to data collection. In Q3 and Q4 of 2025, the team drew on four existing evidence sources that provided information based upon which to make assessments:

1. Ireland's annual national prevention report to the European Union Drugs Agency (13)
2. *Evaluation of National Drug Strategy "Reducing Harm, Supporting Recovery 2017-2025"* (14)
3. *Report of the Citizens' Assembly on Drugs Use* (15)
4. relevant sessions of the Joint Committee on Drugs Use:
    - 20 November 2025: Engagement on education, awareness and addiction prevention in schools (https://www.oireachtas.ie/en/committees/34/drugs-use/videos/)
    - 4 December 2025: Engagement on youth harm reduction, prevention and diversion (https://www.oireachtas.ie/en/committees/34/drugs-use/videos/).

Not all the information required was available from the above sources. Topics not covered adequately included prevention practitioner training, brief interventions, and DATF prevention structures. Two additional data collection exercises were undertaken in order to inform the assessments:

1. Focus group with 11 members of the Drug and Alcohol Education Workers Forum: This forum is made up of some of the prevention practitioners working in the DATFs, the HSE, and Foróige. The researchers carried out a focus group that explored these practitioners' views and experiences of prevention training, use of evidence and quality standards, and the strengths and weaknesses of Ireland's drug prevention system (see Appendix C).

2. Survey with DATF coordinators: All DATF coordinators were asked to reply to a short online survey using the AidaForm platform (see Section 3 A). It asked about whether prevention featured in their work and, if so, how it was structured. Twelve of the DATFs responded to the questionnaire (see Appendix D).

The qualitative data collected from the six sources indicated above were analysed thematically and used to inform the assessment. There were three steps in this iterative process, through which we reached consensus on the assessment made. First, a member of the HRB research team and a UNODC researcher made their assessments individually based on the evidence available. Second, they met to discuss their decisions and came to a joint agreement on the most appropriate assessment based on the evidence available. Third, a discussion document was circulated to the RePS Research Advisory Group. It presented the provisional assessments made and the reasoning for each decision. These were discussed as a group and any further information needed in order to confirm or adjust the assessment was provided by the group members. As with the assessment process for the interventions explained in Section 3 A1.1, the assessment operated on a consensus model. While each element of the system was assessed by two raters (step 2), and the RePS Research Advisory Group discussed each case in order to reach a consensus on the assessment (step 3), there was no formal assessment of inter-rater reliability. However, there were no instances where the initial raters had radically different assessments, and where there were discrepancies, another review of the evidence resulted in consensus being reached.

In relation to the survey of the 24 DATF coordinators, as mentioned above, 12 responded – 7 of the Local DATF coordinators and 5 of the Regional DATF coordinators. This response rate represents 50% of DATFs at both levels. Given the lack of existing data on the prevention systems operating at the level of individual DATFs, it was not possible to rigorously assess whether those who did not respond differed systematically from those who responded. The findings from this survey were used predominantly to inform the assessment relating to 2 of the 22 system assessment criteria as they appear in the Standards: the existence of mechanisms of coordination of all sectors at the regional level, and the existence of such mechanisms at the local level (6 p. 45). In an effort to ensure that the assessment was fair given the 50% response rate, these findings were also grounded in the findings of the evaluation of the national drugs strategy, as well as agreement through consensus and discussion among the RePS Research Advisory Group.

B2. Limitations and challenges of the system analysis

Limitations and challenges to this component of the RePS include the following:

- RePS Ireland has based its assessment on the system as it stood in Q4 of 2025. It is a snapshot in time and does not capture any changes brought about by the new national drugs strategy that is due to be published in 2026, which may have particular implications for Ireland's prevention system.
- 2025 was a year of transition for Ireland's national drugs strategy. It is recognised that relevant elements of the delivery structures for the national drugs strategy have not been active since 2024. Of particular relevance in relation to the prevention system is that the prevention Strategic Implementation Group last met in Q2 of 2024.
- The focus of the assessment process is on drug prevention rather than prevention more broadly. It looks at drug prevention in the context of the national drugs strategy and its delivery structures. Gaps will exist when compared with the broader prevention sector in Ireland. However, it is recognised that the work of this broader sector may also impact on substance-related outcomes.
- The descriptions of each element and the associated criteria come from an assessment tool provided by the UNODC which was based on the Standards (6) and the Norwegian pilot (7). Therefore, some of the language used is not directly relevant to the Irish context. Efforts have been made in the assessment process to overcome these challenges.

04

Profile of prevention interventions in Ireland

This section provides a statistical profile of prevention interventions in Ireland. Specifically, it outlines the prevalence and types of interventions based on RePS submissions with respect to HSE health regions, target age group, target risk level, intervention setting, whether there is research supporting the efficacy of the intervention, the extent of training of staff, and the presence of mechanisms to ensure consistency in the intervention's delivery.

A. HSE health regions

With respect to geographic coverage, two pieces of information are provided for HSE health regions: the number of RePS submissions (N=96) and the number of unique interventions (N=121). Figure 6 shows the number of RePS intervention survey respondents based on the HSE health region where the reported interventions are delivered. Among the 96 respondents, most were in the HSE Dublin and Midlands (n=30) and HSE Dublin and North East (n=22) HSE health regions. The HSE Dublin and South East (n=13), HSE South West (n=11), HSE West and North West (n=11), and HSE Mid West (n=7) health regions had fewer respondents. Only two respondents reported working at the national level.

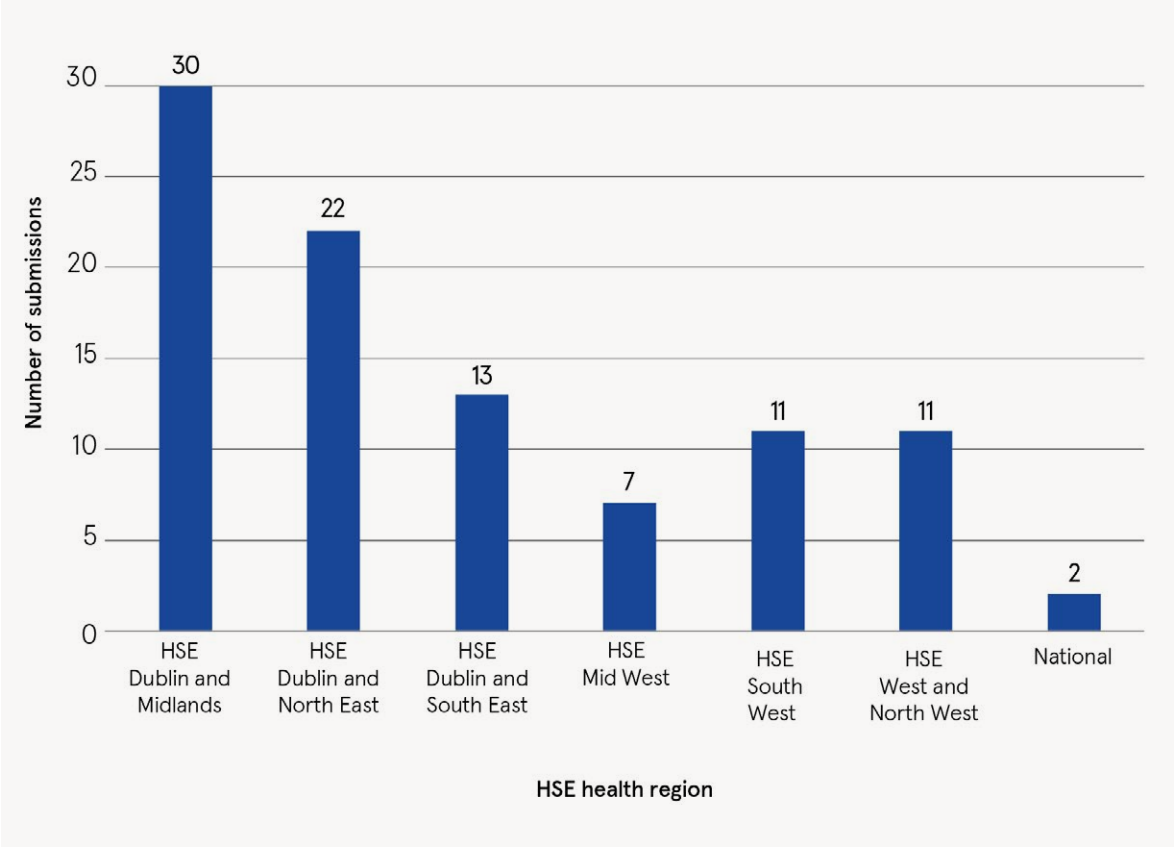

Figure 6: Number of submissions by HSE health region (N=96)

There is a correlation, but only a moderate one, between the location of RePS respondents and the number of discrete interventions reported overall or reported for that region (see Figure 7). The HSE health regions with the largest number of interventions were HSE Dublin and South East (n=30) and HSE Dublin and North East (n=29). The number of interventions was somewhat lower for HSE Dublin and Midlands (n=22) and HSE South West (n=17), as well as for HSE Mid West (n=9) and HSE West and North West (n=11). Three of the reported interventions were explicitly national in scope.

Given the differences between Figures 6 and 7, an important caveat is that variation in the number of interventions by HSE health region does not automatically indicate variation in the population of prevention interventions, as the latter was dependent upon reports of interventions being submitted to the RePS intervention survey. All prevention activities – and, by extension, some target age groups, some target risk levels, some settings, and even some areas – may not be represented by RePS respondents. Given this, there were strategic follow-ups carried out with representatives of these areas (e.g. follow-up invitations to DATF coordinators and project leads for programmes identified through Internet searches). In some instances, these follow-ups were successful, while in other instances, it appeared that websites and email contacts were legacies of programmes that were no longer functioning. A consequence of this is that it is not possible to determine the proportion of the Irish population covered by different types of interventions.

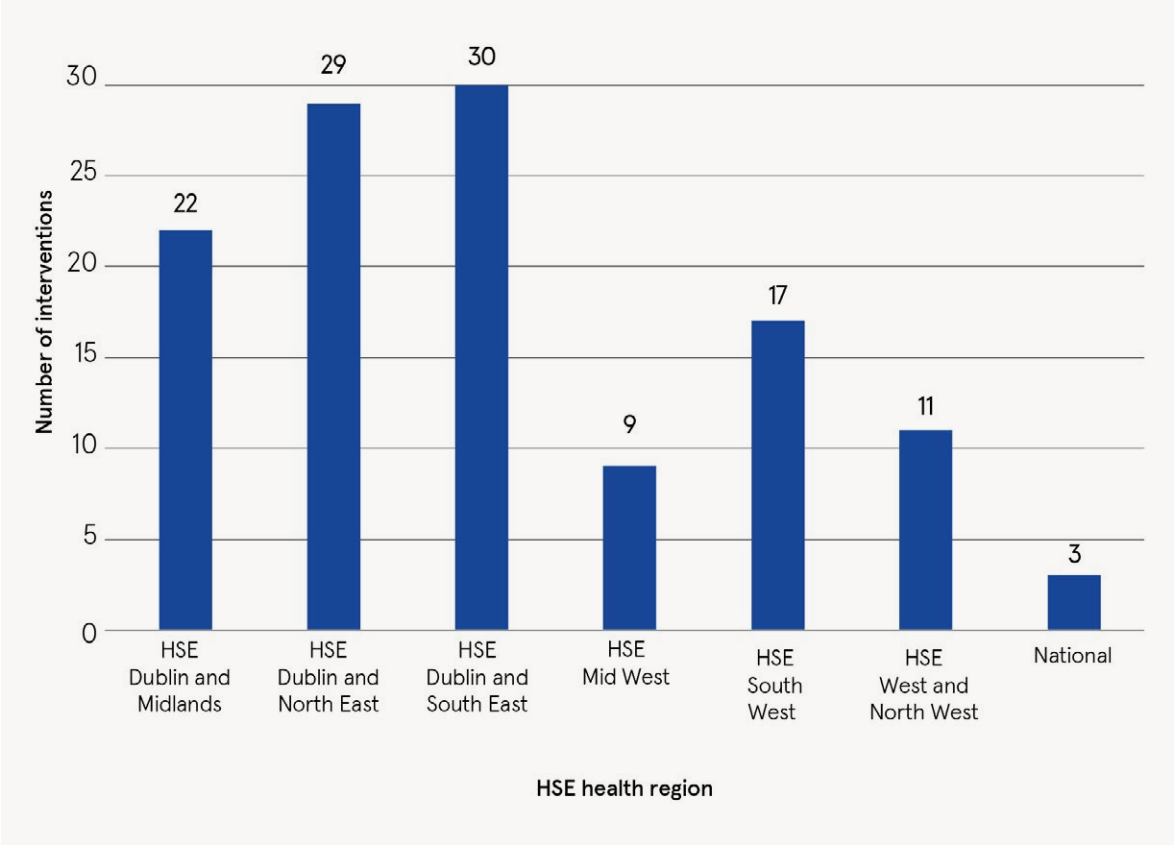

Figure 7: Number of interventions by HSE health region (N=121)

B. Sector

Respondents were asked to indicate the sector(s) in which their organisation operated. These included 'community', 'education', 'health', 'law enforcement and criminal justice', and 'social care'. Respondents were allowed to indicate as many sectors as applied or could provide a separate indication altogether through the 'other' option. The vast majority of 'other' responses involved some variation on 'youth work', which was typically recoded as 'community' given the structure and location of these interventions (e.g. drop-in centres or safe spaces located in community centres). Sector was also identified through a screening question that was a precursor to identification of intervention type. In instances where there was disagreement between the two indications, the qualitative description of the intervention was reviewed in order to attempt to reconcile the difference. Figure 8 shows the number of interventions by sector.

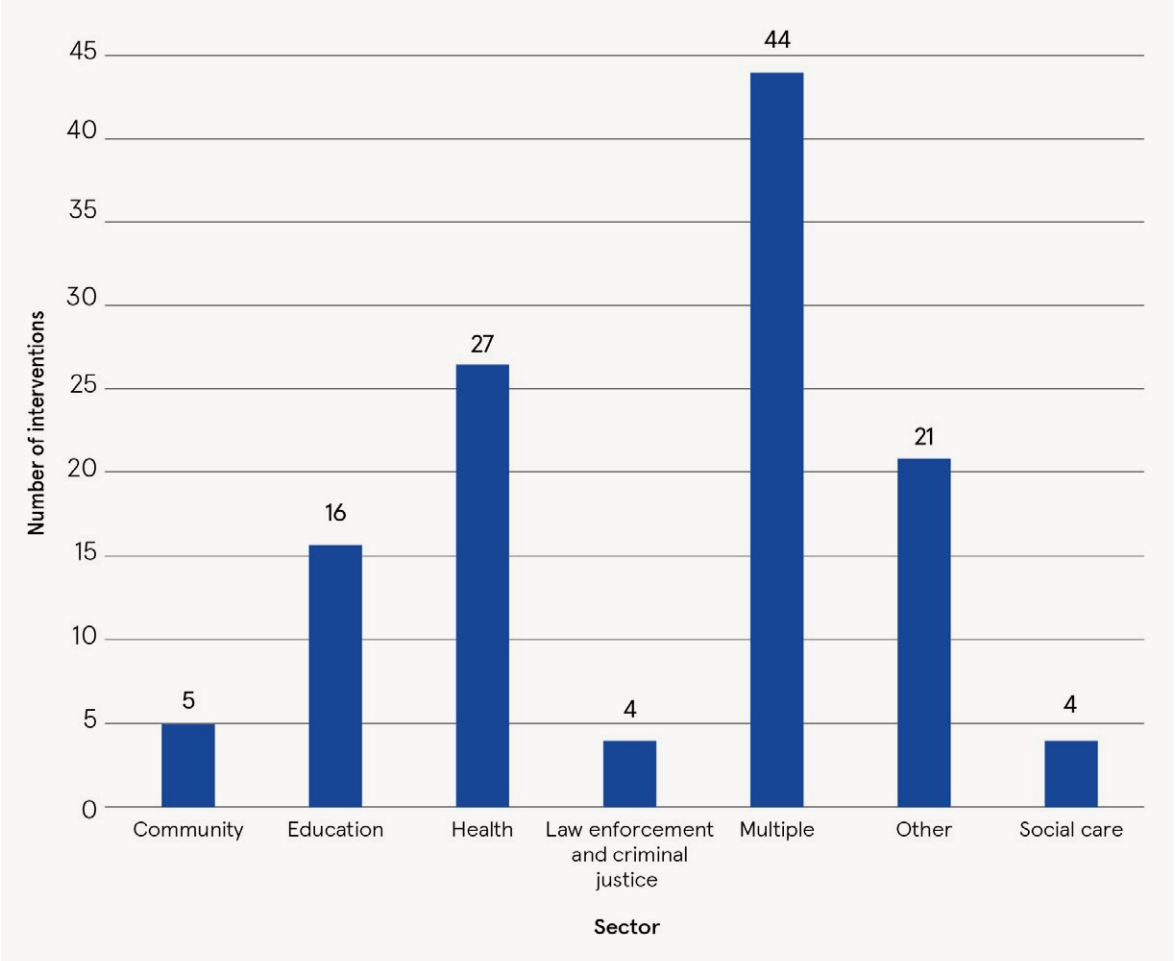

Figure 8: Number of interventions by sector (N=121)

The largest number of interventions were provided in multiple settings (n=44). There were also substantial numbers operating specifically in the health sector (n=27), the education sector (n=16), and other sectors (n=21). The latter was most often described in a follow-up question as some form of youth work. Representation was substantially lower in the community (n=5), social care (n=4), and law enforcement and criminal justice (n=4) sectors.

C. Target age group

Figures 9 and 10 show the number of interventions by targeted age group for the entire country and for each HSE health region. Again, the total number of interventions is significantly larger (271 versus 121) when age is considered, as most interventions target at least two age groups.[7] The majority of interventions target adolescence, with equal numbers focused on early (n=79) and older (n=79) adolescence. There are also a substantial number of interventions that focus on adulthood (n=66), although it is an important qualification that there was typically insufficient information provided to differentiate between young adulthood, middle age, or older adulthood. Further consideration of the type of intervention (e.g. those targeting families with young children) suggests that most of these interventions focus on the early adulthood period. Fewer interventions focused on middle childhood (n=21), with an even smaller number of interventions focused on early childhood (n=4). Only one response specifically described an intervention focused on the prenatal period. Twenty-one interventions had no specific target age group.

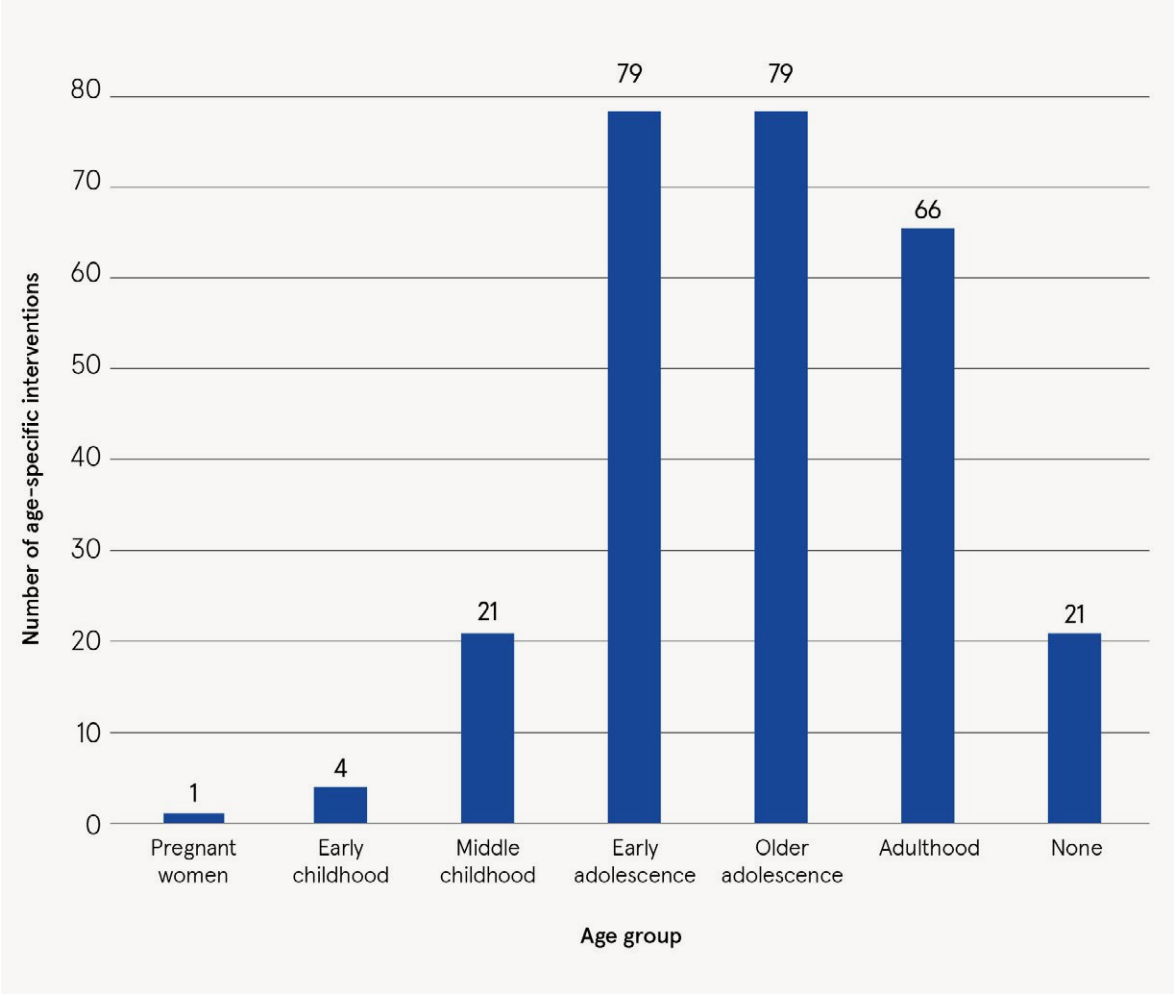

Figure 9: Number of interventions by target age group (n=271)

7. The total number of age-specific interventions used in the analyses can differ between 271 and 272 due to item-specific missing data.

When the HSE health regions are examined separately, the basic distribution is quite similar (see Figure 10). In all six regions, the majority of interventions target early and older adolescence. The next largest number of interventions typically focus on adulthood. As with the national picture, prevention interventions rarely target early and middle childhood and almost never target the prenatal period.

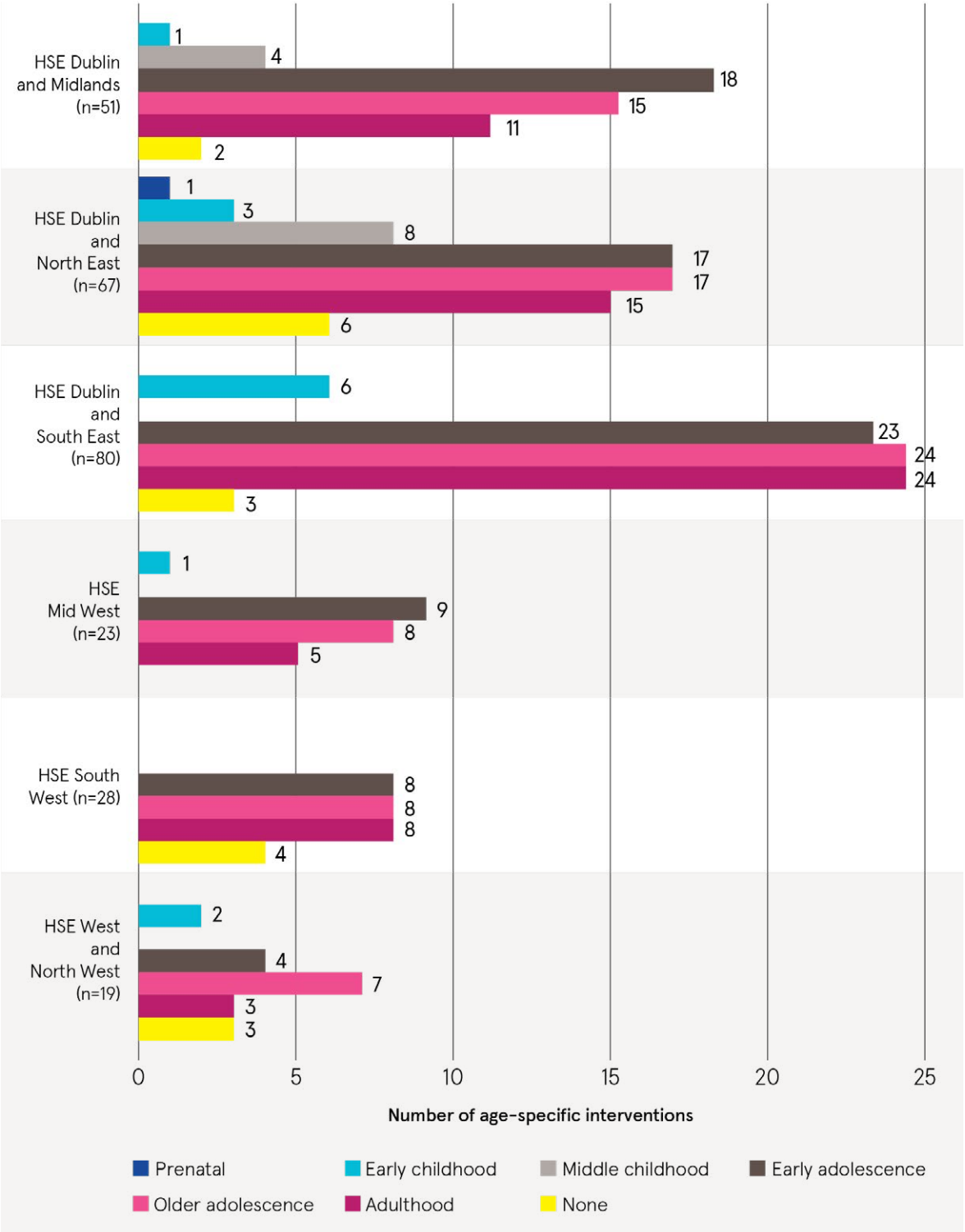

Figure 10: Number of interventions by target age group across HSE health regions[8] (n=268)

8. Interventions operating at a national level were not included in the figure.

D. Target risk level

When risk level is considered for the country in general, selective risk has the largest number of interventions (n=53). This is somewhat larger than the number of interventions that are categorised as indicated risk (n=38). The number of interventions categorised as universal risk is lower still, with 22 interventions targeting such groups. Seven interventions focused on multiple risk groups. This is shown in Figure 11.

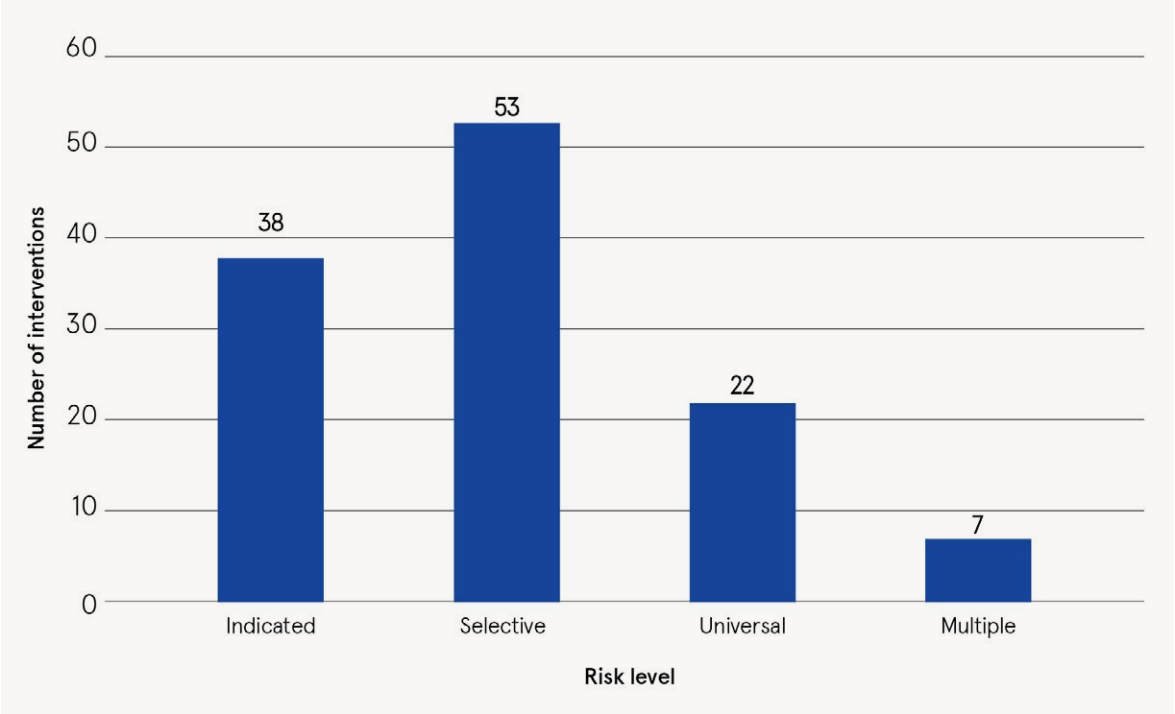

Figure 11: Number of age-specific interventions by risk level (n=120)

An important qualification here is that no direction or definition of risk group was provided to the respondents, and respondents were free to envision a range of possibilities. In the open-ended part of the question, some examples of risk groups were provided, including:

- all adolescents
- all who have been affected by addiction
- area known for drug use
- children and young people at risk due to living in an extremely deprived area
- those living in poverty, who are vulnerable, lack aspiration, suffer from neglect, or are young
- teenagers from deprived backgrounds
- vulnerable adolescents who have histories of substance abuse and the vast majority of whom are from families experiencing substance misuse

- those at risk of exploitation, self-harm, and substance abuse
- those living in electoral divisions that are classified by the Central Statistics Office as marginally below average or disadvantaged
- youth groups that are at risk due to: (1) the local area they live in; (2) family members being affected by problem substance use; (3) being at risk of drug trafficking/grooming; (4) being in the early stages of drug use; (5) being in a peer group that uses drugs; (6) being an early school leaver or at risk of leaving school; and (7) negative views of drug dealing, seeing it as a viable income.

This is clearly a very heterogeneous set of definitions and does not necessarily reflect the clear scientific distinctions of risk groups in the epidemiological and prevention literature (16). This is particularly the case when focusing on adolescence, when substance use is both common and has considerable peer support, and hence there are not clear lines separating universal, selective, and indicated risk groups, or when an entire community is seen as having elevated risk due to the history of substance use within that community. The qualitative data show the variation in conceptualisation, and we return to this issue in the conclusion of this report.

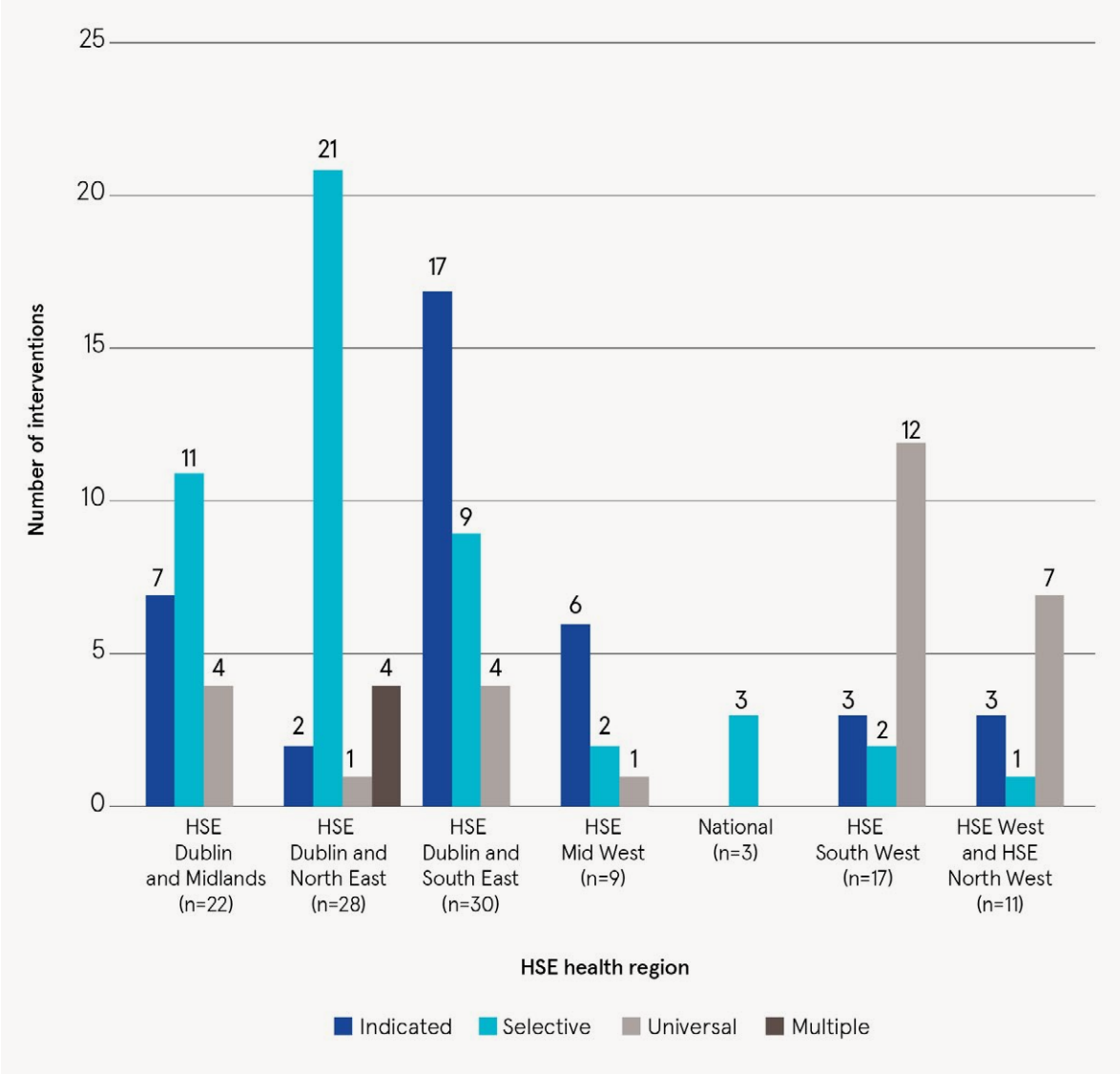

Figure 12: Number of interventions by risk level and HSE health region (n=120)

Interestingly, the distribution of interventions by level of risk is highly variable across HSE health regions (see Figure 12). In HSE Dublin and Midlands, the majority of interventions are selective (n=11), with somewhat fewer focused on indicated risk (n=7) or universal risk (n=4). The predominance of selective interventions is even stronger for HSE Dublin and North East (21 of 28 interventions). In contrast, the majority of interventions in HSE Dublin and South East targeted indicated risk (n=17), with much fewer focused on selective risk (n=9) and even fewer focusing on universal risk (n=4). Prevention services in HSE Mid West were also concentrated on indicated risk (6 of 9 interventions). In contrast, interventions in HSE South West predominantly focused on universal risk (12 of 17 interventions), with approximately equal numbers focusing on indicated (n=3) and selective (n=2) risk levels. HSE West and North West is mostly characterised by universal risk interventions (7 of 11 interventions). In general, very few interventions focused on multiple risk groups, and there is little evidence of variation across regions. Still, interpretation is tempered by the limitations inherent in making comparisons across groups that are themselves characterised by a small number of cases, as is the situation when examining risk across the six HSE health regions.

E. Setting of interventions

Figure 13 summarises the distribution of interventions for all of Ireland by setting. Nationally, almost one-half of interventions are located in community settings (n=59, or 49%). There are approximately equal numbers of interventions in family (n=24, or 20%) and school (n=28, or 22%) settings. There are fewer interventions in health settings (n=7, or 6%). There was only one intervention reported for criminal justice settings explicitly, and only two interventions in multiple settings.

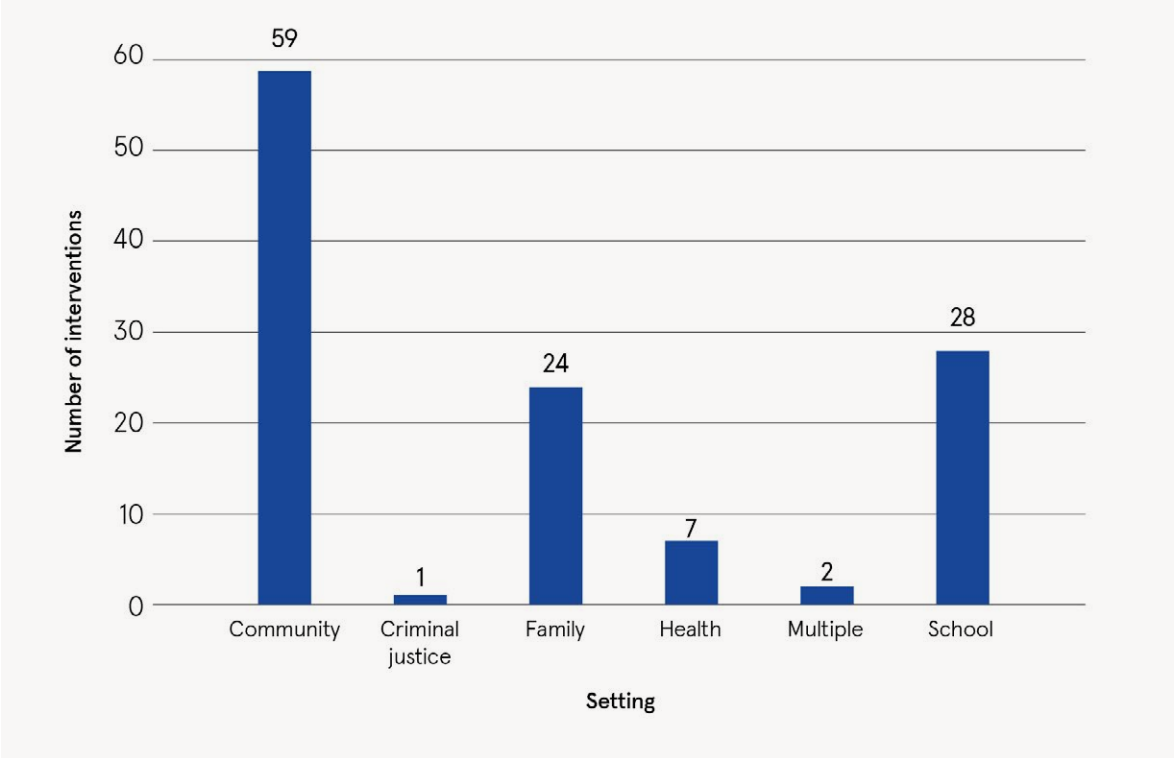

Figure 13: Number of interventions by setting (N=121)

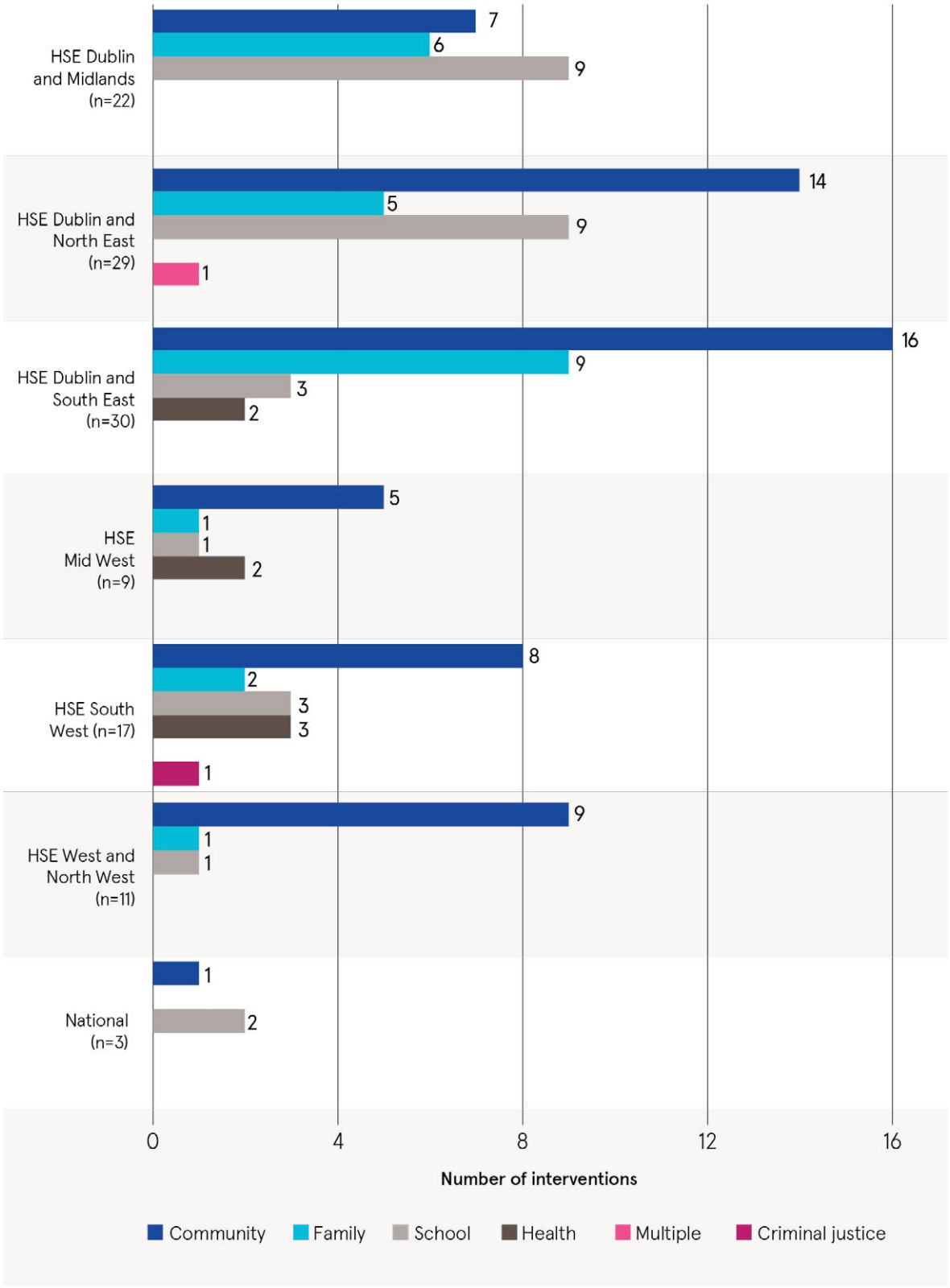

Figure 14: Number of interventions by setting and HSE health region (N=121)

The breakdown of settings by HSE health region is summarised in Figure 14. In general, the distribution seen in each of the six HSE health regions is very similar to the national distribution. Community-based interventions are the most prevalent setting in five of the six regions. The only exception is school-based interventions being relatively and uniquely prevalent in HSE Dublin and Midlands (9 of 22 interventions). Family-based interventions are also comparatively more prevalent in HSE Dublin and South East (9 of 30 interventions) than in other HSE health regions. In addition, HSE West and North West have relatively few interventions that are not community based (approximately 1–2). Again, interpretation needs to recognise the limits of comparisons that involve a very small number of cases that is endemic to examining settings across the six HSE health regions.

F. Perceived empirical support for intervention efficacy

The majority of respondents reported that there is empirical evidence supporting the way in which their intervention is designed and implemented and supporting its effectiveness as a prevention intervention (see Figure 15). Among the 121 interventions, evidence supporting their approach was reported for 68% of interventions. Only 6% indicated that there was not empirical support for their approach. Respondents were unsure for the remaining 26%.

The issues of empirical support for the design, implementation, and effectiveness of the intervention approach were also captured by a follow-up question that asked respondents to describe any documentation that supported their previous answer. Only 39 submissions provided any response to this question, and some submissions included very limited information, such as "Yes", "Evidence based/informed interventions and supports are used to support individuals/groups towards better/positive outcomes", and "UBU Better Outcomes Brighter Futures", which were not informative. An even more specific question focused on whether an intervention evaluation has been conducted, and even fewer submissions – 35 – indicated an evaluation. A similar follow-up question to that described above requested documentation, and this yielded only 18 submissions. In the end, there is a gap between the perception of empirical support for the approach used in interventions and the articulation of evidence backing such perceptions.

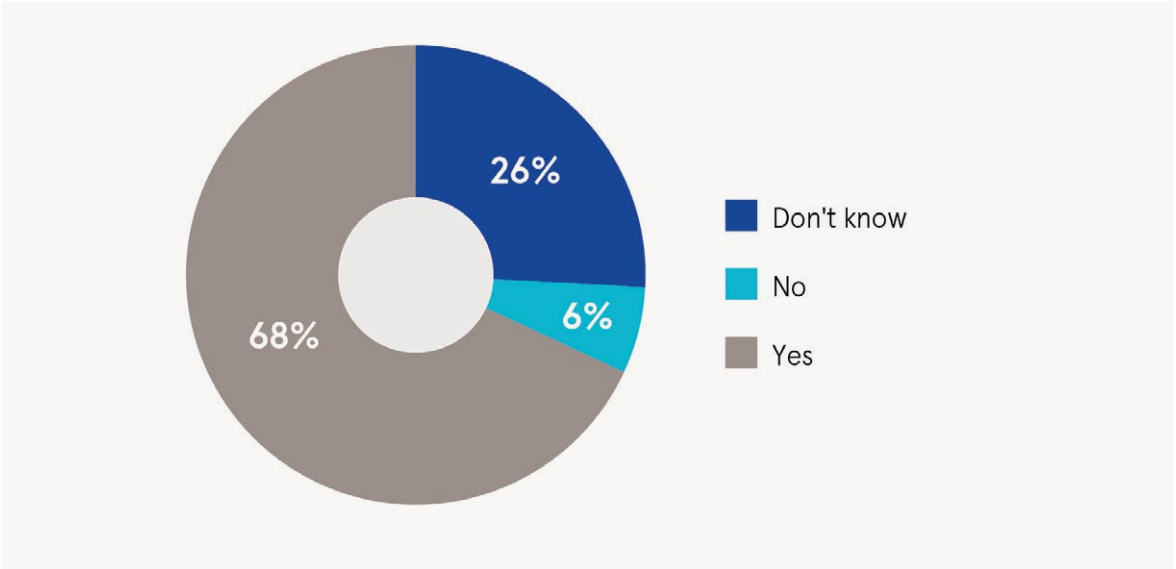

Figure 15: Percentage of interventions by perceived empirical support for design and implementation of intervention (N=121)

As seen in Figure 16, there are some differences across HSE health regions in terms of the perceived empirical support for interventions. In HSE Dublin and Midlands, all 22 interventions were perceived to have empirical support. This is similar in the HSE Mid West, HSE South West, and HSE West and North West regions. There is more ambiguity in the HSE Dublin and North East and HSE Dublin and South East regions, with larger proportions of interventions indicating "Don't know" and "No" for whether there is empirical support.

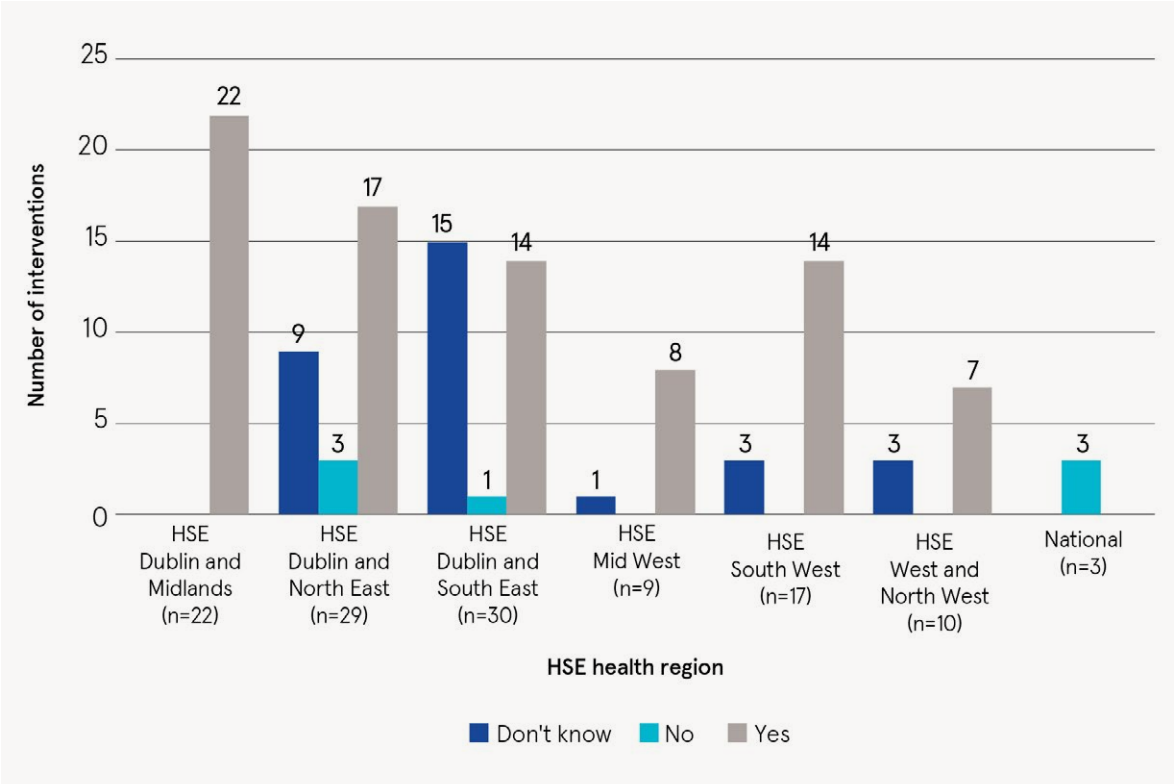

Figure 16: Number of interventions by perceived empirical support for design and implementation of intervention across HSE health regions (N=121)

G. Extent of relevant training of staff

The RePS submissions were almost uniform in reporting that staff had received "relevant training" (see Figure 17). Here, 94% of respondents indicated that their organisation's staff had received relevant training. A further 4% were unsure. Only 2% indicated that there was no relevant training for staff. However, this may be less informative than it seems. A follow-up question asked specifically what training was characteristic of those delivering interventions, and the responses were very diverse and quite idiosyncratic.

In some instances, the training was prevention specific. For example, one respondent reported "All have extensive youth engagement training, participated in the EUPC [European Prevention Curriculum] training and in house programme training". Another reported "EUPC training. Two days. Carried out in Dept of Health by EUPC Master Trainers. Four staff members on team have undertaken this training". Others emphasised more general training in substance use and addiction; for example, one respondent described their training as "3 years college studying addiction studies", while others described their training as specific to particular prevention interventions (e.g. "Know the Score training is delivered to teachers by highly skilled and experienced Health Promotion Officers", "Trainers of Putting the Pieces Together are the WRDATF [Western Region Drug and Alcohol Task Force] Drug Education Workers and have vast experience and participate in regular upskilling and training via the WRDATF and other sources", and "MECC [Making Every Contact Count] training is delivered by skilled practitioners and is subject to ongoing review and quality improvement"). Other training involved simply working with people and community groups, with responses including "1 year studying community groups", "12 week studying team leadership and management", and "A number of our staff would have completed training in house by LIR Training on Working with Young People, this would have been 2-hour sessions once a week over a 6 week period".

There was also an emphasis on training that involved working with vulnerable populations, with responses including "these are a must: SAOR, Mental Health First AID, boundaries, Asist, Safe Talk, Naloxone, child protection", "our team have attended many trainings over the years ranging from SFP (Strengthening Families Programme), CRA (Community Reinforcement Approach), COSAR (Coping Skills for Addiction Recovery), Resilience factor, (Resonance factor (SIC)), STORM (Storm skills in training in self-harm and suicide prevention), Safe Talk, Prime of Life, Circle of Security, motivational interviewing, trauma invloved training, Puttting the Pieces Together, Reduce the Use, the training is delivered by a variety of training bodies; the duration differs per training, between 2 - 5 days per training" (emphasis in the original), and "All staff have been trained in Trauma practice which was 25 hours training, youth work which was 160 hours training, Children first with the HSE, FAR training, 20 hours, these are the key training staff have received". Finally, other respondents emphasised in-house training and lived experience as foundational to qualifications for prevention work. For example, one respondent reported "3rd level preferred but this can vary; lived experience also welcome/ helpful; 6 months". Another indicated training through "Attending information meetings within the area as well as regular link in meetings with other local community groups". In the end, there is simply a wide diversity in training in terms of the content, focus, and duration, and training specific to drug and alcohol prevention (e.g. EUPC training) is only a small part of the overall training landscape.

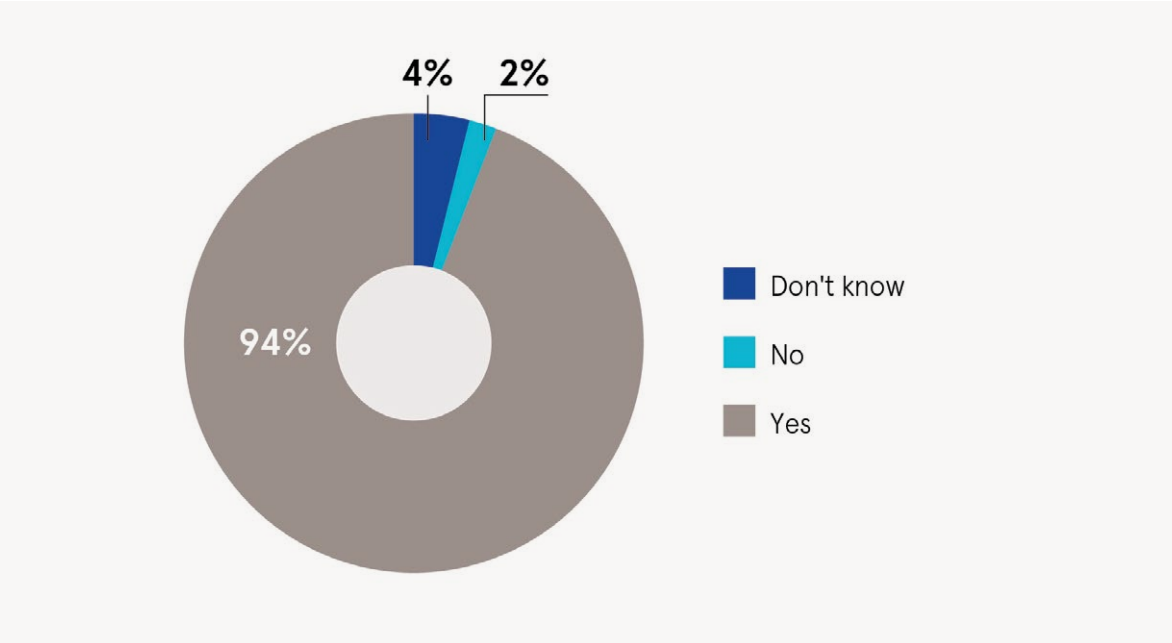

Figure 17: Percentage of interventions by reported relevant training of intervention staff (n=120)

When the prevalence of training is broken out by HSE health region (not shown), there is virtually no variation. This is not surprising given the extremely small number of instances where respondents indicated no training.

H. Procedures or mechanisms to ensure consistency of delivery

Consistency of delivery refers to practices that are delivered in the same manner across people, time, and locations (where relevant). 'Manualised' interventions (such as Unplugged in secondary schools) are a good example of interventions with mechanisms to ensure consistency. A more generic example is the various types of training that providers undertake. Where these are intervention specific, they help ensure consistency in delivery.

Figure 18 shows the percentage of interventions based on reports of whether there were procedures or mechanisms that ensured consistency of delivery. Sixty-eight percent of interventions were reported as having such a procedure or mechanism, while 16% reported that there was no such procedure or mechanism. The remaining 16% were reported as unknown.

Figure 19 reports the breakdown of procedures or mechanisms that ensured consistency of delivery by HSE health region. Such mechanisms were most prevalent in HSE South West (14 of 17 interventions, or 82%), HSE West and North West (8 of 10 interventions, or 80%), and HSE Dublin and South East (24 of 30 interventions, or 80%). Such mechanisms were less prevalent in HSE Dublin and Midlands (11 of 22 interventions, or 50%) and HSE Dublin and North East (14 of 29 interventions, or 48%). Such mechanisms were uniquely absent in HSE Mid West (0 of 9 interventions).

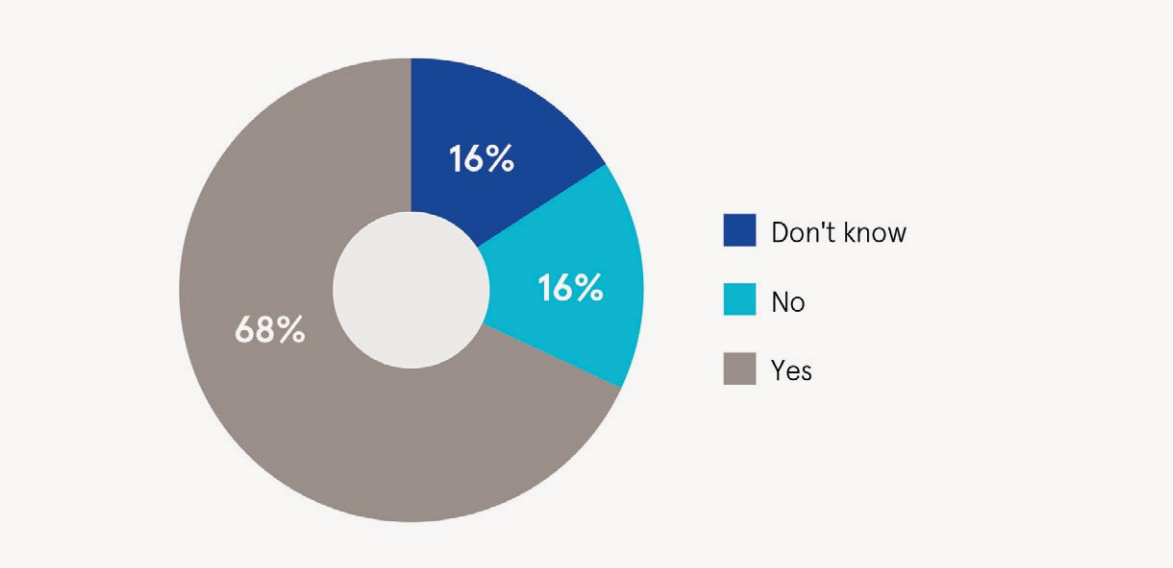

Figure 18: Percentage of interventions by reported mechanisms for consistency in delivery (n=120)

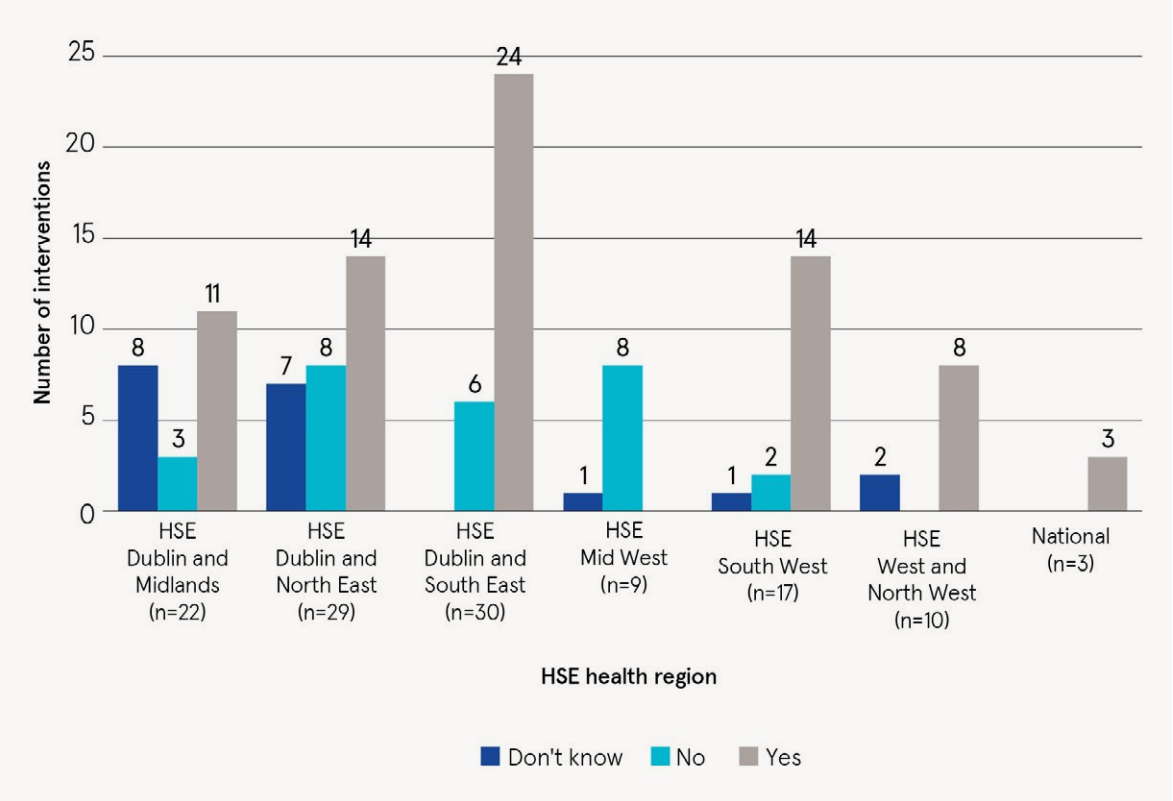

Figure 19: Number of interventions by reported mechanisms for consistency in delivery across HSE health regions (n=120)

05

Quality of interventions

This section describes the results of the assessment process of the interventions. In general, the number and/or percentage of interventions is presented by the quality assessment in line with the *International Standards on Drug Use Prevention*, first for the country as a whole and then disaggregated by targeted age group, level of risk, setting of implementation, HSE health region, perceived empirical basis, the extent of relevant staff training, and the existence of procedures or mechanisms for ensuring consistent delivery.

As discussed earlier, the sample size for these comparisons is larger than the total number of unique submissions, as the assessment of quality is based on targeted age group (n=272).[9] In other words, assessments of quality are based on age-specific interventions rather than discrete interventions in order to align with the logical organisation of evidence in the Standards. As a general principle, interventions characterised as not being evidence based or being weakly evidence informed could warrant some improvement, interventions characterised as being strongly evidence informed could warrant an outcome evaluation, and evidence-based interventions where evaluations were not conducted locally could be locally evaluated.

UNODC Standards classification categories

- **Not evidence based** – Not described and lacking research support for efficacy.
- **Weakly evidence informed** – Intervention has some aspects with empirical support but in general lacks two or more critical dimensions. This was the default when information was lacking.
- **Strongly evidence informed** – Intervention has many aspects with empirical support but has not been formally subject to an outcome evaluation.
- **Innovative** – No research to support or challenge the efficacy of the intervention approach, but where an evaluation with a strong methodology was planned or in process.
- **Evidence based** – Reviewed in the Standards with evidence from outcome evaluations.

9. See earlier discussion in Section 3 A1 regarding the increase in the total sample size when assessing quality due to the age grading of intervention quality in the UNODC/WHO Standards and due to the targeting of multiple age groups within the majority of interventions.

A. Overall assessment of quality

Figure 20 describes the overall quality of 272 age-specific interventions nationally. Only a small number (34 interventions, or 13%) were not evidence based. The biggest group of interventions (117 interventions, or 43%) were weakly evidence informed. This means that they only included some of the characteristics associated with effective interventions. Fifty-seven interventions were strongly evidence informed (21%), with another 55 being evidence based (20%). In the former case, this meant that they included all of the criteria associated with effective interventions. In the latter case, this meant that the interventions had also been subject to a methodologically sound evaluation. Although there were a number of organisational evaluations, there were no reported cases of a locally implemented outcome evaluation. The final nine interventions were innovative in that they were deemed to be of high quality and were currently undergoing outcome evaluation, but they were still not technically covered in the Standards.

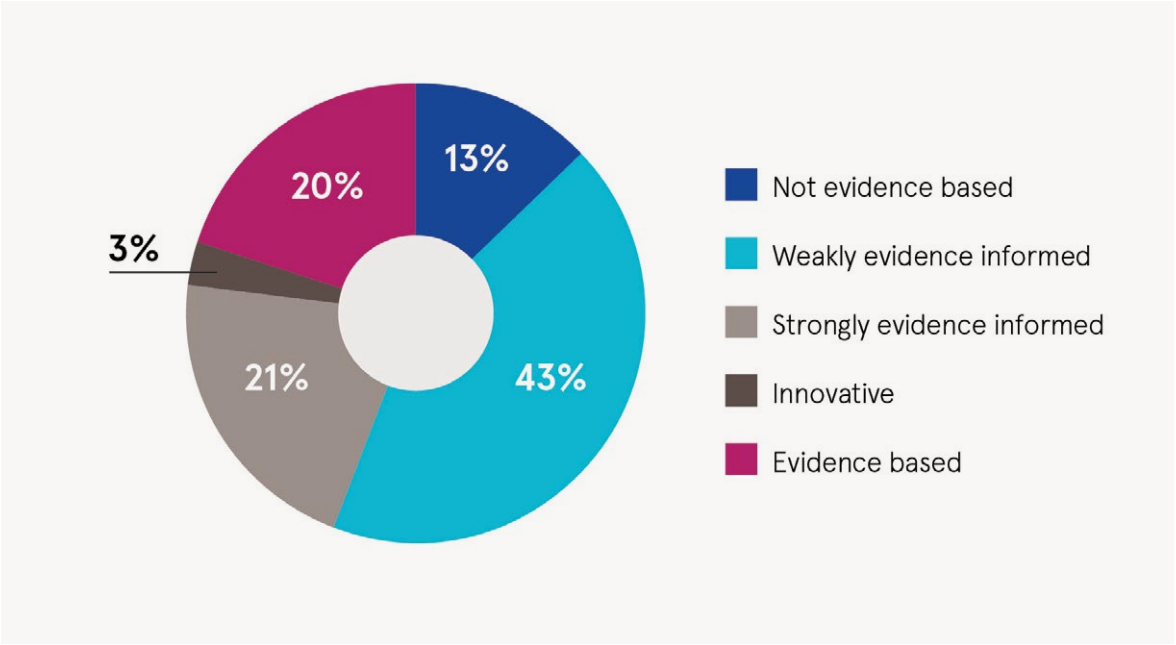

Figure 20: Percentage of age-specific interventions, by quality (n=272)

B. Assessment of quality by targeted age group

Figure 21 presents the data on interventions by quality and targeted age group for support services and the five assessment levels of interventions. As the sample is age specific (i.e. the same intervention is counted for each applicable target age group), the data are shown as a percentage of interventions for each quality classification for each age group. The treatment of the group where no age group was specified in the submission is more complicated when the quality assessment is done, as the quality in the Standards is organised in terms of age grouping or life stage and an intervention can be empirically supported for one age group but not another. In general, the assessment team inferred the target age group or groups based on the nature and description of the prevention intervention. For example, one prevention intervention was described as "early learning supports" and was assessed in relation to interventions in the Standards for "infancy and early childhood". Likewise, another intervention was a school-based programme that focused on fifth-year students, and hence it was evaluated against the evidence for "older adolescence". In general, it was not difficult to infer the age groups targeted by these interventions. Still, we did not recode these cases to other age groups, as this is not consistent with best practices in social science survey research (i.e. rewriting respondent submissions), and hence they are treated as a separate category in the analyses.

In terms of the interpretation of the results, there are two orienting principles:

1. Variation in the height of the bars within the quality designation indicates the balance of quality across age groups.

2. The height of the bars indicates the relative size of each group.

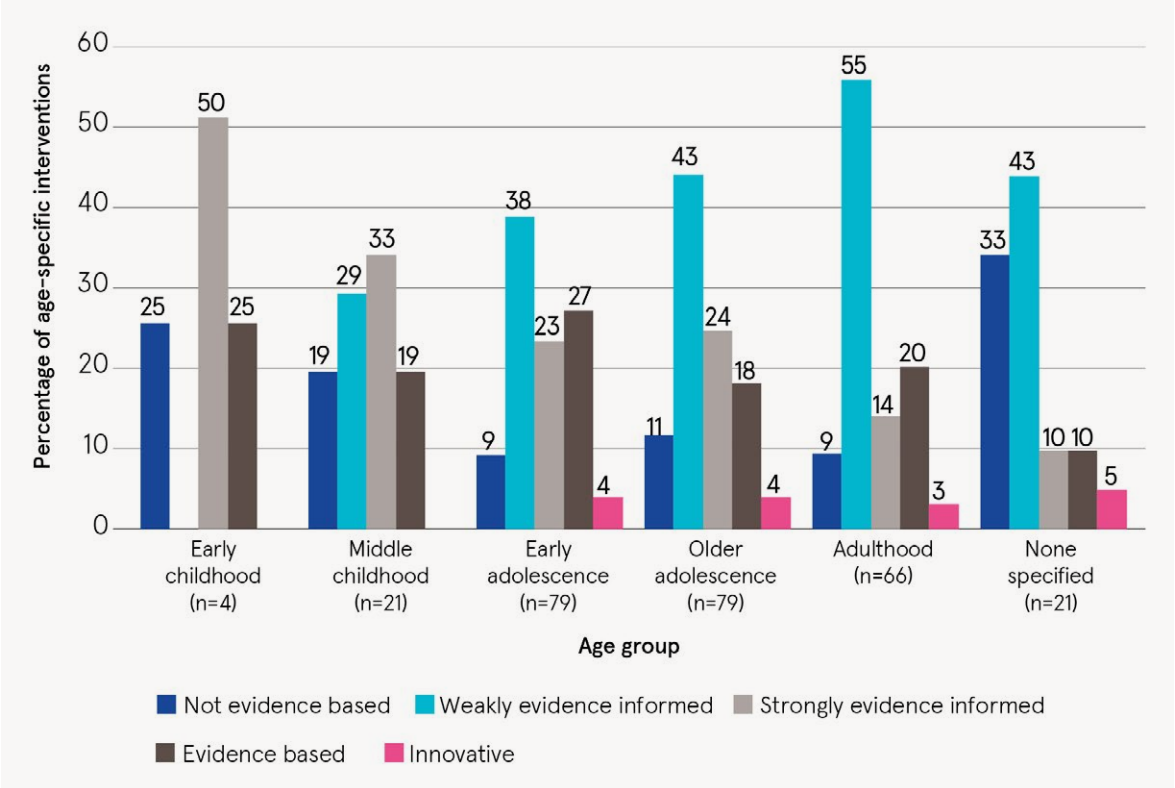

Figure 21: Percentage of age-specific interventions, by quality and targeted age group (n=270)

Among the interventions that were deemed 'not evidence based', the largest percentage was seen in the 'none specified' group (33%). Although the overall number is low, the percentage of interventions classified as 'not evidence based' is also relatively high (25%) for interventions targeting infancy and early childhood and, to a lesser degree, middle childhood (19%). Strong conclusions here are not warranted, as the percentage for the infancy and early childhood age group only refers to one intervention given the small number of total interventions targeting this age group. For the remaining age groups, the proportions are reasonably similar (approximately 10%). Interventions classified as 'weakly evidence informed' were most prevalent in the 'adulthood' age group (55%), with approximately equal proportions (38–43%) for those targeting early and older adolescence and those in the 'none specified' group. With smaller numbers of total interventions, there are clearer differences for strongly evidence-informed and evidence-based interventions. There was a higher proportion of strongly evidence-informed interventions targeting infancy and early childhood (50%) and middle childhood (33%) compared with the other age groups (<25%). Evidence-based interventions are most prevalent among interventions targeting infancy and early childhood (25%) and early adolescence (27%), followed by adulthood (20%), middle childhood (19%), and older adolescence (18%). Higher-quality interventions (i.e. strongly evidence-informed and evidence-based interventions) were comparatively rarer (10%) in the 'none specified' group. Interventions assessed as 'innovative' were largely seen among adolescents and early adults, and comprised approximately 5% of interventions in these groups.

Subsections B1 to B7 provide a descriptive summary of the interventions in each age group by quality of intervention. Table 1 reports the number of interventions by quality and target age group.

Table 1: Number of interventions by quality and target age group (n=270)

	Infancy and early childhood	Middle childhood	Early adolescence	Older adolescence	Adulthood	None specified
Not evidence based	1	4	7	9	6	7
Weakly evidence informed	0	6	30	34	36	9
Strongly evidence informed	2	7	18	19	9	2
Evidence based	1	4	21	14	13	2
Innovative	0	0	3	3	2	1

B1. Prenatal

There was only one intervention that explicitly focused on the prenatal period or pregnant women, and hence it is not included in Figure 21 or Table 1. In total, five submissions indicated interventions of this type, but four of these bundled such work in with a host of other activities and provided little to no information about this type of intervention specifically, and so they were therefore classified according to the age group targeted by the unique intervention type. As a result, it was concluded that there was only one RePS submission that identified interventions for the 'prenatal' target age group. It was deemed to be weakly evidence informed because the submission provided no information about the amount of contact involved in the intervention or the qualifications of contact workers.

Characteristics of prenatal and pregnancy visits associated with efficacy and/or effectiveness include the following:

- Trained health workers deliver the programme.
- Regular home visits are provided from birth to 2 years of age, with visit frequency gradually reduced over time.
- The programme strengthens core parenting skills.
- Mothers receive support to address key socioeconomic challenges, including health, housing, employment, and legal needs.

B2. Infancy and early childhood[10]

Only four of the RePS submissions focused on the infancy and early childhood period. Among the interventions submitted, one was based on the Incredible Years framework, which, although it has been extensively evaluated in other contexts (17), could warrant evaluation in the Irish context. Another two interventions for this age group were classified as strongly evidence informed; these interventions were family focused and involved a combination of parenting skills improvements and early childhood education. The fourth intervention was described as "one-to-one art therapy" and was deemed to be not evidence based due to the lack of detail on substance use prevention, the amount of contact, and the qualifications of the providers. The intervention description also makes general reference to "social and emotional development", which is too broad a description relative to the more focused classifications in the *International Standards on Drug Use Prevention*.

10. In the earlier report on the pilot RePS study in Norway, the categories of 'infancy' and 'early childhood' were deemed to be the same with the exception of one intervention. This lack of differentiation also characterises the Ireland data.

Characteristics of parenting skills programmes associated with efficacy and/or effectiveness include the following:

- The programmes strengthen family relationships by improving parent-child attachment.
- Parents are supported to take a more active role in their children's lives, including monitoring activities and peer relationships and engaging in learning and education.
- Parents are guided on the use of positive, age-appropriate discipline.
- Parents are supported to model positive behaviours for their children.
- Programme design reduces barriers to participation, for example by offering flexible scheduling, meals, childcare, transportation, and completion incentives.
- Programmes typically consist of a structured series of sessions, often around 10 sessions, with longer or more intensive formats for higher need families.
- Activities are designed for parents, children and the family as a whole.
- Programmes are delivered by trained facilitators, who may not require formal professional qualifications.

B3. Middle childhood

For middle childhood, there were 21 interventions. Four were evidence based. These include interventions based on the Incredible Years framework, the Strengthening Families Programme, and the school-based Unplugged intervention. The Incredible Years framework and Strengthening Families Programme emphasise parenting skills as well as personal and social skills education, while Unplugged is grounded in personal and social skills development. All three have been evaluated in other countries and would benefit from local evaluation.

A further seven interventions were categorised as strongly evidence informed. Two of these were family support initiatives, while a third was a locally developed school-based intervention that also emphasised personal and social skills development. Also included in this group were two community-based interventions and two street outreach initiatives. All of these interventions would benefit from formal evaluation.

Characteristics of personal and social skills education associated with efficacy and/or effectiveness include the following:

- The programmes strengthen a broad range of personal and social skills.
- Delivery follows a structured series of sessions, often supplemented with booster sessions over multiple years.
- Programmes are implemented by trained teachers or facilitators.

The six interventions that were deemed to be weakly evidence informed were quite diverse. One was a family-based initiative focusing on improving parenting skills. A second emphasised personal and social skills development. Two further interventions involved street work/outreach and one-on-one supports that focused on addressing mental health and social vulnerabilities. A fifth intervention was a mentoring initiative, and the sixth intervention was a child play and therapy intervention. In general, these interventions included some, but not all, of the effectiveness criteria outlined in the *International Standards on Drug Use Prevention*. In most cases, the number of contacts were either not described or appeared to be limited. In other cases, an emphasis on substance use appeared to be secondary to a focus on improving general health and well-being.

Four interventions were deemed to be not evidence based and largely involved out-of-school interventions focused on arts and sport with minimal emphasis on substance use, even though they targeted selective or indicated risk groups.

B4. Early adolescence

There were 79 interventions that focused on the early adolescent period. Twenty-one interventions were deemed to be evidence based. Six of these were family-based interventions that had been evaluated in other countries. A further 11 of these were manualised interventions in schools emphasising social competence and influence, but they also incorporated elements of interventions aimed at increasing school attachment and addressing psychological vulnerabilities. These include the School Health and Alcohol Harm Reduction Project (SHAHRP) and Unplugged. The latter two interventions have been evaluated in other countries. Another two interventions were one-to-one focused or group based and used the Adolescent Community Reinforcement Approach (A-CRA). The final two interventions were SAOR brief interventions. Interventions of this type have been evaluated and deemed effective for preventing substance use, although no specific evaluation has been done in the Irish context, and therefore local evaluation would be beneficial.

Characteristics of social competence and influence associated with efficacy and/or effectiveness include the following:

- Programmes use interactive learning methods.
- Delivery consists of structured weekly sessions, typically 10-15 sessions, with booster sessions often provided over multiple years.
- Programmes are delivered by trained facilitators, including trained peer educators where appropriate.
- Participants develop a broad range of personal and social skills, particularly coping, decision-making, and resistance skills related to substance use.
- Programmes address perceptions of substance use risk by emphasising immediate and tangible consequences.
- Misconceptions about the prevalence and social acceptability of substance use are actively challenged.

In addition to these interventions, three different organisations offered Know the Score as part of the suite of interventions targeting early adolescents. This was developed by the HSE based on extensive consultation and was assessed as 'innovative', as at the time of writing this report (Q2 2026), an outcome evaluation was ongoing (18).

A further 18 interventions were categorised as strongly evidence informed. These were a broad mix of interventions of reasonably high quality. They included three community development interventions modelled after the Communities That Care and Building SAFER Communities frameworks; two family-based initiatives emphasising a combination of parenting skills, as well as social competence and influence; three school-based interventions that are also based on social competence and influence that were all locally developed; and seven interventions that focus on mental health vulnerabilities.

Two interventions were group-based interventions in community settings. The final intervention in this group was a brief intervention using the Making Every Contact Count (MECC) approach. In each case, intervention details indicated considerable evidence of effective practice according to the *International Standards on Drug Use Prevention*. Evaluations in the local context would strengthen confidence in the efficacy of such work.

Thirty interventions were assessed as weakly evidence informed. This included seven interventions focused on parenting that largely involved stress management interventions or information provision. A further six interventions involved various forms of personal competence and influence improvement that took place in a range of settings. Five interventions for early adolescents focused on psychological vulnerabilities, with a further two being mentoring initiatives. Another five interventions involved different types of street work and outreach or one-on-one supports in the community that reflected the potential significance of brief interventions. Three interventions largely involved information provision, while the final two initiatives were a multifaceted community development programme and a media campaign. In general, these kinds of interventions are useful additions to prevention work, but they typically fall short of a strong empirical foundation as outlined in the Standards due to a lack of sustained involvement with those at risk or a lack of clear information about what kind of involvement takes place.

Characteristics of classroom environment improvement programmes associated with efficacy and/or effectiveness include the following:

- Programmes are typically delivered during the early years of schooling.
- They include strategies to address inappropriate behaviour.
- They include strategies to reinforce and reward appropriate behaviour.
- Clear expectations are communicated and reinforced through regular feedback.
- Students are actively engaged in programme activities.

Seven interventions were categorised as not evidence based. These included information-sharing sessions at local Gaelic Athletic Association (GAA) clubs or other public settings; two student engagement film projects; a tailored workshop for secondary school students; two after-school programmes to which participants are explicitly referred due to multifaceted risk, including substance use; and a programme that offers a range of activities that are meant to serve as alternatives to substance use. In each case, the interventions are described as being explicitly aimed at drug and alcohol prevention, but all of them offer services or are structured in ways that are not consistent with the Standards. There are three areas of limitation that apply to these interventions. First, the extent of contact appears limited or was not clearly articulated. Second, they appear to rely heavily on merely giving information. Third, they appear to be based on unstructured dialogue sessions. Such programmes could be strengthened by emphasising repeated contact, ensuring more interactive and consistent communication, and emphasising the broad issue of alcohol and drug use.

B5. Older adolescence

Many prevention interventions that focus on older adolescence are the same as those that focus on early adolescence and so will only be summarised in brief.[11] In total, there were 79 interventions targeting older adolescence. Fourteen interventions were classified as evidence based. Most were the same or similar manualised, school-based, and family-focused interventions described previously for early adolescence (e.g. the Strengthening Families Programme, the 5-Step intervention, and Unplugged). However, two interventions were variations of targeted talks that speak to addressing individual vulnerabilities using empirically evaluated protocols (e.g. A-CRA). A further two interventions were SAOR brief interventions. All of these interventions could benefit from local evaluation. Three interventions were assessed as innovative and were discussed earlier.

Characteristics of school policies on substance use associated with efficacy and/or effectiveness include the following:

- They help the school run smoothly and do not cause disruptions.
- Policies are made with input from everyone – students, teachers, staff and parents.
- They clearly say which substances are not allowed and where or when the rules apply (like on school grounds or at school events).
- They apply to everyone at school – students, teachers, staff and visitors – and cover all substances.
- They deal with rule-breaking by offering support, such as counselling, treatment, or other health and social services, instead of punishment.
- They are enforced fairly and quickly, and following the rules is positively recognised.

11. See note on page 27 of the *International Standards on Drug Use Prevention*.

A further 19 interventions were assessed as being strongly evidence informed. Again, many of these were the same interventions described earlier for early adolescence (see Section B4). These included five family-focused interventions (e.g. FamiliBase) focusing on a combination of parenting skills and social competence and influence, and three school- or community-based initiatives (e.g. SHAHRP) targeting the same vulnerabilities. A further six interventions focused on psychological vulnerabilities and brief interventions, particularly in the context of street work or outreach. A further intervention in this vein involved the MECC approach. The final four interventions include three examples of multifaceted community development work, and one intervention to provide an alcohol- and drug-free entertainment venue. All these interventions fell short of being deemed evidence based, as outcome evaluations had not been conducted for them.

Characteristics of school-wide programmes to enhance school attachment associated with efficacy and/or effectiveness include the following:

- They support a positive school ethos and commitment to school.
- They support student participation.

Thirty-four interventions targeting older adolescents were deemed to be weakly evidence informed. This includes seven family-based interventions emphasising either parenting supports or information sharing. Another 10 interventions targeted social confidence and influence in a range of settings. Three interventions focused on mental health issues, while another two were mentoring initiatives. Different forms of brief interventions, including street work and outreach, characterised another nine weakly evidence-informed interventions. The final three interventions include a multifaceted community development initiative and two media campaigns. Following the *International Standards on Drug Use Prevention*, these interventions fell short of the stronger endorsement due to limited information concerning the number of interactions, evidence of a lack of connection to other institutional influences (e.g. families or schools), a lack of information about intervention content, and ambiguity regarding the effectiveness of interventions in different settings (e.g. brief interventions outside of a healthcare setting).

Characteristics for addressing individual psychological vulnerabilities associated with efficacy and/or effectiveness include the following:

- They are run by trained professionals, like psychologists or teachers.
- Participants are chosen based on specific personality traits using reliable tests.
- Programmes are set up to avoid making anyone feel singled out or stigmatised.
- They teach participants skills to handle emotions in a positive way.
- They are short, usually 2-5 sessions long.

Nine interventions were deemed to be not evidence based. Seven of these were the same or similar to those that were categorised as such for early adolescence. The remaining two were a one-off intervention targeting secondary school students around times of the year deemed to be high risk for binge drinking (e.g. Transition Year balls), and tailored workshops or talks around health and well-being in general.

Characteristics of mentoring associated with efficacy and/or effectiveness include the following the following:

- Mentors are adequately trained and supported.
- They are based on a highly structured programme of activities

B6. Adulthood

As will be discussed in the conclusions, conventional definitions of adolescence and adulthood do not have clear boundaries, and hence there is overlap both in the interventions provided to older adolescents and young adults, and in the assessment of interventions targeted towards these age groups in the *International Standards on Drug Use Prevention*. With respect to the latter, there were few (n=8) interventions that were exclusive to adults. The remainder were interventions targeting adolescents where the respondent also indicated that adults were served. Given this, previously reviewed interventions will be acknowledged in this section but will not be discussed further.

In total, there were 66 interventions categorised as targeting adults. Of these, 13 were evidence based. These included four family interventions (e.g. the Strengthening Families Programme) and four SAOR brief interventions. Four interventions were school-based, manualised interventions, including SHAHRP and Unplugged. The final intervention was a multifaceted workplace intervention (Prime for Life) involving group interaction and a motivational interviewing format that was manualised and either involved outside referrals or was offered by employers as part of an overall wellness service.

Characteristics of workplace prevention programmes associated with efficacy and/or effectiveness include the following:

- They are created with input from everyone – employers, management, and employees.
- They keep employee information confidential.
- They are based on a workplace substance use policy that everyone helped make and that does not punish.
- They offer brief help, online or in-person counselling, referrals to treatment, and support for returning to work.
- They communicate clearly about the programme and are part of other health or wellness programmes, like heart disease prevention.
- They include stress management courses.
- They train managers, employees, and health staff on their roles in the programme.
- Alcohol and drug testing is only done as part of a full programme with all the features above.

Two interventions implementing the HSE intervention Know the Score, which is typically school-based, were assessed as innovative.

The nine interventions deemed to be strongly evidence informed were also not unique to adults. These included two family-based interventions (e.g. the Strengthening Families Programme and FamiliBase) and five interventions targeting social and psychological vulnerabilities, often using brief interventions in the form of street work or other outreach. The eighth intervention provides an alcohol-free entertainment venue, and the ninth involves brief interventions (e.g. MECC). All interventions in this group are important aspects of the prevention system but could still benefit from local evaluation.

Characteristics of interventions targeting adults and entertainment venues associated with efficacy and/or effectiveness include:

- They train staff and managers in responsible service practices and in identifying and managing intoxicated patrons.
- They provide access to counselling and treatment services for staff and managers who require support.
- They implement a strong communication strategy to increase awareness of the programme and promote buy-in.
- They ensure coordinated involvement of law enforcement, health, and social service sectors.
- They strengthen enforcement of existing substance use laws and policies within venues and across the community.

Thirty-six interventions were weakly evidence informed. Thirteen interventions emphasised brief interventions in different settings, including with SAOR-trained professionals and/or street work and outreach. Nine further interventions appear to focus on social competence and influence and target both adolescents and young adults, but age specification is more complicated in that the interventions are offered by the same organisation to a wide age range. Another seven interventions were family focused and included a mix of foci such as parenting skills, family supports (e.g. mental health and other), and information sharing. Similarly, two interventions involved mental health supports and indicated an age range from early adolescence to early adulthood, while two interventions were mentoring interventions. Although some of these are difficult to reconcile with the age classification of adults in the *International Standards on Drug Use Prevention*, the RePS submissions were explicit in indicating that the target age group included (very) early adulthood (i.e. the early 20s) and typically had parallel efforts targeting early and older adolescents. Hence, they would seem to be relevant prevention activities. The final three interventions in this group are specific to adults in the Standards, and include a community development initiative and two media campaigns. All of the weakly evidence-informed interventions include some, but not all, of the characteristics associated with efficacy and effectiveness as described in the Standards.

Characteristics of community-based, multifaceted initiatives associated with efficacy and/or effectiveness include the following:

- They help enforce local tobacco and alcohol rules.
- They operate in different community places, like homes, schools, workplaces, and entertainment venues.
- They involve universities to support evidence-based programmes and track their results.
- Communities receive proper training and resources.
- Programmes continue for the medium term, usually longer than a year.

Six interventions were not evidence based. All were reviewed previously in this section for younger age groups, and included four information provision activities and two out-of-school activities. All involved the extension of an adolescence-focused intervention to the early adulthood period.

B7. No specific age group

Twenty-one interventions indicated no specific age range or included all age groups. Two interventions were evidence based. One intervention described public policy development and enforcement, while the second intervention was a manualised programme for secondary school students. One intervention was a manualised school intervention undergoing evaluation, and was therefore assessed as being innovative. Two interventions were multifaceted, community development programmes and were deemed to be strongly evidence informed. Nine interventions were weakly evidence informed and included four family interventions offering a range of supports, two school-based initiatives, two brief interventions (e.g. SAOR), and a media campaign. In general, a lack of details prevented these interventions from being classified as strongly evidence informed. In addition, three of the weakly evidence-informed interventions were community safety initiatives that appeared promising but lacked the robustness and detail of the more evidence-based interventions. The final seven interventions were not evidence based and included various forms of information provision in a range of settings, including festivals, GAA clubs, other community centres, and educational institutions. All of the latter have been previously reviewed for other age groups.

Characteristics of media campaigns associated with efficacy and/or effectiveness include the following:

- They clearly identify who the campaign is meant for.
- They are based on strong theories and good research.
- They are closely linked with other drug prevention programmes at home, in schools, and in the community.
- They reach the target group often and over a long period of time.
- They include parents, since this also positively effects children.
- They aim to change social attitudes toward substance use and teach people about its consequences.

C. Assessment of quality by risk level

Figure 22 reports the percentage of age-specific interventions across Ireland by the risk level of the target group, and Table 2 reports the number of interventions. Interventions that are not evidence based were most prevalent among the 'multiple risk levels' group (29%), followed by the 'selective risk' group (18%). The prevalence of non-evidence-based interventions was much lower among the 'indicated risk' group (8%) and the 'universal risk' group (2%). In contrast, weakly evidence-informed interventions were most prevalent among the 'indicated risk' group (62%) compared with the 'selective risk' (43%) or 'universal risk' (18%) groups. Strongly evidence-informed interventions were most common among the 'selective risk' (22%), 'universal risk' (29%), and 'multiple risk levels' (29%) groups, and least common among the 'indicated risk' (14%) group. A similar pattern holds for evidence-based interventions, which were most common in the 'universal risk' group (38%) and least common in the 'selective risk' (18%) and 'indicated risk' (13%) groups. Although the number of interventions is small, evidence-based interventions were reasonably common in the 'multiple risk levels' group (29%). Innovative interventions were most common among the 'universal risk' group (13%).

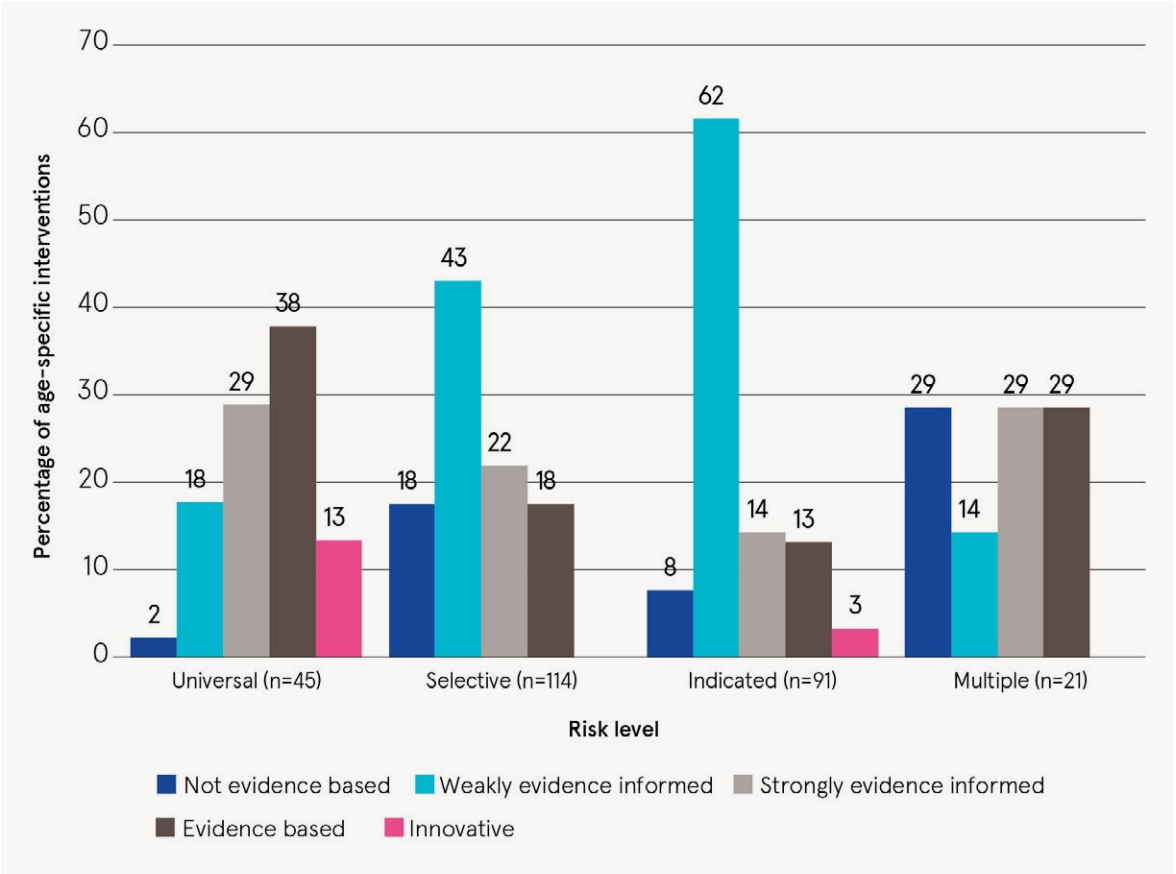

Figure 22: Percentage of age-specific interventions, by quality and risk level (n=271)

The following subsections provide a descriptive summary of the interventions in each of the levels of risk, grouped by quality.

Table 2: Number of interventions by quality and risk level (n=271)

	Universal	Selective	Indicated	Multiple
Not evidence based	1	20	7	6
Weakly evidence informed	8	49	56	3
Strongly evidence informed	13	25	13	6
Evidence based	17	20	12	6
Innovative	6	0	3	0

C1. Universal

The biggest group of 'universal risk' interventions – 17 – were evidence based. This included five family-based interventions (e.g. the Strengthening Families Programme) and seven school-based interventions (e.g. SHAHRP and Unplugged). Four other interventions in this group were SAOR brief interventions. The final intervention was a policy development and enforcement intervention. All 17 interventions have been described in subsection B. They are generally of high quality but could still benefit from local evaluation. Similarly, two different organisations offered six age-specific interventions that were deemed to be innovative.

Strongly evidence-informed interventions were also quite prevalent among 'universal risk' interventions (13 of 45 interventions). These included three education-centred initiatives focusing on social competence and influence, and two mental health support interventions. The remaining initiatives were either brief interventions – specifically MECC – or omnibus community development initiatives (e.g. Communities That Care and Building SAFER Communities). All of these interventions could benefit from evaluation.

Eight 'universal risk' interventions were weakly evidence informed. The majority of these focused on social competence and influence in a range of settings. A further two interventions were different types of brief interventions. Again, these interventions fall short in that they only have some (not all) of the characteristics necessary for strong endorsement given the types of interventions they are. The main issue is ambiguity about or programmatic limits on the number of sessions involved. The *International Standards on Drug Use Prevention* identify more effective practice as interventions involving at least 10–15 sessions and that are organised in a dynamic manner. The latter refers to both the way in which information is conveyed and the process of reflecting on the intervention itself. The one 'universal risk' intervention deemed to be not evidence based was a one-off information-sharing session in a public venue. Critical in the *Standards*' review is that information sharing is only an effective part of an intervention when it is connected to other prevention activities, is interactive in format, and is connected to core social institutions and their activities (e.g. families or schooling).

C2. Selective

The majority of interventions were classified as 'selective risk' (114 of 271) and have all been discussed in subsection B. For evidence-based interventions, there were 20 age-specific interventions from 8 organisations. These included interventions based on the Incredible Years framework, several offerings based on the Strengthening Families Programme, and several school-based interventions, including SHAHRP and Unplugged. All have been evaluated but none were evaluated in the local context.

Of the 25 'selective risk' interventions classified as strongly evidence informed, 5 of these focused on families with an emphasis on parenting skills and/or children's social competence and influence. Another 13 interventions focused on street work, outreach, and mental health vulnerabilities, often in the context of brief interventions. Four more interventions emphasised social competence and influence in adolescents in both school and community settings. The final three interventions in this group were multifaceted community development initiatives. Evaluation in the local context would strengthen confidence in the efficacy of such interventions.

Just under one-half – 49 – of the 'selective risk' interventions were weakly evidence informed. One such intervention targeted pregnant women with substance use challenges. Five interventions were family focused and emphasised parenting skills and family management, but there was minimal information provided about either the nature of the interventions or their duration. Seventeen interventions emphasised personal and social skills in younger children and social competence and influence in adolescents. Seven interventions focused on outreach and brief interventions.

A further four focused on mental health issues and disorders, and psychosocial vulnerabilities. There were also four mentoring interventions and nine variations of brief interventions in a range of settings. The remaining interventions were media campaigns. There was little evidence that media campaign interventions were focused on the target group of the campaign, had a solid theoretical basis, relied on empirical work, or strongly connected to existing interventions or institutions in society. The latter points are critical to the effectiveness of media campaigns in drug and alcohol prevention.

Twenty 'selective risk' interventions were not evidence based. This included 11 out-of-school interventions targeting multiple age groups, and 9 interventions (also targeting multiple age groups) that provide information about substance use. The classification of non-evidence-based interventions reflects a lack of connection to other prevention activities, a lack of information on the style of delivery or evidence of a one-sided approach, limited contact between providers and the target audience, and that they appear to operate in isolation from core social institutions and their activities.

C3. Indicated

Ninety-one interventions were 'indicated risk'. Twelve of these age-specific interventions were evidence based. This included three school-based interventions emphasising social competence and influence (i.e. Unplugged), four brief interventions, and four family-based and youth-group-based interventions using the A-CRA model. The final intervention was a workplace initiative.[12] None of these interventions were evaluated locally. Another high-quality intervention was an HSE-developed school-based intervention that was deemed innovative due to an ongoing evaluation.

There were 13 age-specific interventions that target the 'indicated risk' group and were strongly evidence informed. This included a family-based initiative available to multiple age groups, a community-based group intervention emphasising social competence and influence that was offered to adolescents and young adults, and a mental health support intervention also targeting multiple age groups. The final intervention is an alcohol- and drug-free entertainment venue for older adolescents and young adults. All these interventions are important components of the prevention landscape in Ireland but could benefit from local evaluation.

Fifty-six age-specific interventions were weakly evidence informed. Again, almost all have been reviewed in detail in subsection B. This includes 16 interventions focused on enhancing parenting skills and assisting families, and another 15 interventions focused on personal and social skills in older children and personal competence and influence among adolescents. Nine interventions focused on mental health issues, and another three were mentoring initiatives. The remaining initiatives were different forms of brief interventions, including street work and outreach. While there are a number of limitations to this group of interventions, the two main ones are a lack of sustained engagement with the at-risk individuals and a lack of a standardised and validated approach that guides the engagement.

12. The RePS submission for this programme was quite sparse and did not actually identify the initiative as workplace based. An Internet search provided considerable information and indicated that its primary location is workplaces and stressed that it is manualised, copywritten, and evidence based. It was not possible to locate the details of the programme prior to the writing of this report.

For 'indicated risk' interventions that were classified as not evidence based, all seven interventions targeted multiple age groups. This included three one-off or limited engagement drug and alcohol awareness sessions, and an out-of-school film project for at-risk youth. The former interventions simply are not recognised in the *International Standards on Drug Use Prevention* as effective prevention interventions, while the latter could benefit from more sustained engagement, more dynamic delivery, and stronger connections to other prevention work and core social institutions such as schools and families.

C4. Multiple levels of risk

Although they were small in number, the majority of interventions targeting multiple risk levels were evidence based or strongly evidence informed (12 of 21 interventions). The evidence-based initiatives were either school-based interventions focused on social competence and influence, or brief interventions. Both targeted multiple age groups. The strongly evidence-informed initiatives were either community-based social competence and influence initiatives or interventions providing mental health supports. In both cases, the target age groups were adolescents and early adults. The three weakly evidence-informed interventions provided information to parents about drugs and alcohol. The final six interventions were not evidence based and included information sessions in public venues (e.g. GAA clubs). Again, the Standards' review of research shows that information sharing is only an effective part of an intervention when it is connected to other prevention activities, is interactive in format, and connects to core social institutions.

D. Assessment of quality by setting of implementation

Figure 23 reports the percentage of interventions by quality and setting of implementation. Interventions were reported for all settings of implementation. To offer some general observations, there was only one workplace intervention reported, and it was classified as evidence based (see Table 3). There was also only one submission that genuinely operated across multiple settings – a multifaceted support programme targeting early and older adolescents and young adults that was described as operating in the "school setting, youth work setting, [and] community groups setting" and targeting "those who need drug awareness, harm reduction, signposting… [with the main] activities [being] age appropriate information with interactive activities". As this intervention targeted multiple age groups, it is shown as three age-specific interventions in Figure 23 and Table 3.

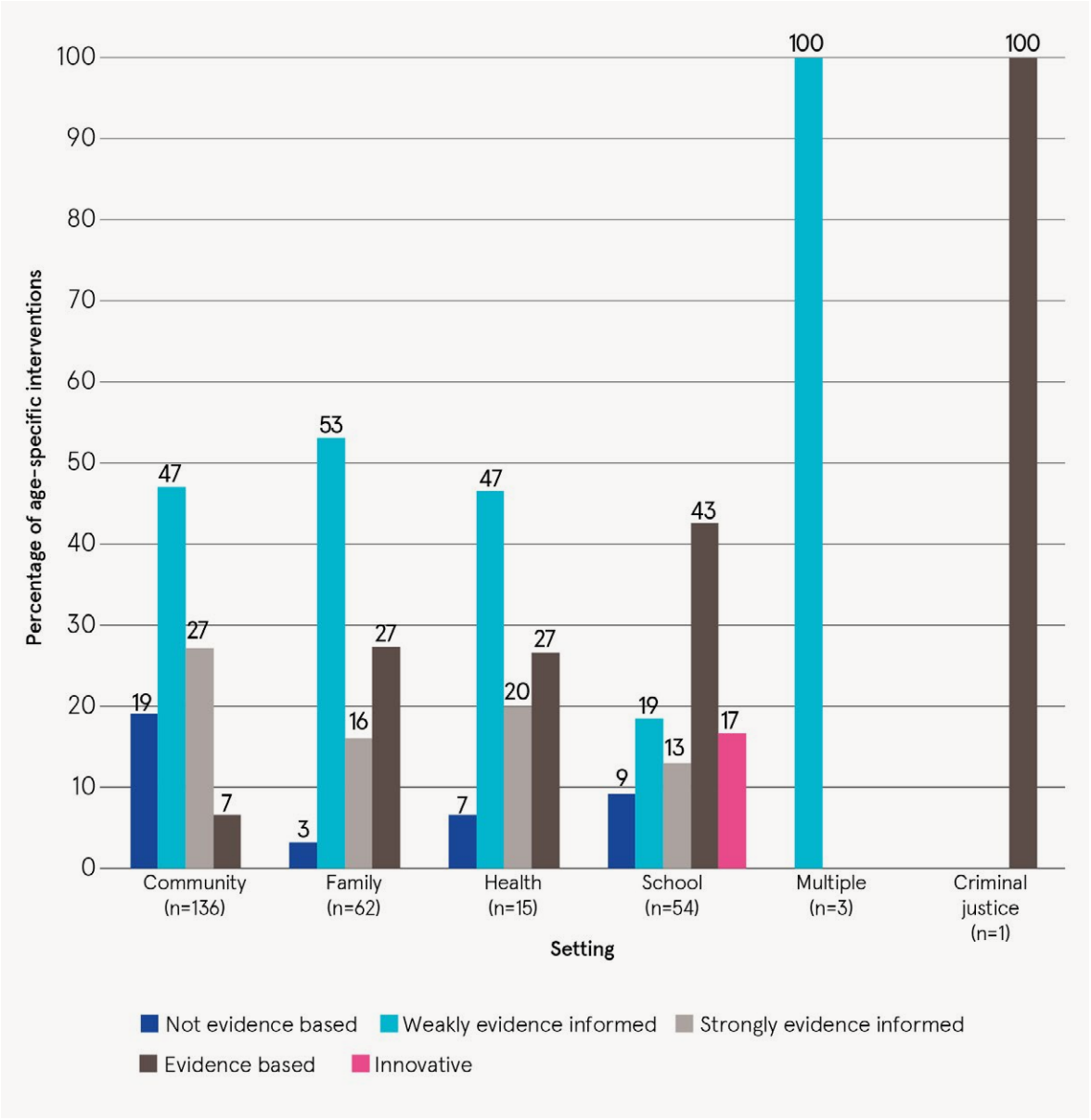

Figure 23: Percentage of age-specific interventions, by quality and setting (n=272)

Evidence-based interventions were most prevalent in school settings (43%), followed by health (27%) and family (27%) settings. They were much less prevalent in community settings (7%). The only intervention delivered in a criminal justice setting was also evidence based. Innovative interventions were only delivered in school settings. Strongly evidence-informed interventions were most prevalent in community (27%) and health (20%) settings. Strongly evidence-informed interventions were less prevalent in family (16%) and school (13%) settings. There were no strongly evidence-informed interventions in criminal justice or multiple settings, but this may reflect the very few number of interventions delivered in these settings captured in the RePS survey. Weakly evidence-informed interventions were reasonably balanced across community (47%), family (53%), and health (47%) settings, but much less prevalent in school settings (19%). All interventions delivered in multiple settings were weakly evidence informed. Finally, interventions that were not evidence based were most prevalent in community (19%) settings.

Subsections D1 to D4 report on the details of the interventions within each setting. There was only one intervention delivered in workplace settings and only one intervention targeting multiple age groups that seemed to operate in multiple settings. The former was classified as evidence based, while the latter was classified as weakly evidence informed.

Table 3: Number of interventions by quality and setting (n=272)

	Community	Family	Health	School	Multiple	Criminal justice	Workplace
Not evidence based	26	2	1	5	0	0	0
Weakly evidence informed	64	33	7	10	3	0	0
Strongly evidence informed	37	10	3	7	0	0	0
Evidence based	9	17	4	23	0	1	1
Innovative	0	0	0	9	0	0	0

D1. Community

The majority of the interventions were categorised as 'community based' (n=136). Only nine interventions in community settings were evidence based. This included the development and enforcement of policy, individual and group-based interventions based on the A-CRA model, and brief interventions (e.g. SAOR). None of them appear to have been locally evaluated, at least with respect to key outcomes.

Thirty-seven community-based interventions were strongly evidence informed. This included eight interventions targeting social competence and influence among adolescents, and personal and social skills in older childhood. Another 11 interventions included street work and outreach through brief interventions. Eight further interventions sought to ameliorate individual psychosocial vulnerabilities. The remaining interventions included eight community development projects targeting multiple age groups and an initiative to provide alcohol-free entertainment venues for multiple age groups. While demonstrating high quality, these interventions could still benefit from outcome evaluations of their effectiveness.

The biggest group of community-based interventions were weakly evidence informed (64 interventions). Twenty-seven interventions focused on personal and social skills education for childhood, and social competence and influence for adolescents. Seven interventions focused on mental health disorders in older children and adolescents. Another seven interventions involved mentoring for at-risk adolescents and young adults and were offered by two related organisations. Seventeen interventions were different types of brief interventions that again often involved street work or other outreach initiatives. There were also six media engagement initiatives.

As discussed earlier, these interventions demonstrate some, but not all, of the criteria for efficacy outlined in the *International Standards on Drug Use Prevention*.

Twenty-six interventions were not evidence based. This included 15 information provision sessions (e.g. events at GAA clubs and outreach at festivals) and 11 out-of-school activities for older children and adolescents. The out-of-school interventions lacked a sufficient focus on substance use prevention. The information interventions lacked the rigour outlined in the Standards and discussed in subsections B1 to B7.

D2. Family

Of the 62 interventions in family settings, 17 interventions were evidence based. The majority of these were variations on the Strengthening Families Programme. Ten further interventions were strongly evidence informed and included an infant parent support intervention and FamiliBase, a local, multifaceted initiative to support families and children of all ages.

The majority of the family interventions – 33 – were weakly evidence informed. Of these, 27 interventions focused on parenting skills and broadly defined family supports. Three further interventions involved information sharing among parents and children, while another three were brief interventions.

There were two family-based interventions that were classified as not evidence based. These were both one-to-one art therapy initiatives.

D3. Health

Fifteen interventions were located in health settings. Four interventions in health settings were evidence based, and all of these were manualised one-on-one (e.g. SAOR) brief interventions with adolescents and adults. Another three interventions were strongly evidence informed and used the MECC approach. Seven further interventions were weakly evidence informed and included six interventions focusing on underlying mental health issues and one brief intervention. The remaining intervention was not evidence based and was an information-sharing initiative based in a health clinic.

D4. School

There were 54 interventions implemented in school settings. The majority of interventions were evidence based (23 interventions) and comprised an even mix of programmes focusing on personal and social skills in early adolescence (e.g. Unplugged) or social competence and influence in older adolescence (e.g. SHAHRP). These also included interventions using the Incredible Years framework. All of these interventions could benefit from local evaluation. Another nine interventions were deemed innovative due to their high quality and having an ongoing evaluation.

Seven interventions were strongly evidence informed. Most emphasised personal and social skills in older children or social competence and influence in young adolescents. Another two interventions addressed mental health vulnerabilities in adolescents. Of the 10 interventions that were weakly evidence informed, most focused on personal and social skills for older children or social competence and influence for adolescents. One intervention of this type involved information provision.

The final five school-based interventions were not evidence based and involved one-off information provision in public settings or third-level institutions, or some other type of student engagement activity. For all of these interventions, the main limitations were a lack of information or indications of limited interactions with the target group; questions about the style of delivery; and a lack of connection to other prevention activities or core social institutions and their activities, or both.

E. Assessment of quality by HSE health region

Figure 24 shows the percentage of interventions by quality within each HSE health region. There is considerable variation across health regions. Evidence-based interventions were most prevalent in the HSE South West (36%) and HSE Dublin and Midlands (40%) regions. They were also quite prevalent in HSE Mid West (26%). Evidence-based interventions were, however, less prevalent in the HSE Dublin and North East (13%), HSE Dublin and South East (10%), and HSE West and North West (5%) regions. Innovative interventions were most prevalent in HSE South West (11%), where the percentage of such interventions was more than double that in any other region.

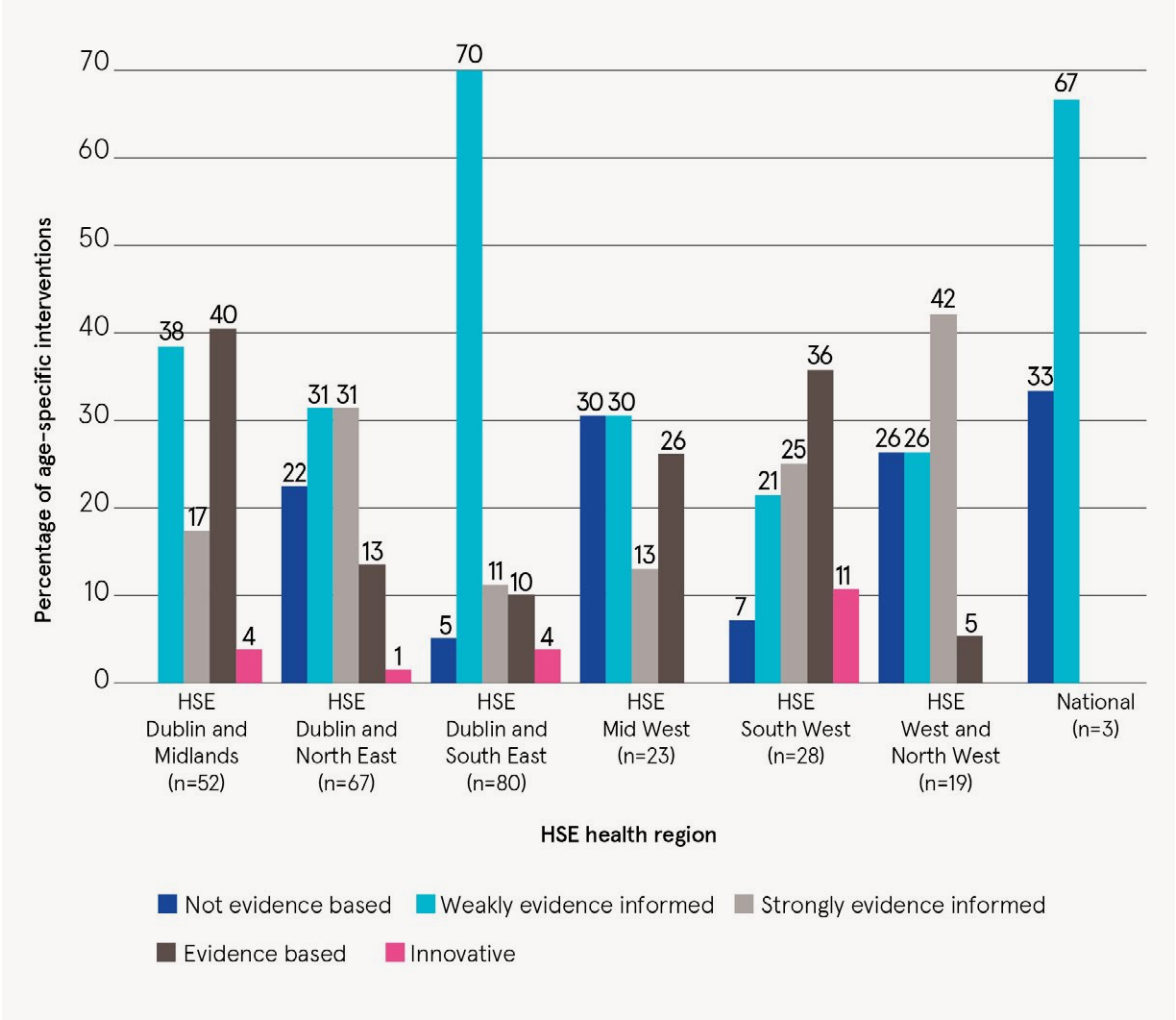

Figure 24: Percentage of age-specific interventions by quality and HSE health region (n=272)

Strongly evidence informed interventions were most prevalent in HSE West and North West (42%), followed by HSE Dublin and North East (31%) and HSE South West (25%). Such interventions were considerably less prevalent in the HSE Dublin and Midlands (17%), HSE Mid West (13%), and HSE Dublin and South East (11%) regions. Weakly evidence-informed interventions were most prevalent in HSE Dublin and South East (70%) and were reasonably evenly distributed across the HSE Dublin and Midlands (38%), HSE Dublin and North East (31%), HSE Mid West (30%), HSE South West (21%), and HSE West and North West (26%) regions. The proportion of interventions that were not evidence based was greatest in HSE Mid West (30%), followed by HSE West and North West (26%) and HSE Dublin and North East (22%). Non-evidence-based interventions were quite rare in the other regions (<8%). There were so few distinct interventions operating at the national level that comparisons of quality are not informative. In general, an important qualification for interpretation is that variation in the number of interventions across regions may mean that the percentages reported are based on a handful of interventions and may not warrant strong conclusions about variation in the overall quality of interventions in a given area.

The following subsections provide a short summary of the interventions by quality in each HSE health region. The reader is reminded that more detailed descriptions of specific interventions were included earlier (see subsections B, C, and D). The number of interventions for each quality classification within each HSE health region is reported in Table 4.

Table 4: Number of interventions by quality and HSE health region (n=272)

	HSE Dublin and Midlands (n=52)	HSE Dublin and North East (n=67)	HSE Dublin and South East (n=80)	HSE Mid West (n=23)	HSE South West (n=28)	HSE West and North West (n=19)	National (n=3)
Not evidence based	0	15	4	7	2	5	1
Weakly evidence informed	20	21	56	7	6	5	2
Strongly evidence informed	9	21	9	3	7	8	0
Evidence based	21	9	8	6	10	1	0
Innovative	2	1	3	0	3	0	0

E1. HSE Dublin and Midlands

There were 52 age-specific interventions in the HSE Dublin and Midlands health region. Almost one-half – 21 interventions – were classified as evidence based, and all of these were either school-based interventions focusing on personal and social skills in older children and social competence and influence in adolescents, or programmes modelled after the Strengthening Families Programme. Again, such interventions could warrant local evaluation.

Two initiatives were innovative, and both were school-based interventions undergoing evaluation at the time of writing. For the nine strongly evidence-informed interventions, five were family-focused interventions emphasising either parenting skills and personal and social skills in children, or social competence and influence in adolescents. Another two interventions focused on mental health vulnerabilities combined with brief interventions (e.g. street work and outreach activities). The final two strongly evidence-informed interventions were multifaceted community development initiatives.

There were 20 interventions in HSE Dublin and Midlands that were weakly evidence informed. These included 1 intervention focusing on enhancing parenting skills among women with young children, 10 interventions emphasising personal and social skills development in children or social competence and influence in adolescents, and 6 interventions focused on mental health difficulties in children and adolescents. The final interventions in this group were media campaigns that have been discussed earlier (see subsections B, C, and D) and fall short of strong endorsement given only partial concordance with the features of effective interventions outlined in the *International Standards on Drug Use Prevention*. There were no interventions that were not evidence based in this HSE health region.

E2. HSE Dublin and North East

There were 67 interventions located in the HSE Dublin and North East health region. There were nine interventions classified as evidence based. This included four school-based interventions (e.g. SHAHRP), three SAOR brief interventions, and interventions using the Incredible Years framework. One intervention was classified as innovative and was a school-based programme emphasising social competence and influence. There were 21 interventions classified as strongly evidence informed. These included 5 parenting skills initiatives, 2 school-based interventions for adolescents, 13 interventions focused on mental health that may include outreach and street work, and 1 multifaceted community development initiative.

Twenty-one interventions were classified as weakly evidence informed. This included one intervention targeting pregnant women with substance use issues, four information-sharing initiatives, and nine school-based initiatives focused on skills and competence among adolescents. The remaining interventions involved mental health supports in adolescents, brief interventions with adults, and a community development initiative. For the 15 interventions that were not evidence based in this HSE health region, 10 involve information provision in public forums offered by 4 different organisations; 3 were out-of-school activities; and 2 involved art therapy targeting multiple age groups.

E3. HSE Dublin and South East

The largest number of age-specific interventions – 80 – were reported for the HSE Dublin and South East health region. Eight interventions in this region were classified as evidence based, and this included four SAOR brief interventions and four family-based initiatives using the Strengthening Families Programme. Three school-based interventions emphasising social competence and influence were classified as innovative. Nine further interventions were classified as strongly evidence informed, and these included one school-based intervention, three interventions providing counselling to at-risk adolescents, and several brief interventions based on the MECC approach.

Fifty-six interventions were classified as weakly evidence informed. This includes 16 interventions focusing on improving parenting skills, 13 interventions focused on personal and social skills in children or social competence and influence in adolescents, and 7 mentoring initiatives. The remaining interventions in this group involved supports for adolescents with mental health issues, which often involved brief interventions.

Four interventions were classified as not evidence based, and this included tailored, one-off workshops targeting multiple age groups and an out-of-school filmmaking intervention for adolescents.

E4. HSE Mid West

There were 23 age-specific interventions in the HSE Mid West health region. The six initiatives that were classified as evidence based in this region utilised the A-CRA model and were targeted at multiple age groups and families. Three initiatives that were strongly evidence informed included one-on-one supports for mental health disorders in adolescents and young adults.

Of the seven initiatives classified as weakly evidence informed, six focused on mental health issues across multiple age groups, with the final intervention being a two-session education intervention for parents and children. Seven interventions were classified as not evidence based. These targeted adolescents and included an out-of-school filmmaking initiative and one-off drug awareness sessions for young people.

E5. HSE South West

There were 28 age-specific interventions identified in the HSE South West health region. The 10 interventions classified as evidence based included 2 school-based interventions emphasising social competence and influence among adolescents, 5 interventions among families, 2 brief intervention initiatives, and 1 policy development and enforcement initiative. Three school-based initiatives were assessed as innovative. Seven further initiatives were strongly evidence informed, and these included community development initiatives (e.g. Healthy Cities Initiative) and the provision of alcohol-free music venues. Six interventions in this region were classified as weakly evidence informed, and these included mental health supports for adolescents, information-sharing 'pods', and brief interventions. The two interventions that were not evidence based were information-sharing initiatives.

E6. HSE West and North West

The HSE West and North West health region had 19 age-specific interventions. The one evidence-based intervention was a manualised workplace prevention intervention targeting adults. Eight further interventions were strongly evidence informed, and all focused on either personal and social skills in children or social competence and influence in adolescents. Five initiatives were weakly evidence informed, and these included a social media campaign targeting adolescents, a mental health support intervention, and a parenting support intervention. The final five interventions were not evidence based, and all were one-off information sessions that have been discussed in subsections B1 to B7.

F. Quality by perceived empirical basis for intervention efficacy

Figure 25 shows the percentage of programmes for each quality classification based on whether the RePS survey respondent reported that there was empirical support for the way in which their intervention is designed and implemented, and for its effectiveness as a prevention intervention. Although the data are mixed, there appears to be some relationship between the two. For interventions where empirical support was reported, 27% were evidence based. In contrast, only 8% of interventions for which no empirical support was reported were evidence based. At the same time, 10% of interventions with empirical support were not evidence based, compared with 46% of interventions without empirical support.

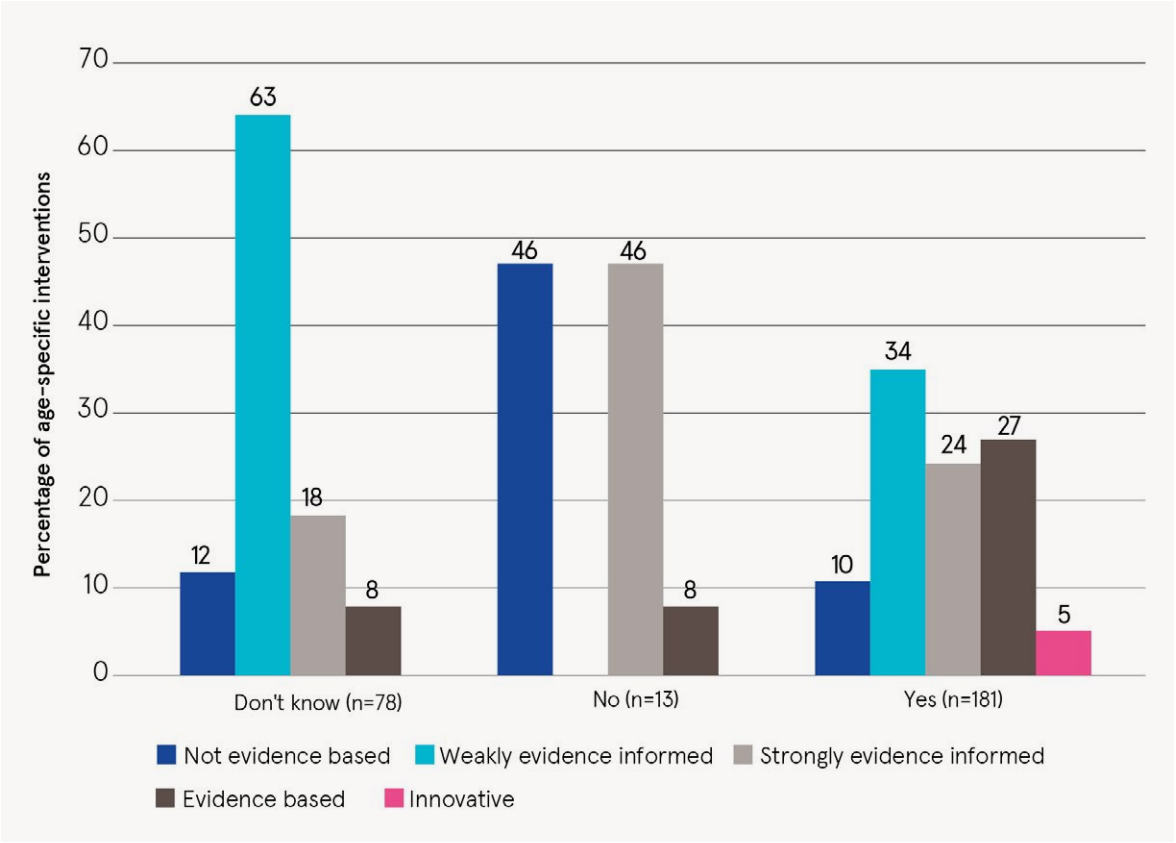

Figure 25: Percentage of interventions by quality and perceived empirical support for design and implementation (n=272)

Given that there were so few interventions where it was reported that there was not any empirical support (7 of 121 interventions), it is not informative to examine the data further by HSE health region.

G. Quality by extent of relevant staff training

Almost no programmes reported that they did not have trained staff, and hence it is not informative to examine them further by either quality or quality and HSE health region.

H. Quality by procedures or mechanisms for ensuring consistency of delivery

Figure 26 shows the percentage of interventions by quality and whether there were procedures or mechanisms in place to ensure consistency of delivery. Although it is again difficult to assess the relationship between quality and mechanisms for consistency of delivery given the limited number of interventions reported as not having such a mechanism, the evidence is mixed as to whether the two are related. Comparing the proportion of interventions with or without a mechanism for ensuring consistency of delivery, 18% of those with such a mechanism were evidence based versus 20% of those without. This speaks against there being a relationship between the two. At the other end of the spectrum, the percentage of interventions that were not evidence based was twice as large (22% versus 11%) among interventions that were reported as not having a mechanism to ensure consistency of delivery versus those that were reported as having such a mechanism. This speaks for the relationship. Even a more general comparison of strongly evidence-informed and evidence-based interventions yields identical proportions (36% versus 31%) with similar implications for weakly evidence-informed and non-evidence-based interventions (63% versus 61%). In the end, there is no evidence to indicate whether or not procedures or mechanisms to ensure consistency of delivery are associated with the overall quality of interventions.

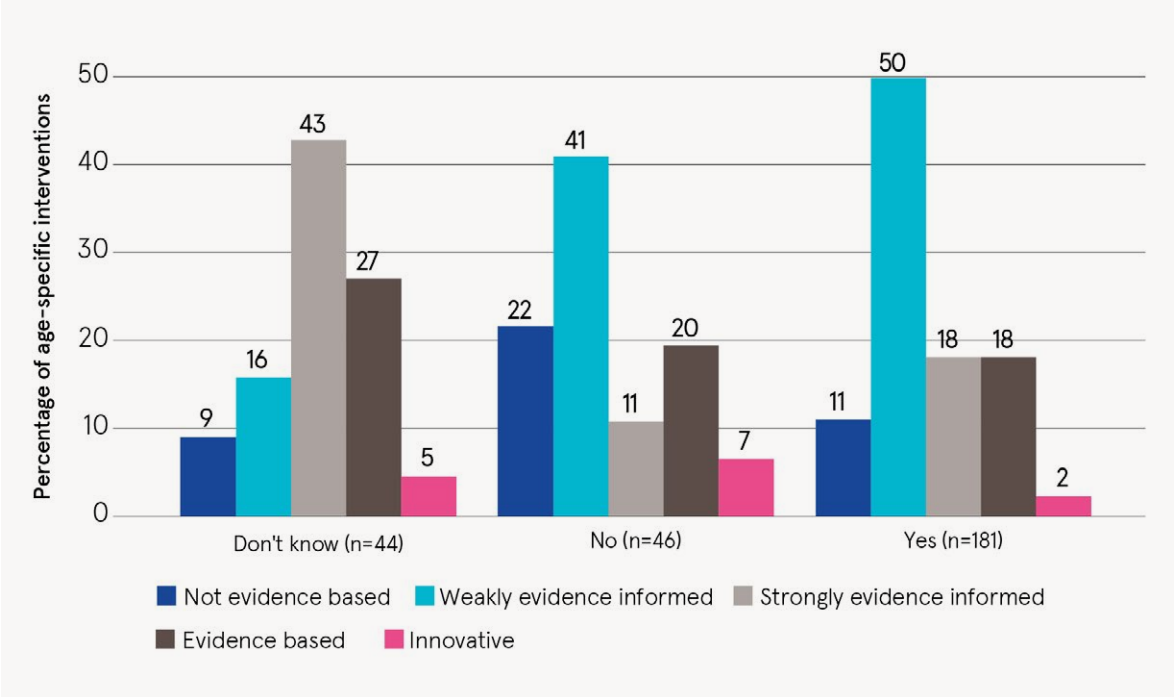

Figure 26: Percentage of interventions by quality and procedures or mechanisms to ensure consistency of delivery (n=271)

06

Quality of the system

This section presents the findings from the second component of RePS, the assessment of Ireland's overall drug prevention system. It explores the elements that make for an effective national prevention system as identified in Chapter III of the *International Standards on Drug Use Prevention*. The Standards argue that in order to "deliver an integrated range of interventions and policies, a system requires strong structural foundations" (6 p. 50).

The foundations identified in the Standards form the elements that are assessed for the systems component of the RePS. These are:

A. a range of interventions and policies based on evidence

B. supportive policy and regulatory frameworks

C. evidence-based planning and use of research

D. coordination among different sectors and levels

E. strong delivery system

F. sustainability.

The review of the quality of the system follows standards set out in Annex 5 of the Norwegian report on RePS (7). The remainder of this section presents the assessments made of the Irish system, and is structured around three strands:

1. Each element, its associated criteria, and the assessment descriptions come from an assessment tool provided by the UNODC which was based on the Standards (6) and the Norwegian pilot (7) (see Annex 5 of the final report of the pilot in Norway (7)). Therefore, some of the language used is not directly relevant to the Irish context. Efforts have been made in the assessment process to overcome these challenges. The assessment made for the Irish system is highlighted in ***bold italics*** within these text boxes.

2. The assessment made for the Irish system is stated.

3. The grounding for the decision provides a brief overview of the information upon which the assessment was based.

A. A range of interventions and policies based on evidence

The assessment of the extent to which Ireland's prevention system includes a comprehensive and evidence-based cohort of interventions is based on Chapter III, Section A of the Standards, which describes the range of interventions and policies that have been found to be effective according to the evidence. The assessment of this element is based on the information analysed in Section 5 of this review.

A1. Use of evidence-based approaches for different age groups

UNODC criteria for assessment

The system implements evidence-based approaches targeting and reaching all ages (if information on reach is not available, rate this based on coverage of age groups).

- Yes, fully: Evidence-based or -informed interventions are provided to all age groups (infancy, early childhood, middle childhood, early adolescence, adulthood, and old age), and a significant part of the targeted populations is reached, especially during the critical transitional periods.
- Yes, almost fully: Evidence-based or -informed interventions are delivered to several (i.e. four or more) age groups, one of them being early adolescence or younger. The reach in the prioritised age and target groups is good.
- ***Partially: Evidence-based or -informed interventions are provided to some age groups, but the reach might not be optimal.***
- Only in a limited manner: Evidence-based or -informed interventions are provided only to one age group with a sufficient reach.
- Not at all: There are no evidence-based interventions available, or they reach only one age group, but the reach is unknown or poor.

Assessment decision: Partially.

Grounding for decision

The RePS intervention survey identified evidence-based interventions for all age groups that appear in the *International Standards on Drug Use Prevention*. However, the prevalence of such interventions was uneven across age groups, with a much greater prevalence for adolescence and less prevalence for infancy, childhood, and adulthood. For infancy, there were simply few examples. For the latter, although adulthood was frequently referenced as a target group, most interventions either targeted the early adult years (typically in tandem with interventions targeting older adolescents) or were family-based interventions involving parents. In many instances, the parents were not the specific target of the intervention. No submissions specifically mentioned older age groups. Reach also seems uneven in that reach is strong for the adolescent years given the prevalence of interventions delivered in secondary school settings, but is more questionable for families and in workplaces.

A2. Use of evidence-based interventions for all levels of risk

UNODC criteria for assessment

The system implements evidence-based interventions targeting and reaching individuals and populations at all levels of risk.

- Yes, fully: Evidence-based or -informed interventions are provided at universal, indicated, and selective risk levels. In addition to universal-level prevention, risk groups and high-risk individuals are recognised and reached with quality preventive interventions and services matching their needs.
- Yes, almost fully: In addition to universal-level prevention, some evidence-based or -informed interventions are provided to the most important prioritised risk group(s) and some high-risk individuals. Other high-risk populations or individuals might be supported with innovative approaches or supportive services.
- ***Partially: Evidence-based or -informed interventions are provided at two levels of risk, reaching at least some high-risk groups or individuals, while other at-risk populations or individuals might be supported with innovative approaches or supportive services.***
- Only in a limited manner: Evidence-based or -informed interventions are provided at two levels of risk, but they might only reach a few at-risk groups or a limited amount of individuals, or the quality might be partially unknown or poor.
- Not at all: Evidence-based or -informed prevention is only available at one (typically universal) level of risk.

Assessment decision: Partially.

Grounding for decision

The RePS intervention survey identified evidence-based and strongly evidence-informed interventions for all three risk levels in multiple forms, but there were significant imbalances or gaps. In general, there were comparatively fewer interventions that were described as universal. This may stem from two issues. First, universal prevention is either socially diffuse or needs an institutional basis; second, there was geographic variation in availability.

Related to the first issue, information provision or media campaigns around alcohol and drugs are universal in scope, but they are typically less effective as universal prevention interventions. It is also very difficult to provide universal prevention interventions for families, and there was not much evidence of specific universal prevention interventions in workplaces. Schools are particularly promising bases for universal prevention, and the HSE, in collaboration with the Department of Education and Youth and other stakeholders, has worked to develop curricular content around drugs and alcohol for Social, Personal and Health Education (SPHE) modules. However, it is dependent upon schools and teachers as to whether programmes or SPHE modules on prevention are incorporated into classes.

It was a limitation of the RePS survey that the approach resulted in very little information on this issue. The extent to which formal prevention interventions are delivered in Irish schools is simply not known. This is discussed further in Section 6 B2. One positive finding is that the majority of interventions targeting universal risk were evaluated as evidence based or strongly evidence informed (30 of 45 interventions). At the same time, the more prevalent interventions targeting selective or indicated risk tended to be somewhat lower quality. For selective risk, less than one-half of the identified interventions – 45 of 114 – were strongly evidence informed or evidence based. Interventions targeting indicated risk were assessed to be of a lower standard. Only 25 of 91 interventions were either strongly evidence informed or evidence based (see Table 2).

Second, there was significant geographic variation in the balance of risk-based prevention interventions in Ireland. To some extent, this is not surprising. Substance use issues are always a reflection of local challenges and social issues. Interventions reflect the nature of these issues and will tilt away or towards universal, selective, or indicated prevention based on an assessment of how best to meet the needs of those in a given area. Places that have a longer history of drug-related problems may prioritise selective or indicated prevention. Likewise, places with different histories may prioritise universal approaches and implement interventions accordingly. Yet, there will always be overlapping risk and a mix of risk groups that necessitate or favour multiple intervention strategies. This is currently not the case in Ireland, where the reality is that two communities that are only a few kilometres apart may have very different interventions and target different risk groups. Adding in information about the quality of interventions simply magnifies these differences. This is an important limitation to the current system.

A3. Use of evidence-based interventions across a range of settings

UNODC criteria for assessment

The system implements evidence-based interventions targeting a range of settings.

- Yes, fully: Evidence-based or -informed interventions are provided in a comprehensive manner in all of the relevant settings in the given context (such as family, education, media, healthcare, workplaces, youth and social work, elderly care, culture and leisure time, and communities at large, and also involving civil society and the private sector), as and if appropriate.
- Yes, almost fully: Evidence-based or -informed interventions are provided in at least four different settings.
- Partially: Evidence-based or -informed interventions are provided in at least three settings.
- ***Only in a limited manner: Evidence-based or -informed interventions are provided in at least two settings.***
- Not at all: Evidence-based or -informed interventions are not available in multiple settings.

Assessment decision: Only in a limited manner.

Grounding for decision

The existence of evidence-based interventions across the range of settings was assessed to be provided 'only in a limited manner'. While the definition of this criterion refers to only two settings, a pragmatic approach was taken to the assessment in order to reflect the reality of what was found through the survey. The RePS intervention survey identified evidence-based or strongly evidence-informed interventions in all five settings. However, there was only one workplace intervention identified. It is positive that this was deemed evidence based, but the lack of workplace interventions in general suggests limited scope, although this may also reflect a limitation in the approach taken to completing the RePS survey in Ireland. The methods used may have missed workplace interventions. The majority of interventions were community based (n=136), but only nine of them were evidence based. It is more positive that 37 were strongly evidence informed, but the overall numbers still suggest limited quality. Similarly, evidence-based interventions were relatively limited in healthcare settings and were almost exclusively brief interventions. There was better representation of evidence-based and strongly evidence-informed interventions in family and school settings, but even in these settings, the distribution is uneven.

A4. Interventions target risk and protective factors at multiple levels of society

UNODC criteria for assessment

The system includes approaches targeting risk and protective factors at the level of individuals, at the level of communities (such as features of school, free-time opportunities, family, and peer groups), and at the societal level (factors such as the availability, price, and marketing of legal substances; access to health and social care services and schooling; and other factors).

- Yes, fully: The system includes evidence-based approaches that target risk and protective factors at the level of individuals, communities, and society alike.
- ***Yes, almost fully: The system includes some evidence-based or -informed approaches targeting risk and protective factors at the level of individuals, communities, and society alike.***
- Partially: The system includes some evidence-based or -informed approaches targeting risk and protective factors at only two of these different levels: individual, community, and society.
- Only in a limited manner: The system includes some prevention activities, although not evidence based, targeting risk factors at two of these different levels: individual, community, and society.
- Not at all: The system operates only at one level of risk factors.

Assessment decision: Almost fully.

Grounding for decision

The RePS intervention survey identified multiple intervention programmes that target both risk and preventative factors and that operate in multiple institutions and at multiple levels of society. At the same time, there are gaps. As mentioned in subsection D of Section 5, the survey found very few interventions in workplace settings, and it found fewer interventions being delivered in family settings than in school and community settings. While schools have reasonable representation in the interventions reported in response to the RePS survey, the total number of schools in Ireland is very large and there is no evidence of the widespread implementation of high-quality interventions in this setting. A different issue exists within community settings. Although the majority of interventions reported in response to the RePS survey were at least loosely implemented in community settings, such interventions were typically of lower quality than those implemented in family, school, and workplace settings. Geographic differences magnify disparities in that there was variation in both the setting and quality of interventions across HSE health regions.

B. Supportive policy and regulatory frameworks

This element is based on Chapter III, Section B, 'Supportive policy and regulatory frameworks', of the *International Standards on Drug Use Prevention* (6 p. 42).

B1. Funding of prevention interventions is conditional on prevention being evidence based

UNODC criteria for assessment

Funding of prevention interventions is conditional on prevention being evidence based.

- Yes, fully: The mechanism(s) to fund prevention interventions require that they are based on evidence and have been evaluated to be effective in preventing drug use. In the case of more complex systems with multiple funding channels for prevention interventions, the major funding channels require this. These requirements would typically include reference to a registry of evidence-based programmes and/or certification of programmes based on evaluation of effectiveness. In addition, certification of organisations and practitioners delivering prevention interventions, or other possible criteria on the quality of prevention interventions, such as committing to conducting outcome evaluations and monitoring when receiving funding, might be required.
- Yes, almost fully: Some funding is tied to the prevention being evidence based, or the major funding channels available require the funded prevention interventions to be in line with the evidence but not necessarily evaluated as such. For example, the funded interventions might be required to be in line with the Standards and the criteria of effective approaches presented in them, or with national guidance documents referring to evidence-based or -informed practices and principles. Also, certification might be required from the persons and organisations delivering the funded activities, as well as mandatory process or outcome evaluations, but without the requirement to use approaches that have been successfully evaluated to be effective.
- Partially: The funding mechanism(s) to fund prevention strategies require the funded approaches to meet some other well-documented and comprehensive quality criteria, but not effectiveness criteria.
- ***Only in a limited manner: The funding mechanism(s) to fund prevention strategies require some quality criteria to be met, but it might not be comprehensive, well-documented, or used consistently across the prevention field.***
- Not at all: The funding mechanism(s) to fund prevention strategies do not require the strategies to have met quality or effectiveness criteria.

Assessment decision: Only in a limited manner.

Grounding for decision

The funding of prevention interventions in Ireland was assessed to be conditional on prevention being evidence based 'only in a limited manner'. The assessment criteria focus on funders of prevention interventions and the conditions they apply to funding decisions, not on the work that practitioners deliver. At a national level, funding for prevention interventions in Ireland is not linked to requirements such as the provision of evidence of effectiveness in preventing drug use, certification of organisations and practitioners, or commitment to outcome evaluations. The Department of Health is responsible for managing the implementation of the national drugs strategy, including the national strategic approach to drug prevention. For example, the Drug and Alcohol Task Forces (DATFs) are a key mechanism for the delivery of drug prevention interventions in Ireland, and their funding is not linked to requirements as laid out in the UNODC criteria (see Section 6 D2 for a description of the DATFs).

While not operating at a national level, there are isolated and local examples of prevention interventions being linked to the evidence base and quality standards as a funding requirement in Ireland:

- In 2023, the Department of Health launched the Prevention and Education Funding Programme. It runs until Q4 of 2026 and aims to increase the focused delivery of evidence-based substance misuse prevention programmes that adhere to international prevention standards. This was made explicit by the Department of Health as part of the funding application process. Under the programme, five projects are being delivered in school, third-level education, youth work, and community-based settings.
- Through a survey carried out with DATF coordinators for this report, it was found that some DATFs required applicants for funding to provide an evidence base for their work, as well as to demonstrate alignment with international prevention standards. However, this was not a universal practice across all DATFs.

B2. Prevention in educational settings

UNODC criteria for assessment

Prevention of substance use is mandatory in educational settings.

- Yes, fully: There exists a legislative or policy mandate to undertake substance use prevention in educational settings. The mandate guides the prevention activities to be in line with the evidence, and the implementation of the policy is supported or monitored. The prevention activities entail both substance use education and other measures, and preferably target both adolescents and younger age groups, or address both individual- as well as school- or classroom-level risk and protective factors.
- Yes, almost fully: There exists a legislative or policy mandate to undertake substance use prevention in educational settings. However, the mandate might not specifically guide providers to implement only activities that are in line with evidence; the implementation of prevention might not be supported and monitored; or the mandate might focus on one form of prevention only, such as substance use education or school substance use policies, relegating other measures to a marginal role.
- ***Partially: There exists a legislative or policy mandate to undertake health promotion activities in educational settings, but prevention of substance use problems might play a more marginal role, or the implementation of the policy might be poor. The prevention activities would still entail at least some elements that are in line with/resemble the approaches described in the* International Standards on Drug Use Prevention *and contribute to substance use prevention.***
- Only in a limited manner: There exists a legislative or policy mandate to undertake health promotion activities in educational settings, with no specific reference to substance use prevention.
- Not at all: There exists no legislative or policy mandate to undertake health promotion activities, including substance use prevention, in educational settings.

Assessment decision: Partially.

Grounding for decision

The existence of mandatory substance use prevention in Ireland's educational settings was assessed as 'partially'. This assessment was in part guided by the assessment of the national drugs strategy, which found that: "Prevention and education efforts within schools and universities were seen as requiring reassessment. Prevention efforts were described by several stakeholders as underdeveloped, inconsistent, and lacking national ownership" (14 p. 85).

SPHE

The main focus for this assessment is the implementation of the SPHE curriculum in Irish schools. The SPHE curriculum is the main vehicle through which substance use prevention is delivered in both primary and post-primary schools. It is a mandatory part of the primary and post-primary (Junior Cycle) school curriculum, and it supports the personal and social development and the health and well-being of students across a set of modules, including one on substance use. The themes and content of modules are built around helping students understand the nature of the social influences that impact on their development and decision-making, as well as developing adequate life skills in order to improve their self-esteem, develop resilience, and build meaningful and trusting relationships. At the time of the RePS assessment (Q4 2025), SPHE is not a mandatory part of the Senior Cycle curriculum.

While SPHE is part of the curriculum in Irish schools, schools and individual teachers have flexibility in terms of how it is delivered. As SPHE is not an examined part of the curriculum, there are no data available on the extent to which it is actually delivered in schools or whether all topics (including substance use) are covered across the school population nationally. Available evidence suggests that there is consensus among stakeholders that SPHE is not delivered in a consistent or coherent way nationally, especially at the level of Senior Cycle. For example, the findings from an assessment of Ireland's national drugs strategy, published in July 2025, found that "significant variation was observed in the delivery of Social, Personal, and Health Education (SPHE) across schools. While many schools adapt the curriculum to address general needs, drug-related content is often omitted or not systematically incorporated" (14 p. 62). The findings of the *Report of the Citizens' Assembly on Drugs Use* support those of the evaluation. For example, the report summarises a statement from a representative of the Department of Health that "while SPHE is compulsory for primary and junior-cycle post-primary students, it is optional for senior cycle students, and only a minority of schools implement the programme at senior cycle level" (15 p. 61).

Third-level education

While there is some evidence of well-being or drug prevention activities in third-level education, these are not delivered universally to all third-level students or in all third-level institutions. The assessment of the national drugs strategy "highlighted the fragmented nature of prevention strategies in third-level institutions" (14 p. 90).

Other

While not specifically focused on drug prevention, national policies and programmes in the educational sector that aim to reduce the levels of early school leaving and promote general well-being in schools were also considered as part of the assessment; for example, Delivering Equality of Opportunity In Schools (DEIS) and its associated supports, Youthreach, and the Department of Education and Youth's Wellbeing Programme. While these activities were viewed favourably in the assessment process, they were not considered to be central to Ireland's drug prevention system.

B3. Prevention in workplace settings

UNODC criteria for assessment

Prevention of substance use is mandatory in workplace settings.

- Yes, fully: There exists a legislative or policy mandate to undertake substance use prevention in workplace settings. The mandate might guide the prevention activities to be in line with the evidence, and the implementation of the policy might be supported and monitored, resulting in most of the targeted population receiving prevention activities.
- Yes, almost fully: There exists a legislative or policy mandate to undertake substance use prevention in workplace settings. However, the mandate might not specifically guide organisations to implement evidence-based prevention activities, and the implementation of prevention activities might not be supported and monitored.
- ***Partially: There exists a legislative or policy mandate to undertake health promotion activities in workplace settings, including in the context of mental health, but prevention of substance use might play only a marginal role.***
- Only in a limited manner: There exists a legislative or policy mandate to undertake health promotion activities in workplace settings with no specific reference to substance use prevention.
- Not at all: There exists no legislative or policy mandate to undertake health promotion activities, including substance use prevention, in workplace settings.

Assessment decision: Partially.

Grounding for decision

Despite there being no legislative mandate in Ireland for drug prevention activities in workplace settings, an assessment of 'partially' was made. This is attributed to the Healthy Workplace Framework, which is a Government strategy to enhance the health and well-being of people working in Ireland (19). It aims to set the strategic direction for workplace policies and programmes to enhance the health of workers in Ireland. As part of its resource hub, it provides links to resources for employers on how to manage drug and alcohol misuse at work (https://healthyworkplace.ie/resource-hub/), which include those that look at developing a preventative culture in the workplace. While this framework and its resources exist, it is not known the extent to which it is applied in workplaces in Ireland.

Other legislation that addresses substance use in the workplace in Ireland is not focused on prevention per se. For example, under the Employment Equality Act, 1998, when an employee is experiencing dependence, the employer is required to provide 'reasonable accommodation' for them to access treatment (http://www.irishstatutebook.ie/eli/1998/act/21/enacted/en/html). Other legislation is focused on health and safety in the workplace; for example, the Safety, Health and Welfare at Work Act 2005.

B4. Motivational interviewing and brief interventions in the health and social care system

UNODC criteria for assessment

Motivational interviewing and brief interventions are mandatory or supported and used comprehensively in the health and social care system.

- Yes, fully: There exists a legislative or policy mandate to utilise brief interventions in healthcare, and possibly also in other service structures such as in social care, as and if appropriate. The implementation of the policy is typically supported and monitored, and standardised tools and training on how to use such interventions are available. The mandate covers alcohol, nicotine products, and illicit substances alike.
- Yes, almost fully: There exists a legislative or policy mandate to utilise brief interventions in healthcare and/or other settings. However, the implementation might not be supported and monitored comprehensively, or the mandate might not address all substances.
- ***Partially: There exists a legislative or policy mandate or a strong practice with available support to utilise brief interventions in healthcare or elsewhere. This might entail only alcohol or nicotine products or illicit substances.***
- Only in a limited manner: There exists a legislative or policy mandate or a strong practice on the provision of information on substance use and on related support services to patients and clients within the healthcare system or other service structures, but there are no mandates or tools available for implementing brief interventions.
- Not at all: There exists no legislative or policy mandate to utilise brief intervention types of prevention approaches for substance use within the healthcare system or related service structures.

Assessment decision: Partially.

Grounding for decision

Motivational interviewing and brief interventions were assessed to be 'partially' supported and used in Ireland's health and social care systems. While there is not a legislative or policy mandate for their use, there is strong practice. The two main delivery mechanisms are SAOR (Support, Ask and Assess, Offer Assistance and Refer) and Making Every Contact Count (MECC).

SAOR

The SAOR Screening and Brief Intervention for Alcohol and Substance Use has been a feature of the Irish prevention system since 2009. The acronym SAOR (which also means 'free' in Irish) is based on the four principle aspects of the intervention, which are: (1) Support, (2) Ask and assess, (3) Offer assistance, and (4) Refer (20). In 2017, the model was revised (SAOR II) to provide an evidence-based framework for screening and brief intervention for all problem substance use. SAOR training is available to any staff member in any service or group who has occasion to ask people about their drug and alcohol use in a diverse range of settings. It is applied in a broad range of health, social care, social, and recreational settings, and for all levels of need; for example, in community-based drugs services, child and family services, homeless agencies, family support services, employment support services, vocational training, criminal justice services, probation services, primary care services, third-level colleges, and sporting organisations. It supports workers from their first point of contact with a service user in order to enable them to deliver brief interventions and help those presenting with more complex needs to access treatment programmes (20). Data are only available on the numbers of those who undertake training, not on the extent to which the SAOR intervention is used. In 2025, 1,641 unique learners completed SAOR eLearning (Project Manager, HSE National Social Inclusion Office, personal communication, 22 January 2026).

MECC

MECC is a national health behaviour change programme developed by the HSE that was launched in 2017. The MECC programme works with healthcare professionals in order to ensure that they have the capability to deliver brief interventions and advice to all patients regarding the key risk factors for chronic disease, including healthy eating and physical activity; alcohol use; and smoking. As part of the training for MECC, there is an alcohol and drugs module, which is a 30-minute interactive module providing up-to-date alcohol and drug information to healthcare staff, as well as demonstrating examples of brief interventions in a variety of settings. Health and social care staff are encouraged to undertake the modules and to engage patients in a conversation and a possible brief intervention on whatever lifestyle issue is most important for that patient. Training includes eLearning and an Enhancing Your Skills workshop, which are available to all healthcare professionals in Ireland. As with SAOR, data are only available on the number of individuals who undertook training, not on the degree of application. In 2025, a total of 2,209 people completed MECC eLearning modules, with 1,148 completing the Enhancing Your Skills workshop (MECC Project Manager, HSE Health and Wellbeing, personal communication, 22 January 2026).

B5. Policies to control the availability, price, and marketing of legal substances

UNODC criteria for assessment

There exist policies to control the availability, price, and marketing of legal substances, namely alcohol and nicotine products.

- Yes, fully: There exists a legislative or policy mandate to control the availability, price, and marketing of legal substances, namely alcohol and nicotine products. The implementation of the policy is supported and monitored, resulting in most of the localities enforcing the policies.
- ***Yes, almost fully: There exists a legislative or policy mandate to control the availability, price, and marketing of legal substances, namely alcohol and nicotine products. The policies cover at least some alcohol and some nicotine products and some forms of control. However, the implementation might not be supported and monitored comprehensively.***
- Partially: There exist some legislative or policy mandates to control the availability, price, or marketing of legal substances, namely alcohol and nicotine products. However, the policies do not cover all alcohol and nicotine products and do not cover all the recommended control approaches, and the implementation is not supported and monitored.
- Only in a limited manner: There exist some legislative or policy mandates or other recommendations to control legal substances, but they are not implemented.
- Not at all: There exists no legislative or policy mandate to control the sale of legal substances.

Assessment decision: Yes, almost fully.

Grounding for decision

Ireland has extensive legislation controlling the sale and consumption of alcohol, tobacco, and nicotine products. It was assessed as 'almost fully' delivering on this element of the prevention system. The legislation considered for this assessment includes:

- Public Health (Alcohol) Act 2018:
  - https://www.irishstatutebook.ie/eli/2018/act/24/enacted/en/html
- Intoxicating Liquor Acts of 2000, 2003, and 2008:
  - https://www.irishstatutebook.ie/eli/2000/act/17/enacted/en/html
  - https://www.irishstatutebook.ie/eli/2003/act/31/enacted/en/html
  - https://www.irishstatutebook.ie/eli/2008/act/17/enacted/en/html

- Public Health (Tobacco Products and Nicotine Inhaling Products) Act 2023:
  - https://www.irishstatutebook.ie/eli/2023/act/35/enacted/
- S.I. No. 422/2017 - Public Health (Standardised Packaging of Tobacco) Regulations 2017:
  - https://www.irishstatutebook.ie/eli/2017/si/422/made/en/print
- Public Health (Tobacco) Acts of 2002, 2004, 2009, 2010, 2011, and 2013:
  - https://www.irishstatutebook.ie/eli/2002/act/6/enacted/en/html
  - https://www.irishstatutebook.ie/eli/2004/act/6/enacted/en/html
  - https://www.irishstatutebook.ie/eli/2009/act/23/enacted/en/html
  - https://www.irishstatutebook.ie/eli/2010/act/39/enacted/en/html
  - https://www.irishstatutebook.ie/eli/2011/act/15/enacted/en/html
  - https://www.irishstatutebook.ie/eli/2013/act/17/enacted/en/html

While these pieces of legislation tend to be implemented and monitored, there are gaps. For example, under Section 12 of the Public Health (Alcohol) Act 2018, it is stipulated that all alcohol products to be sold in Ireland would be required to display:

- a warning informing the public of the danger of alcohol consumption
- a warning outlining the danger of alcohol consumption when pregnant
- a warning informing the public of the direct link between alcohol and fatal cancers
- the quantity (in grams) of alcohol contained in the container concerned
- the calorie content in the container concerned
- details of a website, to be established and maintained by the HSE, providing public health information in relation to alcohol consumption.

This component of the Act has received extensive scrutiny at a national and European Union level. It has also faced extensive opposition from the alcohol industry. Despite being signed into law as part of the Act, it has yet to be implemented. In 2025, the Minister for Health continued to publicly commit to the law coming into operation in May 2026 as per the legislation (21). However, following lobbying from the alcohol industry, in September 2025 the Government postponed its implementation to 2028 (22).

C. Evidence-based planning and use of research

This element is based on Chapter III, Section C of the *International Standards on Drug Use Prevention*, 'A strong basis of research and scientific evidence' (6 p. 43).

C1. Epidemiological research on substance use

UNODC criteria for assessment

The system supports epidemiological research on substance use.

- ***Yes, fully: One or more school or other surveys with a representative sample of adolescents have been undertaken no more than 3 years ago, using established methodologies (such as the European School Survey Project on Alcohol and Other Drugs (ESPAD), Monitoring the Future, the Global school-based student health survey (GSHS), the Health Behaviour in School-aged Children (HBSC) study, the UNODC Global Assessment Programme on Drug Abuse (GAP), or similar). It provides data on the initiation and prevalence of all the major types of substances as well as on key vulnerability factors. In addition, some similar epidemiological data are available on adult populations and from certain risk groups. Ideally, the data would provide information on different modalities of use.***
- Yes, almost fully: One or more school surveys with a representative sample of adolescents have been undertaken no more than 3 years ago, using established methodologies (such as ESPAD, Monitoring the Future, GSHS, HBSC, the UNODC GAP, or similar). However, similar data on adult populations, certain risk groups, or vulnerability factors are not available, or these data are not as up to date (collected 3–5 years ago).
- Partially: One or more surveys on substance use, including on adolescents, have been undertaken within the last 3–5 years, but either the sample was not representative, the survey covered only a smaller part(s) of the geographical region, or there were flaws in the methodology and the survey did not cover all the substances in a meaningful manner.
- Only in a limited manner: Some epidemiological data are available, but they do not fulfil any of these criteria (being up to date, representative, methodologically reliable, covering all the substances of importance in the given geographical area, and covering different populations).
- Not at all: No up-to-date epidemiological data on substance use are available.

Assessment decision: Yes, fully.

Grounding for decision

Ireland has a strong history of gathering national and local epidemiological data, including over the last 3 years. It was therefore assessed to have a system that fully supports epidemiological research on substance use. The full cohort of studies that have been carried out can be accessed through the Health Research Board's National Drugs Library at https://www.drugsandalcohol.ie/prevalence-data/. The most recent outputs from the cohort of studies are:

- School-based and youth surveys:
  - ESPAD: *ESPAD Ireland 2024: results from the European School Survey Project on Alcohol and Other Drugs*
  - HBSC Study: *Trends in health behaviours, outcomes and contexts: 1998–2022. The Irish Health Behaviour in School-aged Children Study*
  - Growing Up in Ireland (GUI): *Growing Up in Ireland: Cohort '98 at age 25 main results*
  - Planet Youth Ireland (in a selection of locations); see, for example, *Planet Youth Tipperary: results of survey 2024* and *Growing up in the west: Planet Youth report 2025: Galway City*
- Adult surveys:
  - GUI: *Growing Up in Ireland: Cohort '98 at age 25 main results*
  - National Drug and Alcohol Survey (NDAS): *The 2019–20 Irish National Drug and Alcohol Survey: main findings*
  - Healthy Ireland survey: *Healthy Ireland survey 2025 - summary report*
- Other survey that may be of relevance:
  - European Web Survey on Drugs (EWSD) 2021: *European Web Survey on Drugs 2021: Irish Results*

C2. The system utilises the results of school-based surveys and other epidemiological studies

UNODC criteria for assessment

The system utilises the results of school-based surveys and other epidemiological studies.

- Yes, fully: Epidemiological data on substance use and on its root causes (the risk and protective factors) are regularly utilised in the planning of all major prevention initiatives or in the planning of national- or regional-level guidance for prevention. The data utilised come from the target groups of the planned interventions, programmes, and policies, which at times also require the availability of locally segregated data or data on specific sub-populations, such as high-risk groups or cultural minorities. The utilised data might come from national surveys as well as from community-level needs assessments.
- Yes, almost fully: Epidemiological data on substance use and on its root causes (the risk and protective factors) are often utilised in the planning of major prevention initiatives. Sometimes the data utilised come directly from the target groups of the planned approaches.
- ***Partially: Some epidemiological data on substance use are sometimes utilised in the planning of prevention initiatives. The data might not provide details of the specific target group in question, lacking information on the features of substance use in the specific population group, as well as on the key risk and protective factors of the targeted behaviour within the targeted group(s).***
- Only in a limited manner: Epidemiological data are rarely utilised in prevention planning, and typically representative data of the actual target groups would not be utilised.
- Not at all: No epidemiological data are utilised in prevention planning.

Assessment decision: Partially.

Grounding for decision

The focus of this element is the use of epidemiological data in planning prevention initiatives. In the Irish context, this was also understood to be in the development of the strategic approach to prevention that is adopted at a national level. While there are instances of epidemiological data being used for these purposes, it is far from a universal practice and was assessed as 'partially' supporting this element. At a national level, some epidemiological data were featured in the prevention strand of Ireland's national drugs strategy (2017–2025) as it stood at the time of the RePS survey (2), and in the associated action plans.

However, it is unclear to what extent it has been used to plan for prevention in a systematic way beyond the strategic documents. In the assessment of the national drugs strategy, an overall finding (not specific to prevention) was that not enough use is made of data collected, particularly in their use to inform planning and actions (14). While this finding is related mainly to meeting the needs of those accessing treatment, it is also related to the planning of prevention activities.

There are examples of epidemiological data being used to plan and select interventions at some local or regional levels. While some of the DATF coordinators who took part in the RePS survey as part of this review reported that they had not used research (including epidemiological data) to inform their prevention policy, planning, or practice in the last 3 years, others did report doing so. The epidemiological data used included national and local data (including those specifically focused on individuals aged under 18 years) and those shared by international organisations. Planet Youth Ireland was reported to be a valuable source of data for informing planning and practice in some regions and localities.

C3. Evaluation of prevention interventions

UNODC criteria for assessment

The system supports the evaluation of prevention interventions.

- Yes, fully: There exists a comprehensive and sufficient mechanism to support the evaluation of the effectiveness of prevention approaches, which might entail available research grants for academic institutions for prevention-related research, funding instruments that require evaluation of effectiveness, and similar.
- Yes, almost fully: There exist some mechanisms to support the evaluation of the effectiveness of prevention approaches, which means that some evaluation research on the effectiveness or efficacy of prevention approaches is available.
- Partially: There exist some mechanisms to support the evaluation of the effectiveness or efficacy of prevention interventions, but the availability of scientific evaluations of national or local prevention approaches is scarce. Some other outcome evaluations (such as efficacy or effectiveness studies on the impact of interventions on intermediate variables, rather than on substance use behaviours, in target groups comprising individuals aged over 10 years), feasibility studies, and process evaluations might be more widely available.
- ***Only in a limited manner: There are only limited opportunities to find support for evaluating the effectiveness of prevention interventions on substance use. Some outcome and process evaluations might be available.***
- Not at all: There is no support for monitoring and evaluating prevention approaches.

Assessment decision: Only in a limited manner.

Grounding for decision

Ireland does not have a culture of evaluating prevention interventions. Where such evaluations do happen, they are very limited and tend to be descriptive process evaluations of interventions rather than outcomes-based evaluations. The overall prevention system was assessed as supporting the evaluation of prevention interventions 'only in a limited manner'. The lack of national and local evaluations creates a situation where policy-makers and practitioners are dependent on international evidence to inform their planning and delivery activities. The following are examples of recent process evaluations of prevention activities in Ireland:

- Harris A, Niece E. *Evaluation of Parents Under Pressure Programme in the Community: A Coolmine-Led Initiative*. Dublin: Coolmine; 2025. Available from: https://www.drugsandalcohol.ie/43376/ (accessed 30 November 2025).
- O'Reilly L, Lawless M. *"Someone to talk to..." Learning to Practice: Implementation of Ballymun Infant Parent Support Project 2012-2022*. Dublin: Ballymun Youth Action Project; 2023. Available from: https://www.drugsandalcohol.ie/42770/ (accessed 30 November 2025).
- Carroll & Daly Consultants. *Evaluation of the Planet Youth Project in Galway, Mayo & Roscommon 2018 - 2022*. Galway: Western Region Drug and Alcohol Task Force; 2023. Available from: https://www.drugsandalcohol.ie/39178/ (accessed 30 November 2025).

This gap in local evaluative evidence is highlighted by both aspects of this RePS review. In the RePS intervention survey, there were very few interventions that had a formal, outcome-based evaluation. Almost all interventions that were deemed to be evidence based were reliant on evaluations that had been done in other contexts and countries. In the survey with DATF coordinators and the focus group with prevention workers that were carried out for this review, some DATF coordinators reported having used evidence on effective prevention approaches shared by international organisations and international research data published in scientific journals in order to inform their prevention policy, planning, or practice in the last 3 years. Prevention workers identified a lack of resources (funding, time, and skills) as a key barrier to carrying out evaluations locally, especially outcome evaluations. This creates a situation where practitioners and decision-makers are reliant on evidence that may not reflect the Irish delivery context. The evaluation of Ireland's national drugs strategy also calls for stronger evaluation mechanisms across the sector (14).

Prevention workers also reported that there is a scarcity of collaborative working relationships between academic institutions and practitioners in Ireland when compared with other countries. Some of those who had attended an international conference on prevention were struck by the research collaborations that had been established elsewhere. There was a perception that supporting the evaluation of prevention activities is not a priority for academia in Ireland.

Evaluation is a requirement of the five projects undertaken by the Department of Health's Prevention and Education Funding Programme, but the findings of these evaluations were not publicly available at the time of writing (Q1 2026).

C4. The system utilises the evaluation of prevention

UNODC criteria for assessment

The system utilises the evaluation of prevention.

- Yes, fully: Recommendations from national or local evaluation studies, especially on the effectiveness and efficacy of the prevention approaches, are taken into account in prevention planning. During the last 3 years, findings from evaluation studies have led to changes in prevention practice and the prevention system.
- Yes, almost fully: Recommendations from national or local evaluation studies, including effectiveness and efficacy studies, as well as feasibility studies and process evaluations, are taken into account in prevention planning. During the last 3 years, findings from evaluation studies have led to at least one change in prevention practice and the prevention system.
- Partially: Recommendations from other scientific publications, such as from international research publications or international or national guidance documents summarising evaluation research, are made available and have led to change(s) in prevention practice and the prevention system.
- ***Only in a limited manner: Evaluation research and similar information is made available and might be utilised to some extent in prevention planning, but it has not led to concrete changes in the planning and delivery of prevention at the level of analysis of this review.***
- Not at all: Evaluation research is not utilised in prevention planning.

Assessment decision: Only in a limited manner.

Grounding for decision

Ireland was assessed to have a system that utilises the evaluation of prevention approaches 'only in a limited manner'. As described in Section 6 C3, national and local evaluations of prevention interventions are rare in Ireland. While the survey with DATF coordinators and the focus group with prevention workers did find examples of international evaluations having been used to inform planning and practice, this does not happen at all levels or in all areas of the country. The use of evaluation evidence was perceived to depend on factors such as the prevention knowledge levels of individual practitioners and the level of priority given to prevention in a region or area. There was variation between different locations, and the findings suggest that the use of evaluation evidence could be considered ad hoc, at best. At the focus group with prevention workers, the use of international evaluation evidence to inform decisions and planning for interventions at a local level was described as happening on a case-by-case basis.

While not an evaluation, one outcome of the *Mid-Term Review of the national drugs strategy, Reducing Harm, Supporting Recovery and Strategic Priorities 2021-2025* (23) was the identification of six new strategic priorities for Ireland's national drugs strategy.

One of these new strategic priorities was to strengthen the prevention of drug and alcohol use and the associated harms among children and young people. This priority was accompanied by a set of actions for 2023–2024 (24). This led to the establishment of a set of Strategic Implementation Groups (SIGs), including one for the delivery of the prevention priority for the remainder of the strategy's lifetime. While not referring to the prevention SIG specifically, the SIG structure was found to be a positive element of the national drugs strategy's system in the evaluation of the strategy (14). This illustrates the potential value of evaluative activities and how they could be used to inform Ireland's strategic approach in this field.

D. Coordination among different sectors and levels

This element is based on Chapter III, Section D of the *International Standards on Drug Use Prevention*, 'Different sectors involved at different levels' (6 p. 45).

D1. There exists a mechanism of coordination across all sectors at national level

UNODC criteria for assessment

There exists a mechanism of coordination across all sectors at national level.

- Yes, fully: All relevant sectors take part in coordination in a purposeful manner. The cooperation is well-organised (i.e. there exists a solid mechanism for coordination, with a strong lead and coordinating agency and well-defined roles for all stakeholders, with a clear mandate and a written plan for the joint action, which is created based on actual needs and is monitored, and which supports the planning and implementation of evidence-based approaches across the sectors). There is good coherence between the prevention approaches implemented across the different sectors.
- Yes, almost fully: Most of the relevant sectors take part in coordination. The level of actual cooperation is often sufficient. The cooperation is organised and there is good coherence between the prevention approaches across the different sectors.
- ***Partially: Only a few sectors take part in coordination, and the level of actual cooperation might be somewhat poor and insufficiently organised for achieving coherent multisectoral prevention delivery.***
- Only in a limited manner: There are no coordination mechanisms and little actual coordination between the sectors at a national level.
- Not at all: The coordination of prevention is not officially mandated and does not take place.

Assessment decision: Partially.

Grounding for decision

Ireland's national drugs strategy for 2017–2025 describes a mechanism of coordination across sectors at the national level for delivery of the strategy, including the prevention elements (2). However, the implementation of this mechanism has faced challenges, which have been taken into consideration in making the assessment that it 'partially' delivers on the coordination of all sectors at the national level.

From 2017 through to the end of 2024, national-level strategic decisions relating to prevention were made through the national drugs strategy structure (see Figure 27). The SIG that had a focus on prevention was established midway through the lifetime of the strategy following a mid-term review (23). The lead agencies for developing and delivering prevention-related actions under the national drugs strategy, and which were reflected in the membership of the SIG, included the Department of Health with support from the HSE; the Department of Education and Youth; the Department of Children, Disability and Equality; An Garda Síochána; DATFs; and service providers, including non-governmental organisations. During the evaluation of the national drugs strategy, a general finding for the SIGs was that their introduction was perceived to have improved coordination in the implementation of the strategy, as well as engagement in the process among stakeholders. However, the assessment for the current criteria acknowledged that the prevention SIG had not met since Q2 of 2024.

Other findings from the national drugs strategy evaluation suggest that the strategy's delivery mechanisms for prevention had limitations. In their consultation with stakeholders, the evaluators found that it was perceived that "the lack of a clearly defined national agency and mandatory rollout framework has contributed to an inconsistent implementation of prevention efforts. Several stakeholders also noted that these efforts are often underfunded and, in some cases, lack strategic direction or alignment with current drug use trends" (14 p. 62). Furthermore, "prevention was widely viewed as under-resourced and lacking strategic focus" (14 p. 122). An overall finding of the evaluation identifies the challenges that this causes:

> The national drugs strategy (2017–2025) has yielded notable progress, particularly in advancing a health-led approach and enhancing coordination and stakeholder engagement. However, challenges remain in the areas of prevention, recovery, and governance. Our review has indicated that strengthening interdepartmental collaboration and establishing clearer governance mechanisms are critical considerations in the development and implementation of future drug strategies. (14 p. 117)

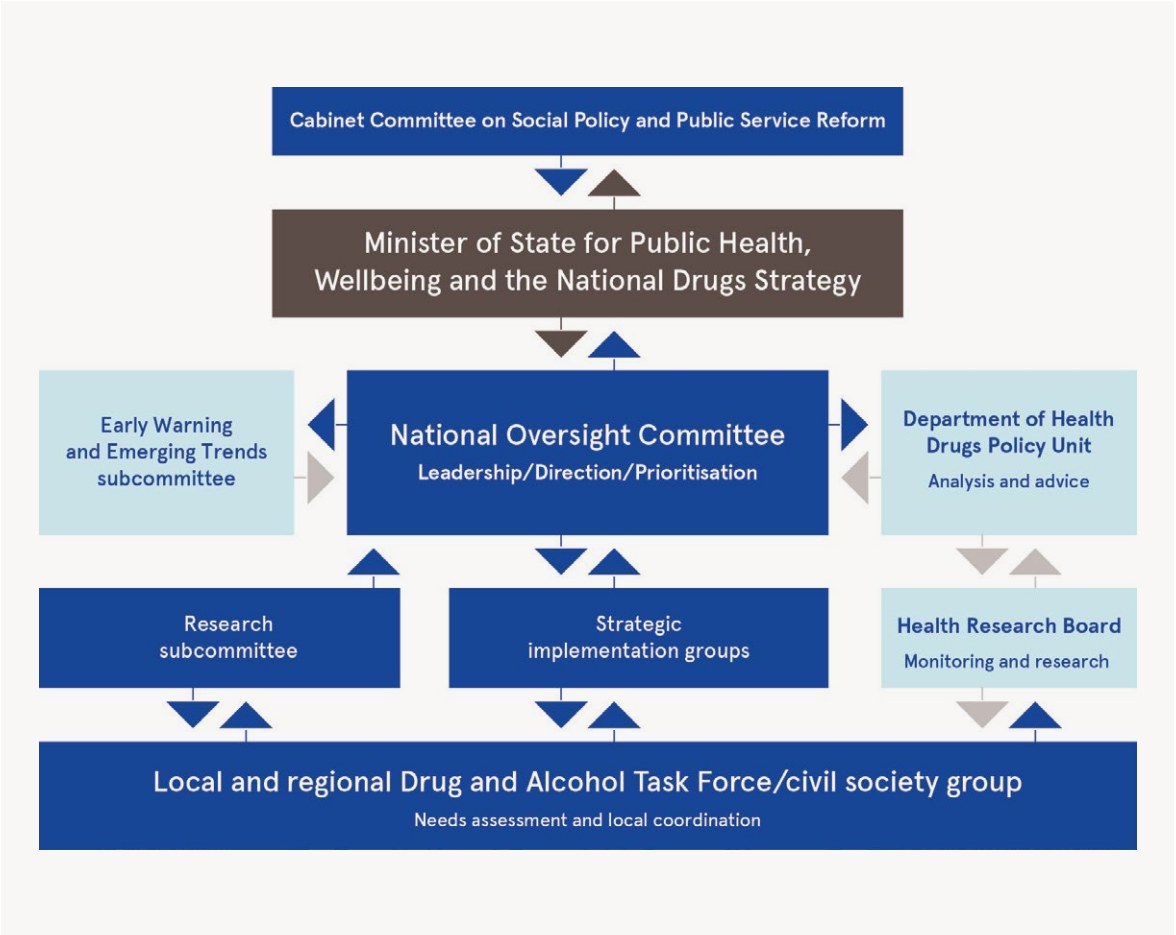

Figure 27: Coordination of bodies for the implementation of the national drugs strategy (2021–2025)

Source: Drugs Policy and Social Inclusion Unit, 2021 (23 p. 37)

Note to provide context for assessments against criteria D2 and D3

The language used in the next two assessments presented challenges when making assessments in the Irish context for criteria D2 and D3. The language used in the criteria suggests that there is a uniformity of structures across the geographical levels through which prevention is delivered, which is not the case in Ireland. The DATFs operate at regional and local levels. However, as the main delivery mechanisms for the national drugs strategy, they form the basis of the assessment under criteria D2 and D3. There is a lot of overlap in the grounding of the assessment decision for both criteria. For context, the following is a brief description of the DATF structure, which explains how it functions as a mechanism through which the coordination of sectors may happen:

- Strategic decisions are made at the local and regional levels by the DATFs, which identify local or regional needs, plan strategically to meet these needs, and coordinate the responses. They represent a partnership between the statutory, voluntary, and community sectors. While their structure may vary, the DATFs tend to be composed of representatives from a range of relevant agencies, such as the HSE, An Garda Síochána, the Probation Service, Education and Training Boards Ireland, local authorities, and local youth services, as well as elected public representatives and voluntary and community sector representatives.

- Some of Ireland's DATFs play a key role in the national drug prevention landscape, as their activities vary in the extent to which prevention features in the profile of their work. Based on their terms of reference, the role of DATFs is to focus on assessing the extent and nature of the drug and alcohol problem in their areas, and to coordinate action at the local level so that there is a targeted response to the drug problem in local communities (including any prevention response).
- Some DATFs have mechanisms that include relevant stakeholders from their communities (e.g. youth workers, individuals working in education, and gardaí) to support the planning and management of their prevention activities, whereas others do not have such mechanisms.

D2. There exists a mechanism of coordination across all sectors at regional level

UNODC criteria for assessment

There exists a mechanism of coordination across all sectors at regional level.

- Yes, fully: All relevant sectors take part in coordination in a purposeful manner. The cooperation is well-organised (i.e. there exists a solid mechanism for coordination, with a strong lead and coordinating agency and well-defined roles for all stakeholders, with a clear mandate and a written plan for the joint action, which is created based on actual needs and is monitored, and which supports the planning and implementation of evidence-based approaches across the sectors). There is good coherence between the prevention approaches implemented across the different sectors.
- Yes, almost fully: Most of the relevant sectors take part in coordination. The level of actual cooperation is often sufficient. The cooperation is organised and there is good coherence between the prevention approaches across the different sectors.
- ***Partially: Only a few sectors take part in coordination, and the level of actual cooperation might be somewhat poor and insufficiently organised for achieving coherent multisectoral prevention delivery.***
- Only in a limited manner: There are no coordination mechanisms and little actual coordination between the sectors at a regional level.
- Not at all: The coordination of prevention is not officially mandated and does not take place.

Assessment decision: Partially.

Grounding for decision

This was a challenging assessment to make due to the variations at the regional level. Given the language used under the criterion outlined above, the assessment made was 'partially', although it was argued by some stakeholders that 'only in a limited manner' would be a better reflection of the regional prevention situation in Ireland. The DATFs were considered to be valuable mechanisms for supporting collaboration, but this does not necessarily happen in relation to prevention activities.

The evaluation of the national drugs strategy examined the interagency work of DATFs. When referring to DATF work overall (rather than prevention work specifically), it was determined that civil society organisations and the DATFs play a key role in implementing the national strategy at a community level. They were described as well-positioned to respond to local needs and priorities. Interagency collaboration was reported to have strengthened over the course of the strategy (14).

However, prevention is a part of the strategic approach of only some DATFs at a regional level. Where such a strategic approach does exist, it includes some DATFs that have additional structures in place that relate to drug prevention (e.g. Planet Youth Ireland and Communities That Care). The RePS survey identified examples of these mechanisms functioning and enabling coordination between sectors in DATFs, although it was far from a universal experience, and the findings must be considered in the context of a 50% response rate from DATFs.

D3. There exists a mechanism of coordination across all sectors at local level

UNODC criteria for assessment

There exists a mechanism of coordination across all sectors at local level.

- Yes, fully: All relevant sectors take part in coordination in a purposeful manner. The cooperation is well-organised (i.e. there exists a solid mechanism for coordination, with a strong lead and coordinating agency and well-defined roles for all stakeholders, with a clear mandate and a written plan for the joint action, which is created based on actual needs and is monitored, and which supports the planning and implementation of evidence-based approaches across the sectors). There is good coherence between the prevention approaches implemented across the different sectors.
- Yes, almost fully: Most of the relevant sectors take part in coordination. The level of actual cooperation is often sufficient. The cooperation is organised and there is good coherence between the prevention approaches across the different sectors.
- ***Partially: Only a few sectors take part in coordination, and the level of actual cooperation might be somewhat poor and insufficiently organised for achieving coherent multisectoral prevention delivery.***
- Only in a limited manner: There are no coordination mechanisms and little actual coordination between the sectors at a local level.
- Not at all: The coordination of prevention is not officially mandated and does not take place.

Assessment decision: Partially.

Grounding for decision

The explanation provided under criterion D2 is also the basis for the assessment of coordination at the local level. Similarly, while there are some localities where there is very good coordination across relevant sectors for the purpose of prevention, this does not exist in others. There is some evidence that the DATF structure is particularly suited to supporting a collaborative approach at the local level. Speaking of the work of DATFs more broadly, rather than just in relation to prevention, the evaluation of the national drugs strategy found that:

> Stakeholders also referenced community and service engagement in relation to the work of DATFs. Participation at the local level was regarded as contributing to the continuity of implementation efforts, particularly in addressing community-specific needs. In some instances, it was suggested that this local engagement enabled a more contextually grounded approach to service delivery and policy application. (14 p. 58)

D4. Policy coherence across different levels

UNODC criteria for assessment

There exists policy coherence across different levels.

- Yes, fully: Policies across all relevant sectors and levels are consistently aligned, with clear mechanisms ensuring coordination and no significant gaps or contradictions.
- Yes, almost fully: Policies are largely coherent and coordinated, with only minor inconsistencies or gaps that do not significantly affect overall alignment.
- ***Partially: Some sectors or levels show alignment, but there are noticeable gaps or inconsistencies that limit effective coordination.***
- Only in a limited manner: Policy coherence exists in isolated areas or for specific issues, but overall coordination is weak and/or fragmented.
- Not at all: There is no meaningful alignment or coordination of policies across sectors or levels; approaches are disconnected.

Assessment decision: Partially.

Grounding for decision

When looking across sectors at a national level, there is some alignment between the prevention elements of Ireland's national drugs strategy and other relevant policy documents such as *Young Ireland: National Policy Framework for Children and Young People 2023-2028* (25) and the *Youth Justice Strategy 2021 - 2027* (26). At the local and regional levels, while only some DATFs have a strategy for prevention, these should still be in alignment with the national drugs strategy, as per the DATFs' terms of reference.

E. Strong delivery system

This element is based on Chapter III, Section E of the *International Standards on Drug Use Prevention*, 'Strong infrastructure of the delivery system' (6 p. 46). The assessments are focused on the situation in the professional fields where most of the prevention activities are delivered.

E1. The individuals who deliver prevention activities have specialised training and technical support that meets their needs

UNODC criteria for assessment

The individuals who deliver prevention activities have specialised training and technical support that meets their needs.

- Yes, fully: Almost all professionals who deliver prevention activities have specialised training on prevention, and their education provides them with the necessary prevention-specific competencies. In addition, they would typically receive other technical support (such as on-the-job training on prevention on an ongoing basis, materials such as manualised programmes, and other tools and technical guidance).
- Yes, almost fully: Most of the professionals who deliver prevention activities have some specialised training in prevention, or they have appropriate educational backgrounds providing competencies for prevention practice. In addition, they would typically receive other technical support.
- ***Partially: Some of the professionals who deliver prevention activities have some training on prevention, and otherwise have an appropriate educational background providing some competencies for prevention practice.***
- Only in a limited manner: Only a few prevention practitioners have prevention-specific training or an educational background that would provide prevention-specific competencies, and in general there is not much support available for their prevention practice.
- Not at all: The professionals who deliver prevention activities typically do not have any prevention-related training or a relevant educational background, and they receive no or only very limited other support.

Assessment decision: Partially.

Grounding for decision

Based on guidance from the UNODC, this assessment focuses on the professionals who deliver most prevention activities: drug prevention workers (especially those linked to DATFs), teachers delivering Social, Personal and Health Education (SPHE), and, to a limited degree, youth workers. However, it is recognised that there are other practitioners in Ireland who may be involved in drug prevention as part of their work. While there is some drug prevention training available for practitioners in Ireland, it is not delivered in a systematic way, and therefore an assessment of 'partially' was made. Prevention training in Ireland includes the Putting the Pieces Together programme, the European Prevention Curriculum (EUPC) (although practitioners are not the target audience for this course), and training associated with specific prevention programmes. The Health Research Board (HRB) maintains a directory of courses and training programmes on drug misuse in Ireland, which includes training in the area of prevention. The course directory can be found at: https://www.drugsandalcohol.ie/php/uploads/courses.pdf.

Drug prevention workers: The findings from the focus group with drug prevention workers and the RePS intervention survey illustrate the diversity within this cohort in terms of their professional backgrounds and training profiles. The group included drug prevention workers based in DATFs, the HSE, and Foróige. Their professional and educational backgrounds included youth work, community work, education (including school teaching), social care, psychology, sociology, and health promotion. They varied from those who had decades of experience working with young people or more broadly in the area of drug use, to those just starting out in drug prevention work. Their related qualifications included certificates and diplomas in addiction studies. In the discussion on training there was general consensus on the following points:

- People came into the prevention practitioner role from a variety of disciplines with different levels of qualifications.
- There is no baseline or minimum requirement to get the role. It depends on the requirements of individual organisations.
- Once in the role, practitioners upskilled in drug prevention, drawing on different opportunities to develop their skills. The upskilling was largely self-sourced, with no training or professional development plans being designed at an organisational level.
- Factors that influenced practitioners' access to training included: access to information about the training available; access to funding to undertake training; practitioners' relationship with their line manager; the attitude of their line manager to prevention; the attitude of senior managers to prevention; practitioners' ability to advocate on their own behalf to managers in order to be given the resources (time and money) to attend training; and time available to undertake training.
- In the absence of formal prevention training, practitioners described learning as coming from communities of practice and peers.
- Among the sources of prevention training mentioned were the EUPC, attendance at the European Society for Prevention Research conference, the Putting the Pieces Together programme, and training undertaken as part of developing skills in a manualised programme.

- The EUPC training had been accessed by some respondents. Views on its value for practitioners varied. Overall, it was not thought to have the right focus for practitioners; for example, it focuses on the allocation of funding, but practitioners were rarely involved in funding decisions.

SPHE teachers: As explained in Section 6 B2, SPHE is the universal prevention intervention through which drug prevention is delivered in Irish schools. Beyond having a teaching degree, a teacher is not required to undertake specialised training in order to deliver SPHE in school. While specialised training is available to teachers, data are not collected systematically on the teachers who have undertaken the training provided by Oide (supported by the Department of Education and Youth). The Department of Education and Youth acknowledged the need for more training and support for teachers of SPHE in its contribution to the *Report of the Citizens' Assembly on Drugs Use* (15 p. 150).

Youth workers more broadly: The Putting the Pieces Together training programme takes a cascading approach to upskilling those working with young people outside the formal education setting. For example, Foróige has its own team of trainers in Putting the Pieces Together.

E2. Individuals who decide on and manage prevention interventions have specialised training that meets their needs

UNODC criteria for assessment

Individuals who decide on and manage prevention interventions have specialised training that meets their needs.

- Yes, fully: The professionals who decide on and manage prevention activities have comprehensive training on prevention, and they have appropriate academic educational backgrounds.
- Yes, almost fully: Most of the professionals who decide on and manage prevention activities have some specialised training on prevention. In addition, their educational background typically provides good competencies for prevention planning.
- ***Partially: Some of the professionals who decide on and manage prevention activities have some training in prevention, and their educational background typically provides some competencies specific to prevention planning.***
- Only in a limited manner: Only a few of the professionals who decide on and manage prevention activities have prevention-specific training or educational backgrounds that would provide prevention-specific competencies.
- Not at all: The professionals who decide on and manage prevention activities do not have any prevention-related training or education.

Assessment decision: Partially.

Grounding for decision

Based on guidance from the UNODC, this assessment focuses on the professionals who are responsible for most of the prevention planning decisions and management: those with responsibility for planning and managing drug prevention at a policy-making level (Government Departments and organisations) and coordinators of the DATFs. For this section, they will collectively be referred to as decision, opinion, and policy-makers (DOPs). An audit of the skills of those working at this level was not carried out as part of this review. Evidence is not available on the educational backgrounds of DOPs or the extent to which they have prevention expertise or have accessed training in the field of prevention. Therefore, this assessment is based on input from the RePS Research Advisory Group, and an assessment of 'partially' was made.

There is no requirement for DOPs involved in drug prevention planning and decision-making to have undergone prevention training. Anecdotal evidence would suggest that like prevention practitioners, DOPs come from a variety of training and educational backgrounds, and that learning in relation to drug prevention is done on the job. A key training tool for DOPs is the EUPC. The Department of Health in Ireland actively supports staff in the Drugs Policy and Social Inclusion Unit to take part in and deliver the EUPC training courses. The EUPC was first delivered by Department of Health staff in Ireland in May 2024. As of October 2025, it had been delivered 4 times to a total of 48 people. Some of the people trained have progressed to the online PLATO training and may become EUPC trainers themselves. The 48 who have received training included: DATF staff (13 DATF staff and 1 coordinator); youth work managers; staff of the HSE; academics involved in prevention; the Garda National Drugs and Organised Crime Bureau; and staff from the Irish Community Action on Alcohol Network. Combined with the findings of the Drug and Alcohol Education Workers Forum focus group, this would suggest that the EUPC is being delivered beyond its target group of DOPs.

F. Sustainability

This element is based on Chapter III, Section F of the *International Standards on Drug Use Prevention*, 'Sustainability' (6 p. 47).

F1. There exists a substance use prevention policy for the medium term (3–5 years)

UNODC criteria for assessment

There exists a substance use prevention policy for the medium term (3–5 years).

- Yes, fully: There exists a written substance use prevention policy that covers all substances; supports the delivery of evidence-based prevention approaches; includes measurable substance use prevention goals and indicators for them; has a clear time frame; and is regularly monitored and reviewed and adjusted accordingly.
- ***Yes, almost fully: There exists a written substance use prevention policy that covers the most relevant psychoactive substances and supports the delivery of at least some prevention approaches in line with the evidence.***
- Partially: Substance use prevention is covered by a wider policy (such as public health, safety, etc.). The written policy covers some of the most relevant psychoactive substances and includes some substance use prevention goals. However, the time frame might be unclear, the prevention goals might not have specific indicators, or they might not be regularly reviewed in order to adjust the policy.
- Only in a limited manner: There exists a policy with some substance use prevention goals, but the policy might focus on other health issues and leave substance use prevention in a marginal role, it might be for a shorter time frame or not reviewed and adjusted, or it might not be officially agreed on among all relevant stakeholders and thus not written.
- Not at all: There exist no substance use prevention policies for the medium or longer term.

Assessment decision: Yes, almost fully.

Grounding for decision

Ireland's national drugs strategy is in a state of transition, with a new strategy under development at the time of gathering data for this review (Q4 2025). Ireland's most recent national drugs strategy, titled *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025*, is structured around five goals (2). Goal 1 focuses on prevention: To promote and protect health and well-being. Through this, the strategy "aims to protect the public from threats to health and well-being related to substance misuse by preventing early use of alcohol and other drugs among young people, influencing behaviour and challenging social norms and attitudes and providing targeted interventions aimed at minimising harm for those who have already started to use substances" (2 p. 17). The agencies identified as leads or partners for the delivery of specific actions under this goal are: the Department of Health; the HSE; the Department of Education and Youth; the Department of Children, Disability and Equality (previously the Department of Children, Equality, Disability, Integration and Youth and, before that, the Department of Children and Youth Affairs); Child and Adolescent Mental Health Services; Tusla – Child and Family Agency; DATFs; and the HRB.

Assessments would suggest that while prevention is covered in the written strategy, in practice it has not been regularly monitored, reviewed, and adjusted. In the *Report of the Citizens' Assembly on Drugs Use*, a representative of the Department of Health's Drugs Policy and Social Inclusion Unit described the actions on prevention in the strategy for 2017–2021 as "high level and vague, which has led to them not being implemented" (15 p. 147). Improvements were made through the development of a prevention SIG following a mid-term review of the strategy (23). However, this group has not met since Q2 2024. In the evaluation of the national drugs strategy, it was found that prevention was widely viewed as under-resourced and lacking strategic focus (14).

F2. The policy includes a funding structure for its delivery

UNODC criteria for assessment

The policy includes a funding structure for its delivery.

- Yes, fully: The prevention policy/plan is fully funded, with the funding typically being linked to the monitoring of the successful implementation of the policy. In general, prevention funding is predictable, allowing for long-term planning.
- Yes, almost fully: The prevention policy/plan is sufficiently funded. Some of the prevention funding is awarded on a long-term basis and is predictable.
- ***Partially: The prevention policy/plan is only partially funded, and only a minor part of the funding is partially predictable.***
- Only in a limited manner: The funding is not predictable, but there might be some funding available for activities in line with the policy/plan.
- Not at all: No funding is available.

Assessment decision: Partially.

Grounding for decision

This criterion was interpreted in the Irish context as being about whether there is a suitable and functioning funding system that allows for long-term planning and ring-fenced funding for prevention activities. The Irish funding system for prevention was assessed as 'partially' delivering on this element.

The Minister for Health has overall responsibility for Ireland's national drugs strategy, while a range of Government Departments and State agencies, as well as the community and voluntary sector, have responsibility for delivering on its actions. There is no centrally held or ring-fenced budget allocated to the national drugs strategy, including its prevention elements. Instead, delivery of the strategy is funded by each Government Department securing the budget for the activities it is responsible for and has committed to delivering. Government Departments negotiate their budgets as part of Ireland's annual national budgetary process. Allocations will be included for maintaining existing services/activities, as well as changes to resources or requests for additional resources. Therefore, under the current structures, drug prevention does not have ring-fenced funding. In addition, funding allocations tend to be made on an annual basis (e.g. DATF funding), which does not allow for long-term planning. However, some prevention work that is linked directly to a Government Department has received investment over the long term. For example, SPHE, Delivering Equality of Opportunity In Schools (DEIS), and related national programmes are a core part of the Department of Education and Youth's work.

In the *Report of the Citizens' Assembly on Drugs Use*, a representative of the Department of Health's Drugs Policy and Social Inclusion Unit said of funding for prevention that "the funding streams are disparate" (15 p. 147). Among the suggestions from the stakeholder consultations for the evaluation of the national drugs strategy was the need for a dedicated funding stream for drug prevention (27 p. 18).

F3. The system ensures that prevention is implemented in an ethical manner

UNODC criteria for assessment

The system ensures that prevention is implemented in an ethical manner.

- Yes, fully: Ethics are explicitly discussed in prevention planning. The substance use prevention system is embedded in a health-centred drug policy, linked to public health policy, and based on an understanding of substance use disorders as a chronic health condition. The entire system is geared towards ensuring real benefits for the final recipients of the prevention policies, programmes, and interventions. This entails, among other things, that prevention planning considers the possibility of causing unintended side effects and seeks to actively prevent them; that the planning is based on a good understanding of the target population and their realities and reasons for using substances; and that the planning also considers high-risk and marginalised groups. Where applicable, participants' rights and autonomy are protected by ensuring voluntary and consented participation, as well as the acceptability of the planned activities within the target groups. The prevention system contributes to dispelling stigma. Prevention activities are not funded by the alcohol, tobacco, or other similar industries.
- Yes, almost fully: Ethics are sometimes discussed in prevention planning. The substance use prevention system is embedded in a health-centred drug policy, linked to public health policy, and based on an understanding of substance use disorders as a chronic health condition. The system is mostly geared towards ensuring real benefits for the final recipients of the prevention policies, programmes, and interventions. Most of these criteria are met: prevention planning considers the possibility of causing unintended side effects and seeks to actively prevent them; the planning is based on a good understanding of the target population and their realities and reasons for using substances; and high-risk and marginalised groups are considered in prevention planning. Where applicable, participants' rights and autonomy are protected by ensuring voluntary and consented participation, as well as the acceptability of the planned activities within the target groups. The prevention system contributes to dispelling stigma. Prevention activities are not funded by the alcohol, tobacco, or other similar industries.

- ***Partially: The system is partly geared towards ensuring real benefits for the final recipients of the prevention policies, programmes, and interventions. Some of these criteria are met: prevention planning considers the possibility of causing unintended side effects and seeks to actively prevent them; the planning is based on a good understanding of the target population and their realities and reasons for using substances; and high-risk and marginalised groups are considered in prevention planning. Where applicable, participants' rights and autonomy are protected by ensuring voluntary and consented participation, as well as the acceptability of the planned activities within the target groups. The prevention system contributes to dispelling stigma. Prevention activities are not funded by the alcohol, tobacco, or other similar industries.***
- Only in a limited manner: In some parts of the system, the focus is on ensuring real benefits for the final recipients of the prevention policies, programmes, and interventions. Few of these criteria are met: prevention planning considers the possibility of causing unintended side effects and seeks to actively prevent them; the planning is based on a good understanding of the target population and their realities and reasons for using substances; and high-risk and marginalised groups are considered in the prevention planning. Where applicable, participants' rights and autonomy are protected by ensuring voluntary and consented participation, as well as the acceptability of the planned activities within the target groups.
- Not at all: Ethics are not considered in prevention planning.

Assessment decision: Partially.

Grounding for decision

This is a difficult assessment to make, as there is no central prevention strategy that outlines the specific criteria as laid out in the assessment description above. At a system level, there is no consistent approach taken to ethics in the field of prevention. Therefore, an assessment of 'partially' was made. However, there are features of the Irish national drugs strategy – which includes prevention – that indicate an ethical and human rights-based approach to people who use drugs and the related issues. These include that it takes a health-led approach to drugs use; is underpinned by the values of compassion, respect, equity, inclusion, and partnership; is evidence informed; and incorporates human rights in some elements (for example, introducing medically supervised injecting facilities and exploring alternative approaches to criminal prosecution for the possession of small quantities of drugs).

It is recognised by Government Departments that the alcohol industry should not be involved in delivering prevention interventions in schools. Following pressure from the Department of Education and Youth, as well as public health advocates, in March 2023, the alcohol industry body Drinkaware ceased roll-out of its Junior Cycle alcohol education programme in schools. However, Drinkaware continues to work with parents.

Summary

Table 5 summarises the assessment decisions made on the Irish prevention system, based on the criteria laid out by the UNODC.

Table 5: Summary of Irish prevention system assessment decisions

UNODC/RePS criteria	Fully	Almost fully	Partially	Limited	Not at all
A. A range of interventions and policies based on evidence					
A1. The system implements evidence-based approaches targeting and reaching all ages.			X		
A2. The system implements evidence-based interventions targeting and reaching individuals and populations at all levels of risk.			X		
A3. The system implements evidence-based interventions targeting a range of settings.				X	
A4. The system includes approaches targeting risk and protective factors at the level of individuals, at the level of communities, and at the societal level.		X			
B. Supportive policy and regulatory frameworks					
B1. Funding of prevention interventions is conditional on prevention being evidence based.				X	
B2. Prevention of substance use is mandatory in educational settings.			X		
B3. Prevention of substance use is mandatory in workplace settings.			X		
B4. Motivational interviewing and brief interventions are mandatory or supported and used comprehensively in the health and social care system.			X		
B5. There exist policies to control the availability, price, and marketing of legal substances, namely alcohol and nicotine products.		X			

UNODC/RePS criteria	Fully	Almost fully	Partially	Limited	Not at all
C. Evidence-based planning and use of research					
C1. The system supports epidemiological research on substance use.	X				
C2. The system utilises the results of school-based surveys and other epidemiological studies.			X		
C3. The system supports the evaluation of prevention interventions.				X	
C4. The system utilises the evaluation of prevention.				X	
D. Coordination among different sectors and levels					
D1. There exists a mechanism of coordination across all sectors at national level.			X		
D2. There exists a mechanism of coordination across all sectors at regional level.			X		
D3. There exists a mechanism of coordination across all sectors at local level.			X		
D4. There exists policy coherence across different levels.			X		
E. Strong delivery system					
E1. The individuals who deliver prevention activities have specialised training and technical support that meets their needs.			X		
E2. Individuals who decide on and manage prevention interventions have specialised training that meets their needs.			X		
F. Sustainability					
F1. There exists a substance use prevention policy for the medium term (3–5 years).		X			
F2. The policy includes a funding structure for its delivery.			X		
F3. The system ensures that prevention is implemented in an ethical manner.			X		

07

Conclusion

While the overall quality of prevention interventions in Ireland is good and there are some strengths at a system level, there are clear areas for improvement. Although some areas of prevention in Ireland appear to be high-quality, evidence-based practice (e.g. evidence-based, manualised interventions in secondary school settings), 43% are weakly evidence-informed and 13% not evidence-based, and local evaluation is practically absent. Still, many of the conclusions of this report have relevance at both the intervention and system levels. For the purpose of clarity, the conclusions are presented in two sections below: intervention level, and system level.

A. Intervention level

Local delivery

In terms of the larger ecology of prevention work in Ireland, intervention is very much a local enterprise with local agencies – often DATFs either developing and delivering interventions themselves or working with other local community groups to do so. There is nothing wrong with this, except that it makes the overall landscape of prevention quite idiosyncratic. In some areas and for some groups, prevention is very prevalent and multifaceted, but this is not the case in others. It may be that the different entities focus their resources on different aspects of substance use. For example, some areas in Ireland simply have a longer history of drug use and its associated problems, and hence have developed strategies that are tailored to the circumstances and priorities they face. This may lead to a greater focus on harm reduction and treatment than on prevention. But this does not erase the need for broad-based prevention as the front line in social responses to problematic substance use.

Research and evaluation

Two related findings frame the understanding of issues related to research and evaluation. First, the majority – 68% – of RePS prevention interventions are reported as being supported by empirical work, yet only 15% of interventions included any evidence of said support, even though respondents were directly asked to provide such documentation. In one respect, this is not surprising. It is methodologically challenging to expect people responding to a survey to simultaneously locate and submit documentation that they likely would not have at their fingertips. Yet, it also highlights a more substantive problem. Practitioners, coordinators, and project leads are not researchers, and have a different role and skill set from those who produce research on the efficacy of evaluations. It is very likely that those delivering interventions simply assume that research supports their approach rather than having direct knowledge that it does. As the RePS assessment shows, 43% of interventions are weakly evidence informed, which implies that research does not fully support the existing prevention practices in Ireland.

Second, and related, very few prevention interventions in Ireland are based on practices that have been subject to outcome evaluations, and almost no interventions have been evaluated locally. Yet, the responsibility for ensuring the quality and evaluation of interventions is also largely localised. This is very problematic. There does not appear to be either a culture of or infrastructure for outcome evaluation in Ireland. The findings of the system assessment illustrate that while Ireland has an extensive body of high-quality epidemiological evidence on drug use, its prevention evaluation landscape is sparse. Across the spectrum of interventions included in this review, very few reported that local evaluations had been done, and those that did report local evaluations undertook process rather than outcome evaluations. Moreover, evaluation methodologies typically involved small convenience samples, using one-off qualitative interviews that assessed how people felt about the intervention or their experience with it.

Although there were a handful of interventions that had undergone outcome evaluations, these interventions were evaluated in other contexts and countries. As the factors determining outcomes vary according to the environment, local evaluation is essential to find out what's working in a particular context. Importantly, this would involve a cultural change in which intervention providers see evaluation as a key component of their work. At the same time, there would need to be significant investments in infrastructure for evaluation. One element in this is funding. There currently is not a clear mechanism or block of funding to support evaluations of prevention interventions in Ireland. This should be developed. A second element is the lack of expertise in programme evaluation. There currently is not a routine mechanism or block of funding to support evaluations of prevention interventions in Ireland. While the Department of Health's Prevention and Education Fund, established in 2022, included funding for the evaluation of five prevention projects, there is a need to develop funding for evaluation on a more routine basis. Evaluation research is its own branch of the social sciences and is not a typical part of either undergraduate or postgraduate curriculums outside of, perhaps, economics or social studies and sociology. On the quantitative side, expertise is needed in longitudinal designs, difference-in-difference estimation, regression discontinuity, instrumental variable analysis, randomised controlled trials, and synthetic cohort approaches, to name a few. Expertise also needs to be developed in carrying out evaluations using rigorous and systematic qualitative research and analysis. Qualitative research is an essential element of a comprehensive evaluation landscape. It is critical that Government Departments invested in prevention support the development of evaluation expertise either through the development of postgraduate certificates, diplomas, or degrees, or by offering in-house workshops on outcome evaluation.

Geographic and demographic variation

Although geographic and demographic coverage was generally good, there are still gaps. In terms of geography, the majority of interventions were located in Dublin and the surrounding areas. This is not surprising given this area's population density and its history of drug-related issues. At the same time, it was surprising how few prevention interventions were identified in other cities in Ireland. It is possible that this reflects a sampling problem in that active interventions simply were not submitted to the RePS survey. Yet, even if this is the case, it would still indicate that prevention interventions in other urban areas in Ireland are largely disconnected – both socially and organisationally – from the agencies that are largely responsible for responding to substance use issues in these areas (e.g. State funding bodies, Government Departments, DATFs, city and county councils, and other community organisations). Ensuring the presence of effective prevention activities in all urban areas in Ireland is critical.

In addition to geographic variation, there is significant variation in target age groups for prevention. Like most countries, the majority of prevention in Ireland focuses on the adolescent years, when problematic behaviour in general both begins and peaks (28). Yet, problematic substance use tends to violate the basic age–crime curve by often continuing deep into the life course (29). Most forms of deviance (e.g. violence, robbery, or theft) decline much more sharply over the adult years (i.e. after the age of 25 years) compared with substance use. The latter presents a challenge for prevention systems because it highlights the importance of interventions across the adult years. Yet the RePS survey identified few interventions that targeted those in middle and later adulthood. Interventions that specifically mentioned adults as one of the reference age groups often also targeted early and older adolescent groups.

This suggests that the real focus is 'emerging adulthood' rather than midlife or later (30). The earlier RePS pilot in Norway even included interventions focused on seniors, yet no interventions in the Ireland RePS survey submissions focused on this age group. Collectively, this suggests that few interventions target middle-aged or older adults. Whether this is critical or not is unclear. Almost all evidence points to the earlier part of the life course as the period in which substance use is initiated and problematic substance use develops. By older adulthood, it may be more important to develop harm reduction and treatment interventions rather than prevention.

At the other end of the age spectrum, there was also a limited number of interventions that targeted pregnant women, early childhood, and middle childhood. Developmental science has long recognised both the importance of in-utero exposures (31, 32) and early life as a critical period (33) for successful development deep into the life course. At the extremes, excessive substance use by women during pregnancy can have a negative effect on the child's both physical and psychological development (34). But equally important is the role that substance use during pregnancy can play in increasing health risks for women (35). Similarly, substance use issues among parents can negatively impact on young children, undermining the parent–child relationship (36, 37), negatively affecting children's psychosocial development (38) and increasing the risk of substance use among children moving forward (39). Expanding prevention interventions' target age ranges to include pregnant women and those in early childhood is a critical need for prevention interventions in Ireland over the coming decades.

Clarifying the language of risk

There are also issues and gaps with respect to the type and level of risk. The critical issue is variation in both the definitions and recognition of different types of risk. Put simply, a review of the RePS submissions identified wide discrepancies in the understanding of what constituted universal, selective, or indicated risk and prevention. In some submissions, the designation of risk was inconsistent with the definitions used in epidemiological work. Yet, rather than this being an error or misunderstanding, the designation offered reflected a particular perception of the group being targeted by the intervention. For example, epidemiological work would view adolescents in general as having universal risk, but some practitioners viewed adolescents as being uniquely exposed to substance use problems, with well-regarded theory and research organised around social modelling, social influence, and peer pressure. Consequently, they defined their interventions as being selective in focus. Similarly, some interventions, particularly those located in communities with a history of drug use and its harms, viewed all community members as having elevated risk, and again designated their work as being selective in focus.

A parallel set of problems exists for indicated risk, with a noted lack of distinction between prevention interventions and treatment or harm reduction interventions. The triage procedure guiding the RePS evaluation deliberately excluded harm reduction and treatment interventions, but in some instances, there either was not enough information provided to draw definitive conclusions, or the intervention was part of a multifaceted initiative that made separation of the activities challenging. Ultimately, our understanding of the coherence of different prevention interventions was undermined by unclear definitions.

The significance of this for evaluation of the overall system is equally critical. On the one hand, the problem could be viewed as largely semantic and not particularly important. Prevention organisations typically have multiple options for interventions and likely implement the interventions that they deem most appropriate for the community being targeted. Whether they view this as universal, selective, or indicated may not matter so long as services are delivered. However, this view is very problematic. As the *International Standards on Drug Use Prevention* carefully describe, interventions need to be tailored to risk groups, and the evidence supporting or refuting the efficacy of any particular intervention is predicated on a coherence and connection between the programme and the targeted risk group. Selecting the most effective intervention requires an accurate understanding of the level of risk. Equally important, intervention evaluations are only effective when they identify appropriate outcomes, and outcomes are entirely dependent upon level of risk. For universal prevention, appropriate outcomes would likely involve increased knowledge of drugs and alcohol risks and/or reductions in the uptake of substance use. In contrast, appropriate outcomes of selective and indicated risk prevention interventions would focus more on decreases in the extent of substance use, evidence of desistance, and harm reduction.

Without a consistent understanding of targeted risk, evaluation and assessment is compromised. Inconsistency in risk definitions also undermines effective prevention policy. Here, policy-makers will always have multiple options for initiating, championing, and funding prevention activities and should seek a balanced prevention portfolio that provides comprehensive services at all levels of risk. This requires consistent language for and understanding of risk across the different levels of prevention. If practitioners define their work differently from policy-makers, the task of developing a coordinated and effective prevention system is compromised. To some degree, this echoes issues in the idiosyncratic nature of training in the Irish prevention system, and it seems necessary to establish some mechanism in order to ensure the consistent conceptualisation of and language used for risk in drug and alcohol prevention.

The gaps in coverage are more straightforward. The majority of interventions were described as targeting either selective or indicated risk groups. Some aspects of this are definitional and reflect the fact that there was simply wide variation in how selective or indicated risk was conceptualised, and frequently included entire communities, schools, age groups, etc. The evidence from the RePS intervention survey is that universal prevention – prevention that targets entire, undifferentiated populations – is less common. This could be ameliorated through the broader adoption of school-based, high-quality, evidence-based prevention interventions such as Unplugged and the School Health and Alcohol Harm Reduction Project (SHAHRP).

Delivery settings

With respect to settings, three gaps are particularly apparent. Although there are a significant number of interventions in community, school, and healthcare settings, there are comparatively fewer in family, workplace, and criminal justice settings. The family is an important institution in Ireland – perhaps uniquely important – and one that has historically operated without significant interference from the State or community (40). So, although it is perhaps not surprising that substance use interventions are less common in this setting, there are significant gaps. There are very few interventions among pregnant women or women with infant children, even though this is a critical point of intervention given the developmental consequences of substance use among parents and the huge externalities of those parenting in challenging situations.

The second gap is the absence of workplace interventions. Only one RePS submission explicitly described a workplace intervention. Importantly, this was one of the few evidence-based interventions, but the lack of evidence of similar programmes in other locations is concerning. Still, this may not indicate that such programmes do not exist. Indeed, as outlined in Section 6 B3, Ireland has the Healthy Workplace Framework, which is a Government strategy to enhance the health and well-being of people working in Ireland (19), although the extent to which it has been applied in workplaces in Ireland is unclear. Also, as described in Section 6 B3, legislation mandates that employers provide health supports for workers through the Safety, Health and Welfare at Work Act 2005. Evidence outside the RePS submissions suggests that much alcohol and drug prevention occurs in the context of such supports, including screening and assessments and brief interventions. What is less clear is the existence of universal prevention interventions that have sufficient focus, a long enough duration, and an interactive quality that is the basis of effective prevention.

The RePS intervention survey also identified very few interventions that were located in criminal justice settings. One submission articulating the activities of An Garda Síochána emphasised its intervention work in communities and schools. Another submission described educational and family supports in prison settings that were ultimately deemed support services. Beyond these, there was a single activity – a SAOR (Support, Ask and Assess, Offer Assistance and Refer) brief intervention – associated with the Probation Service in the HSE West and North West health region. Ultimately, what prevention interventions exist in criminal justice settings and how they stack up in relation to the UNODC *International Standards on Drug Use Prevention* is unknown. Still, it is difficult to not conclude that the RePS survey failed to adequately capture a range of activities involving criminal justice actors and taking place in criminal justice settings, which is a limitation of the work. That said, it still suggests that such activities are not organisationally connected to the myriad interventions identified and are not integrated into the overall architecture of prevention planning. Even when respondents were given the opportunity to provide information about other prevention interventions that they were aware of, none of the RePS submissions identified activities in criminal justice settings. Understanding what interventions exist and connecting them to the broader system of prevention in Ireland should be an important objective moving forward.

Improving the quality of interventions

In terms of quality, there are further areas for improvement. The issue of evaluation and its critical role in assuring quality have already been discussed, but a further area for improvement highlighted by the RePS intervention survey involves the frequency of delivery of interventions. The main limitations that resulted in lower assessments of existing interventions were the extent of contact and the mode of delivery. While this could reflect a lack of information provided, there were not many interventions that seemed to involve multiple distinct contacts, which are fundamental to effective interventions. Although there is no 'magic number', early childhood education is most effective when contact is near daily. It is not clear that any interventions outside of the routine operations of schools satisfy this criterion. From middle childhood on, the various skill enhancement interventions all recommend a minimum of 10 sessions and as many as 15. It is clear that many schools opt for a more one-off approach where experts are brought in. Manualised interventions such as Unplugged, Know the Score, and SHAHRP are designed to have a sufficient number of sessions. However, they are typically offered as part of the broader SPHE curriculum in schools, which covers many different topics, including alcohol and drug prevention. Equally important is that there do not appear to be any manualised prevention interventions that explicitly target middle childhood and are offered in primary schools in Ireland. Currently, it is unknown whether prevention is typically included in school curricula or, when it is, whether it includes a sufficient number of sessions to be truly effective. At minimum, there should be a more systematic accounting of how frequently prevention is included in the curriculum and how many sessions are typical. Moreover, training in the curriculum should emphasise the importance of delivering a sufficient number of sessions to maximise impact.

Relatedly, a third area for improvement is the style of delivery. More effective interventions are dynamic rather than lecture-style and do more than simply provide information about substance use. They are most effective when the focus is on developing a strong base of personal and social skills (including coping mechanism, decision-making, and resistance skills), and on providing opportunities to test such skills in relation to substance use. Most interventions reviewed fell short on at least two of these dimensions. In particular, there were a large number of interventions around mental health and social support that were clearly quite intensive and engaging but lacked a connection to substance use prevention. The same applies to a number of community-based, out-of-school activity programmes. There are also a number of community engagement forums that offer information about substance use to young people and their families. For such programmes, it is largely unclear how interventions are delivered or what training is provided for those involved. In contrast, manualised interventions provide detailed instruction kits on how best to deliver the interventions, and increasing numbers of teachers are trained in pedagogical approaches that model such practices. Lessons should be learned from the latter, and they should provide templates for more effective interventions.

B. System level

Supportive policy and regulatory frameworks

Ireland's prevention system was assessed as strong in relation to its policies and legislation that create a controlled environment for the sale, marketing, and price of tobacco products and alcohol. The prioritisation of public health in developing and implementing this approach is to be welcomed when considering effective prevention. However, industry interests maintain a strong influence in the Irish context and have been seen to reduce the potentially positive impact of health-led legislation (for example, in the postponement of applying health labels to alcohol products). It is also critical that Government policy continues to state firmly that the alcohol industry has no role to play in prevention within schools.

Evidence-based planning and use of research

As mentioned above, while Ireland does not have a culture of evaluating prevention activities, the system review assessed it as having a strong foundation of epidemiological research on drugs use. However, using these data to inform prevention policy and practice was not a strong feature of Ireland's system. There needs to be a clearer understanding of the barriers to and facilitators of utilising epidemiological data, evaluations, and other research findings effectively in the planning and implementation of prevention policy and practice. It is important that policy-makers across the Government and practitioners nationally are supported in accessing and understanding existing data and how these data can help inform their work. In an environment where service providers may be increasingly required to demonstrate an evidence base in order to receive funding, they need to be suitably equipped and supported to do so.

Coordination among different sectors and levels

Ireland's national, regional, and local structures for prevention need to be strengthened in order to ensure the coherence and meaningful involvement of all stakeholders across levels. Prevention appears as a key element of Ireland's national drugs strategy, and this was reflected in the establishment of the Strategic Implementation Group (SIG) to implement this work from 2021 through 2024. However, the findings of the assessment would suggest that this needs to be strengthened so that a national-level mechanism like the SIG can be sustained on a more permanent basis and not be impacted by the expiration of the national drugs strategy's lifetime. Also, if national policy is to translate into effective delivery at the regional and local level, effective structures need to be supported that include all relevant stakeholders. The findings from the RePS intervention survey would suggest that there is a lot of good practice happening at a local level, which may not be being accessed or disseminated to other local areas, regions, or nationally. A barrier to doing so would be a lack of coordinated and effective structures in some areas.

Developing a training system

The findings suggest that Ireland's prevention system needs to better support training for those who are delivering prevention interventions, as well as their managers and those responsible for decision-making at local, regional, and national levels. Prevention workers described a system in which they depended on self-sourced training and learning once they were already working in drug prevention. There were high levels of commitment among those consulted for the RePS system assessment, and an environment in which communities of practice supported their learning and training in the field. However, these happened by chance, and access to training often depended on a supportive manager and access to resources; practitioners did not have equal access to training resources. These findings would suggest that there is extensive knowledge of the field among these workers, but that they would benefit greatly from support to develop forums or communities of practice in which to share their knowledge, as well as the development of formal training opportunities relevant to the field. While the European Prevention Curriculum is a valuable part of the landscape, in the absence of other courses it may be expected to meet the training needs of those beyond its target audience.

Sustainability

The UNODC considers national strategies and associated funding as part of its assessment of sustainability within a country's overall prevention system. Since 2001, Ireland has had a series of national drugs strategies that have included prevention in some form. The most recent national drugs strategy (2017–2025) had prevention as one of its goals. While a new national drugs strategy is at a draft stage at the time of writing (Q2 2026), the structures of the previous strategy were stepped down in 2025. The SIG on prevention last met in 2024. It could be the case that this impacted on the delivery and progress of prevention in Ireland.

C. Concluding comment

In Ireland, there are illustrations of good practice across the elements identified by the UNODC as foundations for an effective prevention system. However, these are often isolated and confined to a few areas or localities. The overall assessment indicates that the current structures associated with prevention in Ireland do not constitute an effective national prevention system. The findings suggest that there are many opportunities for improvement and examples of good practice that could be built upon.

Appendix A.

Review of Prevention Systems survey for Ireland, 2025

Introduction

The purpose of this survey is to gain knowledge about the overall nature of drug and alcohol prevention in Ireland in order to help develop the next national drugs strategy.

This survey is directed toward practitioners - those who actually deliver or help deliver - prevention interventions in Ireland. By prevention interventions, we mean those that

> ...have as their primary objective "to help people—especially, but not only, young people—to avoid or delay the initiation of the use of psychoactive substances, or, if they have already initiated use, to avert the development of substance use disorders (harmful substance use or dependence)" [UNODC, 2020, p.2].

RePS will map out what is and is not offered in Ireland and the degree to which interventions reflect empirical research on effective prevention at a system level.

By contributing to this survey, you are helping shape the future of prevention activities in Ireland and efforts to develop better and more effective prevention.

If you wish to participate, please click "Continue"

Part 1 – Basic information about the institution filling (in) the questionnaire

Section 1A: Information about the organisation

1. What is the name of your organisation?

You can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking "start," and clicking "record." Please remember to save your text or recording at the end by clicking on the check mark.

2. What is the geographic scope of your organisation's activities?

- National (the whole country)
- One particular region/district
- One particular city, suburb, town or village
- Other, please specify

A. If one PARTICULAR REGION/DISTRICT or CITY/SUBURB/TOWN/VILLAGE,
Please specify:

3. What kind of organisation are you?

- Governmental agency
- Non-governmental or civil society organisation (not-for-profit)
- Research institute
- For-profit entity or foundation linked to a for-profit entity
- Other (please specify)

4. Which sector is your organisation in?

If more than one sector, click all that apply.

- Health
- Education
- Social welfare and/or social development
- Law enforcement and criminal justice
- Other (please specify)

5. Contact details

- Name
- Title
- Email address
- Contact number

Part 2 – Prevention intervention(s) implemented by

Your organisation

6. Thinking of the INTERVENTION that you are most involved with, what is its name?

You can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking "start," and clicking "record." Please remember to save your text or recording by clicking on the check mark at the end.

7. Does your organisation operate in the HEALTH sector?

- Yes
- No
- Don't know
- Other, please specify

8. Which of the following best describes your prevention intervention?

- Programme targets pregnant women - Pregnant women are advised of potential health risks of substance use to themselves and to their babies and treatment and care of substance use disorders are offered as appropriate
- Prenatal and infancy visits - Trained health or social workers visit mothers-to-be and new mothers from marginalized communities to provide them with basic parenting skills and support in addressing a range of issues including health, housing, employment, etc.
- Mental health services for children and/or adolescents - Services to support children and/or adolescents and their families in addressing emotional and behavioural disorders as early as possible.
- Workplace prevention programmes - Multi-component initiatives, including information and/or policies against substance use in the workplace and/or screening, brief interventions and referral to treatment and care of substance use disorders.
- Alcohol policies - A series of policies and interventions as endorsed by WHO, aiming at reducing the harmful use of alcohol.
- Tobacco policies - A series of policies as endorsed by WHO, aiming at reducing the availability and accessibility of tobacco and tobacco smoking.
- Screening and brief intervention - Sessions delivered by trained health or social workers in a variety of settings to identify whether there is a substance use problem and provide immediate appropriate basic counselling and/or referral for additional treatment.
- Media campaign
- Other (please specify)

9. Does your organisation operate in the education sector?

- Yes
- No
- Don't know
- Other, please specify

10. Which of the following best describes your prevention intervention?

- Early childhood education - Programmes in educational settings to support the social and cognitive development of preschool children (2–5 years of age) from deprived communities.
- Parenting skills programmes - Programmes to improve the parenting skills of caregivers of children and early adolescents (e.g. setting rules for acceptable behaviours, strengthening parent-child bond, monitoring free time and friendship patterns, etc.).
- Personal and social skills education - Programmes mostly (but not exclusively) delivered in educational settings and by trained teachers for children to learn and practice a range of personal and social skills.
- Classroom environment improvement programmes - Programmes that strengthen the classroom management abilities of teachers by implementing classroom processes that promote pro-social behaviours in children, socializing them in their role as a student and reducing early aggressive and disruptive behaviours.
- Policies to retain children in school - A series of effective policies to support the attendance of children in schools and improve their educational outcomes.
- Mentoring - Programmes that match children and adolescents from marginalized situations, with adults, who commit to arranging activities and spending some of their free time with the young person on a regular basis.
- Drug prevention education for adolescents - Programmes delivered by trained facilitators to discuss information with and provide personal and social skills to adolescents.
- School policies on substance use - Policies mandating that substances should not be used on school premises or during school functions and activities by either students or staff.
- School-wide programmes to enhance school attachment - Programmes to support student participation, positive bonding and commitment to school.
- Screening and brief intervention - Sessions delivered by trained health or social workers in a variety of settings to identify whether there is a substance use problem and provide immediate appropriate basic counselling and/or referral for additional treatment.
- Media campaign
- Other (please specify)

11. Does your organisation operate in the social care or social service sector?

- Yes
- No
- Don't know
- Other, please specify

12. Which of the following best describes your prevention intervention?

- Prenatal and infancy visits - Trained health or social workers visit mothers-to-be and new mothers from marginalized communities to provide them with basic parenting skills and support in addressing a range of issues including health, housing, employment, etc.
- Early childhood education - Programmes in educational settings to support the social and cognitive development of preschool children (2–5 years of age) from deprived communities.
- Parenting skills programmes - Programmes to improve the parenting skills of caregivers of children and early adolescents (e.g. setting rules for acceptable behaviours, strengthening parent-child bond, monitoring free time and friendship patterns, etc.).
- Personal and social skills education - Programmes mostly (but not exclusively) delivered in educational settings and by trained teachers for children to learn and practice a range of personal and social skills.
- Policies to retain children in school - A series of effective policies to support the attendance of children in schools and improve their educational outcomes.
- Mentoring - Programmes that match children and adolescents from marginalized situations, with adults, who commit to arranging activities and spending some of their free time with the young person on a regular basis.
- Drug prevention education for adolescents - Programmes delivered by trained facilitators to discuss information with and provide personal and social skills to adolescents.
- Mental health services for children and/or adolescents - Services to support children and/or adolescents and their families in addressing emotional and behavioural disorders as early as possible.
- Community-based initiatives - Initiatives to bring together different actors in a community to address substance use, by identifying risk and protective factors and respond through appropriate evidence-based components in different settings.
- Screening and brief intervention - Sessions delivered by trained health or social workers in a variety of settings to identify whether there is a substance use problem and provide immediate appropriate basic counselling and/or referral for additional treatment.
- Media campaign
- Other (please specify)

13. Does your organisation operate in the law enforcement/criminal justice sector?

- Drug prevention education for adolescents - Programmes delivered by trained facilitators to discuss information with and provide personal and social skills to adolescents.
- School policies on substance use - Policies mandating that substances should not be used on school premises or during school functions and activities by either students or staff.
- Workplace prevention programmes - Multi-component initiatives, including information and/or policies against substance use in the workplace and/or screening, brief interventions and referral to treatment and care of substance use disorders.
- Entertainment venues initiatives - Multi-component interventions, including training of staff and managers on managing intoxicated patrons; enforcing laws and policies on serving minors or intoxicated patrons or on driving under the influence of alcohol and/or drugs; communication; and offering treatment to managers and staff.
- Community-based initiatives - Initiatives to bring together different actors in a community to address substance use, by identifying risk and protective factors and respond through appropriate evidence-based components in different settings.
- Screening and brief intervention - Sessions delivered by trained health or social workers in a variety of settings to identify whether there is a substance use problem and provide immediate appropriate basic counselling and/or referral for additional treatment.
- Media campaign
- Other (please specify)

14. Please provide a short description of your prevention intervention. Again, we would like you to describe the prevention intervention that you are most involved in.

To the best extent possible, indicate: Where does the programme take place? Who does the programme target? What does the programme do? What are its main activities and components? If the programme included any education and training, what is their content? Who delivers the activities? And what are their training or qualifications?

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking “start,” and clicking “record.” Please remember to save your text or recording by clicking on the check mark at the end.

15. What is the level of coverage of your prevention intervention in terms of the relevant location and communities reached?

- Full: Our programme exists in nearly all relevant locations
- Extensive: Our programme exists in a majority of relevant locations
- Limited: Our programme exists in more than a few relevant locations
- Rare: Our programme exists in just a few relevant locations
- I don’t know
- Other (please specify)

16. What is the age range of the population targeted by your prevention intervention?

Please use the age of the population among which the programme intends to prevent substance use. For example, a parenting programme for parents of early adolescents should indicate "from 11 to 15" as the programme seeks to prevent substance use among this age group (even if the participants are parents).

- No specific age range
- Up to age 5
- From age 6 to age 10
- From age 11 to age 15
- From age 16 to 18
- Age 18 or older
- I don't know
- Other (please specify)

17. Based on the age groups indicated previously, what is the total number of females (e.g. approximately 200) that were served by your intervention in the last year?

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking "start," and clicking "record." Please remember to save your text or recording by clicking on the check mark at the end.

18. Based on the age groups indicated previously, what is the total number of males (e.g. approximately 200) that were served by your intervention in the last year?

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking "start," and clicking "record."

Please remember to save your text or recording by clicking on the check mark at the end.

19. What is the typical level of risk for the population targeted by your prevention intervention?

- No specific risk or universal prevention
- Group particularly at risk or selective prevention
- Individual particularly at risk or indicated prevention
- Other (please specify)

A. If you indicated a "group particularly at risk selected or selective," how would you describe this group?

B. If you indicated an "individual particularly at risk selected or indicated," how would you describe this group?

Part 3 – Relevant evidence on effectiveness

20. Is there any research or studies that provide support for the way in which your programme is designed and implemented and support its effectiveness as a prevention intervention?

This could include published research, reports (e.g. governmental, non-governmental) of activities, websites, reviews, etc.

- Yes
- No
- Don't know

21. Please provide a description of any documentation that supports the design and implementation of your prevention intervention.

If you indicated that there is research support on the effectiveness of your programme, please provide as much detail as possible including if possible the author/organisation, the title of the publication or site, where it can be found (e.g. journal, issue, volume, web link), and when it was published/released.

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking "start," and clicking "record." Please remember to save your text or recording by clicking on the check mark at the end.

A. If you have any relevant documentation on hand, please upload it here.

22. Please indicate whether the effectiveness of your specific programme has been evaluated. In the case of previously existing programmes, the evaluation might have been not in the same location or country.

- Yes
- No
- Don't know

23. Please provide a description of any documentation that is an evaluation of your prevention intervention.

If you indicated that there is research support on the effectiveness of your programme, please provide as much detail as possible including if possible the author/organisation, the title of the publication or site, where it can be found (e.g. journal, issue, volume, web link), and when it was published/released.

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking "start," and clicking "record." Please remember to save your text or recording by clicking on the check mark at the end.

A. If you have any relevant documentation on hand, please upload it here.

24. Please describe the duration and content of the TRAINING provided, including who delivers it.

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking “start,” and clicking “record.” Please remember to save your text or recording by clicking on the check mark at the end.

25. Please provide a description of any documentation that describes the training of staff related to your prevention intervention.

If you indicated that there was specific training for your programme, please provide information on the source of the training. Where possible, this includes the author/ organisation, the title of the publication or site, where it can be found (e.g. journal, issue, volume, web link), and when it was published/released.

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking “start,” and clicking “record.” Please remember to save your text or recording by clicking on the check mark at the end.

A. If you have any relevant documentation on hand, please upload it here.

26. Does your prevention intervention include a mechanism or procedure to ensure that it is always implemented in a similar manner?

- Yes
- No
- Don’t know

27. Please describe what these mechanisms are and how they work?

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking "start," and clicking "record." Please remember to save your text or recording by clicking on the check mark at the end.

A. If you have any relevant documentation on hand, please upload it here.

Part 4 – Knowledge of other prevention programmes

Please report on up to three programmes.

28. Thinking about another prevention intervention outside of your own Drug and Alcohol Task Force, can you briefly describe who they are, where they operate, and what they do? If you know of a specific contact person, please provide this information as well.

First programme:

Again, you can either enter your answer as text by clicking the icon below or record your answer by clicking on the microphone/audio icon, clicking "start," and clicking "record." Please remember to save your text or recording by clicking on the check mark at the end.

29. Is there another programme that you could describe?

- Yes
- No
- Don't know

Thank you for filling this questionnaire!

By doing this, you have contributed to an important process of learning and improving our work for the health and well-being of children, youth and people!

Appendix B.

List of interventions, organisations, and locations

Intervention	Organisation
YMCA - drug and alcohol-free youth performance venue	YMCA Ireland
YMCA - supporting vulnerable youth	YMCA Ireland
Third-level education	An Garda Síochána
Primary education	An Garda Síochána
Media campaigns	An Garda Síochána
Information	Sexual Health Centre
Brief Intervention	Sexual Health Centre
Five-step method/family support programme	Drug/alcohol prevention project based in Cork City Partnership
Know The Score	Drug/alcohol prevention project based in Cork City Partnership
Drug and alcohol information pods (Workshops)	Drug/alcohol prevention project based in Cork City Partnership
Unplugged	Tallaght Local Drugs and Alcohol Task Force
Strengthening Families Programme	Tallaght Local Drugs and Alcohol Task Force
Lots Of Other Bits Media Campaigns	Tallaght Local Drugs and Alcohol Task Force
Individual supports (SAOR)	CBDI West Waterford
Education and awareness	CBDI West Waterford
Information and advice	CBDI West Waterford
Counselling	Be Well Team - Limerick Youth Service
Supporting Youth Groups For Positive Mental Health	Be Well Team - Limerick Youth Service
In-class prevention and education programmes	Finglas Cabra Local Drug and Alcohol Task Force
Work with pregnant women with SA issues	Finglas Cabra Local Drug and Alcohol Task Force
DEPS Film Project	Limerick Youth Service - Drug Education and Prevention Department
SAOR	North Dublin Regional Drug and Alcohol Task Force
SHAHRP	North Dublin Regional Drug and Alcohol Task Force
GAA workshops	North Dublin Regional Drug and Alcohol Task Force
Parent comhrá (information provision)	North Dublin Regional Drug and Alcohol Task Force
Know The Score	Dublin North East Drug and Alcohol Task Force
Prevention Education	Dublin North East Drug and Alcohol Task Force

Intervention	Organisation
One-to-one counselling	Frontline Project (WSTCYS)
Tailored workshops	Waterford and South Tipperary Community Youth Service
One-on-one interventions	Waterford and South Tipperary Community Youth Service
Community outreach (festivals)	North East Regional Drug and Alcohol Task Force
GAA workshops	North East Regional Drug and Alcohol Task Force
Safer Communities Initiative	North East Regional Drug and Alcohol Task Force
Student engagement activity (filmmaking)	Dun Laoghaire Rathdown Drug and Alcohol Task Force
Strengthening Families	South Western Regional Drug and Alcohol Task Force trading as: SURF
Building SAFER Communities	South Western Regional Drug and Alcohol Task Force trading as: SURF
Communities That Care (Foróige)	South Western Regional Drug and Alcohol Task Force trading as: SURF
Unplugged	Tallaght Drug and Alcohol Task Force
Drugs and alcohol awareness sessions	Clare Youth Service
One-on-one support	Clare Youth Service
Communities That Care	Foróige (Drug Prevention & Education Initiative)
Infant Parent Support Programme	Ballymun Local Drug and Alcohol Task Force
Attendance at festivals	NWRDATF and HSE
Steroid Information	NWRDATF and HSE
Parenting Support Programmes	NWRDATF and HSE
Pre/after-school programme	Frontline Make Change and Frontline Bikes
School-based intervention	Crosscare Bray Youth Service, Drug Education and Prevention Project
Incredible Years framework	Step by Step, Child and Family Project
One-to-one art therapy	Step by Step, Child and Family Project
Bluebell Youth Project	Step by Step, Child and Family Project
Aisling Afterschool Project	Aisling Project
SHAHRP	Blanchardstown Local Drug and Alcohol Task Force
SPHE - Know The Score	Health Service Executive - HSE Alcohol Programme
SAOR	Health Service Executive - HSE Alcohol Programme

Intervention	Organisation
MECC	Health Service Executive - HSE Alcohol Programme
FamiliBase	FamiliBase
Unplugged	Dublin 12 Local Drugs and Alcohol Task Force
Strengthening Families	Dublin 12 Local Drugs and Alcohol Task Force
SHAHRP	Southern Regional Drug and Alcohol Task Force
Know The Score	CDATF
Unplugged	CDATF
Outreach street work	STAR Project Ballymun - Easy Street Outreach Team
Street education	STAR Project Ballymun - Easy Street Outreach Team
Primary school programme (Making My Own Choices)	STAR Project Ballymun - Easy Street Outreach Team
Putting the Pieces Together	Finglas Cabra Local Drug and Alcohol Task Force
Making My Own Choices (5th Class)	Ballymun Anseo School Completion Programme
One-on-one interventions	Ballymun Anseo School Completion Programme
Detached youth work	Ballymun Regional Youth Resource
Let's Learn about Drugs and Alcohol Together	HSE Mid-West Drug and Alcohol Service, Education Officer
One-on-one interventions	STAR Project Ballymun - Easy Street Outreach Team
Unplugged	Clondalkin Drug and Alcohol Task Force
Young people's support programme	Clondalkin Drug and Alcohol Task Force
St Andrew's Talk About Youth Project	St Andrew's Resource Centre
Dublin North East Drug And Alcohol Task Force	Dublin North East Drug and Alcohol Task Force
One-on-one	My Project... Minding You (MyP)
Group work	My Project... Minding You (MyP)
Family support programme	My Project... Minding You (MyP)
Core Youth Service T/A St Michael's Parish Youth Project Ltd	Core Youth Service T/A St Michael's Parish Youth Project Ltd
Practical support and crisis management	Barnardos Ballyogan/Tivoli and Bray Family Intensive Family Support Services
Partnership with parents - infants	Barnardos Ballyogan/Tivoli and Bray Family Intensive Family Support Services

Intervention	Organisation
Parent-child work	Barnardos Ballyogan/Tivoli and Bray Family Intensive Family Support Services
This Is Me	Barnardos Ballyogan/Tivoli and Bray Family Intensive Family Support Services
Brief intervention	Barnardos Ballyogan/Tivoli and Bray Family Intensive Family Support Services
Meitheal	Barnardos Ballyogan/Tivoli and Bray Family Intensive Family Support Services
Strengthening Families	St Fergal's Young Women's Project
Life skills programmes	St Fergal's Young Women's Project
Street work and outreach	St Fergal's Young Women's Project
One-on-one supports	St Fergal's Young Women's Project
Mentoring	St Fergal's Young Women's Project
Life skills programmes	Bray Family Resource and Development Project CLG
One-on-one supports	Bray Family Resource and Development Project CLG
Mentoring	Bray Family Resource and Development Project CLG
Family support	Bray Family Resource and Development Project CLG
Street work and outreach	Bray Family Resource and Development Project CLG
Child play & therapy	Walkinstown Greenhills Resource Centre
Crosscare Ronanstown Youth Service	Crosscare Ronanstown Youth Service
Youth drug and alcohol education and prevention project	Foróige Youth Drug and Alcohol Education and Prevention Project Donegal
Unplugged (First Years)	Clondalkin Youth Service/Clondalkin Drug and Alcohol Task Force
Young people's support programme (Fourth Years)	Clondalkin Youth Service/Clondalkin Drug and Alcohol Task Force
Group work	Foróige Alcohol and Drug Education and Prevention Project
One-on-one interventions	Foróige Alcohol and Drug Education and Prevention Project
STAR: family support programme	Ballyfermot Local Drug and Alcohol Task Force

Intervention	Organisation
STAR: early learning supports	Ballyfermot Local Drug and Alcohol Task Force
Drug education and prevention for young people and families	Canal Communities Regional Youth Service/ Bluebell Youth Project
One-on-one interventions	Canal Communities Regional Youth Service/ Bluebell Youth Project
Foróige: drug and alcohol education and prevention programme	Foróige
Aftercare	Northside Partnership
Unplugged delivered to First Years	St John Bosco Youth Centre
Tailored talk	Western Region Drug and Alcohol Task Force (WRDATF)
Stay Safe Stay Sober	Western Region Drug and Alcohol Task Force (WRDATF)
Social media campaign	Western Region Drug and Alcohol Task Force (WRDATF)
One-on-one interventions (A-CRA)	Community Substance Misuse Team (Mid-West)
Group work (A-CRA)	Community Substance Misuse Team (Mid-West)
Family Interventions (A-CRA)	Community Substance Misuse Team (Mid-West)
Prevention	Western Region Drug and Alcohol Task Force
Policy initiatives (MUP, restrictions on sales)	Health Promotion & Improvement
Health promotion workshops (open to the public)	Health Promotion & Improvement
Healthy Cities Initiative	Health Promotion & Improvement
Service responses (SAOR, etc.)	Health Promotion & Improvement
The SHAHRP Programme	Southern Regional Drug & Alcohol Task Force
Brief intervention (SAOR trained)	Probation Service

Appendix C.

Topic guide for focus group with members of the Drug and Alcohol Education Workers Forum

- Introduction of Review of Prevention Systems (RePS)
- Focus on the systems element
- Professional backgrounds
- Training:
  - How members came to work in prevention
  - Development of expertise in prevention
  - Sources of prevention training (formal/informal)
  - Gaps in capacity building in Ireland
- Evidence in practice:
  - Role of evidence in practice (access, application)
  - Any role of quality standards (e.g. Drug and Alcohol Education Workers Forum)
- General view on extent/nature of:
  - Social, Personal and Health Education (SPHE) and work with schools
  - Brief interventions
- Strengths and weaknesses in Ireland's prevention system

Appendix D.

Systems questionnaire for Drug and Alcohol Task Force coordinators

Questionnaire for DATFs

This is the second survey in the Review of Prevention Services (RePS) in Ireland. Its purpose is to gain knowledge about Ireland's prevention system, and the role Task Forces have in this system. This system survey is designed to complement the earlier survey looking at prevention interventions. This part of the RePS study focuses on three areas:

- How prevention is structured in your Task Force
- Your use of evidence in prevention policy, planning or practice
- Any application of quality standards and prevention

By prevention, we mean activities that:

> ...have as their primary objective "to help people—especially, but not only, young people—to avoid or delay the initiation of the use of psychoactive substances, or, if they have already initiated use, to avert the development of substance use disorders (harmful substance use or dependence)" [UNODC, 2018, p.2].

By contributing to this survey, you are helping shape the future of prevention activities in Ireland and efforts to develop better and more effective prevention.

If you wish to participate, please click "Continue"

Note: If the answer to the first question is no then no need to respond to the rest of the questions.

Respondent details

What is your name?

Which Task Force do you work with?

What is your role within the Task Force?

Prevention context

1. Does your Task Force have a role in the field of drug prevention in your area?

- Yes
- No
- Other

If yes, please provide a brief description of your Task Force's role in relation to prevention

2. Does your Task Force have a strategy/action plan (or similar) for drug prevention?

- Yes
- No
- Other

If yes, please provide a brief description

---

3. Does your Task Force employ a prevention worker?

- Yes
- No
- Other

4. Does your Task Force fund another organisation to deliver prevention in your area?

- Yes
- No
- Other

5. Is there a mechanism or structure (e.g. a working group or subgroup) for coordinating prevention activities across your area?

- Yes
- No
- Other

If yes, please give a brief description of the mechanism or structure.

---

6. Which statutory organisations/other stakeholders are involved in the planning of prevention in your area (eg as members of the Task Force or a prevention subgroup)? (Tick all that apply)

- Health
- Education (e.g. Education Training Board, schools)
- Youth
- Social Welfare (e.g. TUSLA)
- Sport (e.g. Local Sports Partnerships, clubs)
- Law enforcement
- Civil society (e.g. local community organisations)
- Local businesses
- Political (e.g. local councillor, T.D.)
- Residents
- Religious organisations
- Research organisations
- Other (please specify)

Please give a brief description of the statutory organisations and other stakeholders' roles in relation to prevention in your area.

---

7. How would you rate the overall level of cooperation between these statutory organisations/other stakeholders when working in prevention in your area?

- High
- Medium
- Low
- I don't know

Please describe what works well, and not so well, in the cooperation of these statutory organisations/other stakeholders when working on prevention in your area.

Use of evidence in prevention policy, planning or practice

8. Has your Task Force used research/evidence to inform its prevention policy, planning or practice in the last 3 years?

- Yes
- No
- Other

If yes, what kind of research/ evidence has been used to inform the prevention policy, planning or practice in the last 3 years? (Choose all that apply)

- National/ local epidemiological data collection on children (under 18 years of age)
- National/ local other epidemiological data collection
- Epidemiological information shared by international organisations (e.g. EMCDDA, UNODC, WHO, etc).
- National/ local evaluation research on the effectiveness of prevention approaches
- Evidence on effective prevention approaches shared by international organisations (e.g. EMCDDA, UNODC, WHO, etc).
- Drug-related international research data published in scientific journals
- Other, please specify:

Any other comment:

Please name the evidence sources and give a brief description of how the evidence was used to inform prevention policy, planning or practice in your area.

9. When selecting which prevention initiative/ programme/ practice to fund/deliver in your area, are criteria based on standards of evidence-based prevention used? (Choose one)

- Yes
- No
- Other

If yes, which standards are applied (Tick all that apply)

- The UNODC-WHO International Standards on Drug Use Prevention
- The European Drug Prevention Quality Standards
- National/local standards
- Other standards or criteria, such as being included in a registry of evidence-based programs, pls. specify:

Any other comment:

10. Is there any other mechanism (e.g. working group) in place, not described above, to ensure that prevention approaches that are funded and implemented are based on evidence, and that they are effective and safe? If yes, please give a brief description.

References

1. European Commission. *Communication from the commission to the European Parliament and the Council on the EU Drugs Strategy.* Brussels: European Commission; 2025.

2. Department of Health. *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025.* Dublin: Department of Health; 2017. Available from: http://www.drugsandalcohol.ie/27603/

3. Butler E, Keane R, Rowley C, *et al.,* editors. *A manual in quality standards in substance use education.* Dublin: Drug Education Workers Forum; 2007.

4. European Monitoring Centre for Drugs and Drug Addiction. *European drug prevention quality standards: A manual for prevention professionals.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction; 2011. Available from: https://www.emcdda.europa.eu/publications/manuals/prevention-standards_en

5. United Nations Office on Drugs and Crime. *International Standards on Drug Use Prevention.* Vienna: United Nations; 2015.

6. United Nations Office on Drugs and Crime, World Health Organization. *International Standards on Drug Use Prevention: Second updated edition.* Vienna: United Nations Office on Drugs and Crime and World Health Organization; 2018. Available from: https://www.drugsandalcohol.ie/30048/

7. United Nations Office on Drugs and Crime, KORUS Oslo. *Review of National Prevention Systems based on the UNODC/WHO International Standards on Drug Use Prevention: Final report of the pilot in Norway.* Vienna: United Nations Office on Drugs and Crime; 2023. Available from: https://www.drugsandalcohol.ie/41014/

8. United Nations. Global issues: Drugs [Internet]. United Nations; nd. Available from: https://www.un.org/en/global-issues/drugs

9. Babor T, Caulkins J, Edwards G, *et al. Drug Policy and the Public Good.* Oxford: Oxford University Press; 2010.

10. United Nations Office on Drugs and Crime, KORUS Oslo. *Review of National Prevention Systems based on the UNODC/WHO International Standards on Drug Use Prevention: Final report of the pilot in Norway. Annex 3. Assessment of existing interventions.* Vienna: United Nations Office on Drugs and Crime; 2023.

11. Government of Ireland, Health Service Executive. *Organisational reform: HSE Health Regions.* Dublin: Department of Health; 2023. Available from: https://assets.gov.ie/static/documents/hse-health-regions-implementation-plan.pdf

12. Macmillan R, editor. *The Structure of the Life Course: Standardized? Individualized? Differentiated?* Vol. 9, 1st ed. Oxford: Elsevier JAI; 2005.

13. Health Research Board. Irish National Focal Point to the European Union Drugs Agency. (2026) *Focal Point Ireland: national report for 2025 – Prevention*. Dublin: Health Research Board.

14. Thornton G. *Evaluation of the National Drug Strategy "Reducing Harm, Supporting Recovery 2017-2025"*. Dublin: Department of Health; 2025. Available from: https://www.drugsandalcohol.ie/43790/

15. Citizens' Assembly. *Report of the Citizens' Assembly on Drugs Use*. Dublin: Citizens' Assembly; 2024. Available from: https://www.drugsandalcohol.ie/40393/

16. Gordon RS Jr. An operational classification of disease prevention. *Public Health Rep*. 1983;**98**(2):107–9. PubMed PMID: 6856733; PubMed Central PMCID: PMC1424415.

17. Davenport J, Tansey A. *Outcomes of an Incredible Years Classroom Management Programme with Teachers from Multiple Schools*. Dublin: National Educational Psychological Service; 2009. Available from: http://www.drugsandalcohol.ie/25601/

18. HSE Alcohol Programme. *Know the Score: Substance Use Resource Materials for Senior Cycle SPHE*. Dublin: Health Service Executive; 2019. Available from: https://www.drugsandalcohol.ie/31359/.

19. Healthy Workplace Ireland. Healthy Ireland @ Work [Internet]. Healthy Workplace Ireland; 2025. Available from: https://healthyworkplace.ie/

20. O'Shea J, Goff P. *SAOR model. Screening and Brief Interventions for Problem Alcohol Use in the Emergency Department & Acute Care Settings*. Waterford: Health Service Executive; 2009. Available from: https://www.drugsandalcohol.ie/15791/

21. Minister for Health. Parliamentary Debates Dáil Éireann. Product Labelling [36271/25]. 9 December 2025. Available from: https://www.oireachtas.ie/en/debates/question/2025-07-02/233/

22. Minister for Health. Parliamentary Debates Dáil Éireann. Healthcare Policy [45136/25] 9 December 2025. Available from: https://www.oireachtas.ie/en/debates/question/2025-09-08/2214/#pq_2214

23. Drugs Policy and Social Inclusion Unit. *Mid-Term Review of the national drugs strategy, Reducing Harm, Supporting Recovery and Strategic Priorities 2021-2025*. Dublin: Department of Health; 2021. Available from: https://www.drugsandalcohol.ie/35183/

24. Department of Health. *National Drugs Strategy Strategic Action Plan 2023-2024*. Dublin: Department of Health; 2023. Available from: https://www.drugsandalcohol.ie/39064/

25. Department of Children, Equality, Disability, Integration and Youth. (2023) *Young Ireland: the national policy framework for children and young people (0-24) 2023-2028*. Dublin: Government of Ireland.

26. Department of Justice. *Youth Justice Strategy 2021 - 2027*. Dublin: Department of Justice; 2021. Available from: https://www.drugsandalcohol.ie/34061/

27. Healy G, Walsh K. Stakeholder consultations to inform the development of a successor national drug strategy: Summary of key findings. Dublin: Department of Health; 2025. Available from: https://www.drugsandalcohol.ie/44454/

28. Ayano G, Rooney R, Pollard CM et al. Risk and protective factors of youth crime: an umbrella review of systematic reviews and meta-analyses. *Clin Psychol Rev.* 2024;**113**:102479. https://doi.org/10.1016/j.cpr.2024.102479

29. Vasilenko SA, Evans-Polce RJ, Lanza ST. Age trends in rates of substance use disorders across ages 18–90: Differences by gender and race/ethnicity. *Drug Alcohol Depend.* 2017;**180**:260–4. https://doi.org/10.1016/j.drugalcdep.2017.08.027

30. Arnett JJ. Emerging adulthood. A theory of development from the late teens through the twenties. Am Psychol. 2000;**55**(5):469–80. PubMed PMID: 10842426.

31. McCrory S, Sharif F, Burke J et al. Fetal Alcohol Spectrum Disorder in Ireland. *Ir Med J.* 2026;**119**(1):17.

32. Zheng T, Zhang J, Sommer K et al. Effects of Environmental Exposures on Fetal and Childhood Growth Trajectories. *Ann Glob Health.* 2016;**82**(1):41–99. https://doi.org/10.1016/j.aogh.2016.01.008

33. Colombo J. The critical period concept: research, methodology, and theoretical issues. Psychol Bull. 1982;**91**(2):260–75. PubMed PMID: 7071261.

34. Gupta KK, Gupta VK, Shirasaka T. An Update on Fetal Alcohol Syndrome—Pathogenesis, Risks, and Treatment. *Alcohol Clin Exp Res.* 2016;**40**(8):1594–602. https://doi.org/10.1111/acer.13135

35. Oei JL. Alcohol use in pregnancy and its impact on the mother and child. Addiction. 2020;**115**(11):2148–63. https://doi.org/10.1111/add.15036

36. Pisinger VSC, Bloomfield K, Tolstrup JS. Perceived parental alcohol problems, internalizing problems and impaired parent - child relationships among 71988 young people in Denmark. Addiction. 2016;**111**(11):1966–74. https://doi.org/10.1111/add.13508

37. Dube SR, Anda RF, Felitti VJ et al. Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction. *Child Abuse Negl.* 2001;**25**(12):1627–40. https://doi.org/10.1016/s0145-2134(01)00293-9

38. Christoffersen MN, Soothill K. The long-term consequences of parental alcohol abuse: a cohort study of children in Denmark. *J Subst Abuse Treat.* 2003;**25**(2):107–16. https://doi.org/10.1016/s0740-5472(03)00116-8

39. Visser L, de Winter AF, Reijneveld SA. The parent-child relationship and adolescent alcohol use: a systematic review of longitudinal studies. BMC Public Health. 2012;**12**:886. https://doi.org/10.1186/1471-2458-12-886.

40. Daly M. Families and Family Life in Ireland: Challenges for the Future: Report of Public Consultation Fora. Dublin: Department of Social and Family Affairs; 2004.

RePS is an initiative of the United Nations Office on Drugs and Crime (UNODC). This report was undertaken in close collaboration with prevention experts in the UNODC.

Funding for this research was provided by the Department of Health under the national drugs strategy.

An Roinn Sláinte
Department of Health

UNODC
United Nations Office on Drugs and Crime