

The newsletter of
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to the EMCDDA

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Overview of alcohol and other drug use among children and young people in Ireland

Background

This 2022 overview analyses prevalence, trends, and harmful consequences of alcohol and other drug use among children and young people aged 15-24 years in Ireland.¹ The overview is a collation of published literature (both Irish and international), data from national information systems, and survey data specifically focusing on young people or where the survey or publication included young people. The overview also examined potential risk and protective factors that may influence substance use, along with responses to substance use and policies and legislation that govern alcohol and drug use in Ireland.



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In brief

The recently published Health Research Board overview on substance use among young people included some encouraging trends in relation to alcohol consumption. The age at which people start to drink has increased and more adolescents are abstaining from alcohol. In this issue of *Drugnet*, the overview's lead author reviews recent international literature on the topic of changing alcohol consumption behaviour. Explanations for these changes include increased parental awareness of the harms associated with early initiation of alcohol use, a greater emphasis on wellbeing among young people, and more time spent socialising online resulting in fewer opportunities to consume alcohol with peers.

The delay in initiating alcohol use is, of course, welcome. We know from longitudinal studies in many countries that this delay is an important protective factor for hazardous drinking and developing alcohol dependency later in life. While there is some interesting theorising on changes in alcohol use patterns, it is noteworthy that, given data available on all aspects of young people lives, these changes were not predicted.

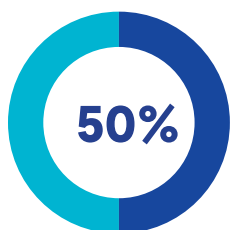
Policy-focused research is an attempt to identify trends that enable policymakers to respond effectively to what is expected to happen in the future. To be successful, this attempt must have some predictive power. Otherwise, how will we know what problems we need to prepare for? Of course, shifts in patterns of drug use do not happen quickly and treatment and harm reduction services have proven to be nimble in adapting to new situations. These are resources that have been developed over many decades and will continue to perform well. But how much better prepared would our responses be if the capacity to anticipate changes could be increased even by a small amount?

We have seen the emergence of foresight thinking in policy development, and a growing confidence that it is possible to shape future events through greater preparedness. This is not prediction, as such, but consideration of a range of responses to emerging phenomena. These approaches rely on observation of shifts in demographic, environmental, political, economic, and technological currents, and how these currents interact and shape each other. Information is gathered through empirical observation, secondary data analysis, and other techniques familiar to the social and health sciences.

When we consider how central the cultural lives of young people is in the decline in alcohol consumption, it is surprising that there has been limited attention to this sphere in anticipating future threats and response opportunities. Particular substances are associated with the prevailing youth culture, for instance the counterculture and experimentation of the 1960s or the search for community in the dance music scene of the 1990s. We should look closer at how young people today meet, play, and interact if we wish to anticipate directions in substance use.

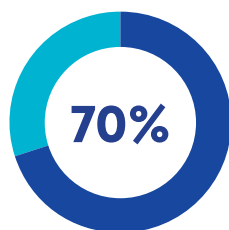
We have detailed information on young people's health, behaviour, and the concerns they have in negotiating the transition to adulthood. We also need to know how they decide on the combination of experiences that will bring them fulfilment, inclusion, and pleasure. This will involve exploring new methods for involving young people in research and using innovative approaches to study expressions of youth culture in popular media. Integrating findings from research outside the traditional health and social science disciplines will be a challenge, but the reward will be a greater appreciation of young people's lives and the culture they experience and help to create.

Overview of alcohol and other drug use continued



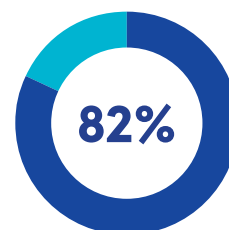
15-year-olds

26%
have been drunk



16-year-olds

46%
have been drunk



17-year-olds

62%
have been drunk

consumed alcohol in their lifetime

Key findings

Alcohol use

Alcohol is the most commonly used substance among young people in Ireland. The Public Health (Alcohol) Act 2018 acknowledges the issue of alcohol use, particularly among young people, and many of its components are specifically aimed at delaying initiation and reducing alcohol use. Survey data indicated a decrease in the number of young people aged 15–24 years who had used alcohol in their lifetime from 89% in 2002 to 74% in 2019 and the age of first alcohol use increased from 15.6 years to 16.6 years in the same period. Among a narrower age cohort (15–16 years), the decline in alcohol use was also obvious; however, it was less so among those aged 17 years.

Between 2002 and 2019, monthly heavy episodic drinking decreased from 74% to 56% among those aged 15–24 years, yet hazardous drinking was found to be commonplace for many (64%) and one in three young drinkers have an alcohol use disorder.

Parents or guardians were the most common source of alcohol for 16-year-old and 17-year-old schoolchildren and most drinking took place in their own home or a friend's home. Adolescents reported most commonly drinking alcohol to enjoy parties or to make social gatherings more fun. However, of concern were those who reported drinking alcohol to help when they are feeling depressed or nervous, to forget about their problems, or to cheer up.

Drug use

Over one-quarter of young people aged 15–24 years reported using an illegal drug in their lifetime (27%), 19% reported use in the last year, and 11% reported use in the last month. Last-year use of any illegal drug among young people plateaued between the period 2014 to 2019, although when examined by sex, males showed a decrease in illegal drug use, whereas females showed an increase. More than two in five third-level students who were current drug users reported using two or more substances on the same occasion.

Cannabis remains the most commonly used illegal drug by young people: 23% reported lifetime use and 15% reported last-year use. A decrease in last-year cannabis use was

observed from 16% in 2014 to 15% in 2019, although this decline was not reflected in the young female data, where an increase was shown. Lifetime cannabis use among 15–16-year-old schoolchildren was higher in Ireland (19%) than the average use across participating countries in the European Schools Project on Alcohol and Other Drugs (16%), and while many European countries have seen a decrease in lifetime use of cannabis since 2011, in Ireland its use has remained constant.

Cocaine use in the last year among young people increased from 3% in 2014 to 4.4% in 2019; although its use decreased among young males, from 5.1% to 4.2%, it increased among females (from 0.8% to 4.5%). Young people in Ireland were ranked second highest users of ecstasy and of cocaine in Europe.



Cocaine
use among young people
in Ireland was the
**2nd highest in
Europe**

Use of magic mushrooms declined between 2002 and 2019 as has the use of solvents; however, the use of poppers increased. The prevalence of new psychoactive substances (NPS) use among young people decreased as a result of legislation introduced in 2010 and the resulting head shop closures; last-year use decreased from 9.7% in 2010 to 1.7% in 2019.

Risk and protective factors

There are a number of protective factors that may help to prevent and/or delay substance use and reduce the potential for harm when use does occur. There are also risk factors in young people's lives that can contribute to early initiation or harmful use. Potential risk factors are early alcohol or other drug initiation; peer and/or parental substance use; parental provision of alcohol; certain personality traits; exposure to alcohol marketing; liberal parental attitudes to drinking and/or drunkenness; and parental or family conflict. Conversely, factors influencing young people to avoid or delay substance

Overview of alcohol and other drug use continued

19% of 15–24-year-olds have used an illegal drug in the last year (21% of males and 16% of females). The 3 most commonly used illegal drugs used in the last year were:



Cannabis



Ecstasy



Cocaine

use include having supportive parents, effective parental monitoring, and positive school experiences, including good grades and good relationships with teachers.

Consequences of alcohol and drug use

The harmful consequences of substance use are outlined in this overview, including the relationship between substance use and mental health. Adolescents classified as problem or hazardous drinkers were most likely to be in the severe category for depression and more likely to have engaged in deliberate self-harm or have attempted suicide. In almost three-quarters of suicide cases among young people, there was a history of alcohol and/or drug misuse. Cannabis users were six times more likely to report mental ill health compared with non-users.



Alcohol was present in **28%** of self-harm hospital presentations among young people

Alcohol-related hospitalisations among young people increased by 12% between 2015 and 2018, but decreased by 16% between 2018 and 2019, while drug-related discharges increased by 26% between 2015 and 2018 but decreased by 3.2% in 2019. Cannabis, followed by opioids and cocaine, accounted for the majority of drug-related hospitalisations, with cocaine-related hospitalisations increasing by 83% between 2015 and 2019.

The overview also examined Garda PULSE data and found that 14% of drink-driving arrests, 30% of drug-driving arrests, and 43% of controlled-drug-offences arrests were of young people aged 18–24 years. Data from the Road Safety Authority indicated that one-half (49%) of young driver fatalities during 2013–2017, with a toxicology result available, had a positive toxicology for alcohol.

Data from the National Drug-Related Deaths Index (NDRDI) indicated that 322 young people aged 15–24 years died due to drug or alcohol poisoning during the period 2008–2017; there were 412 non-poisoning deaths due to trauma (deaths

among people with a lifetime history of drug use/dependency, alcohol dependency, or where alcohol was implicated in the death) in the same period.

When examining Probation Services data, the majority of young people referred to its services had a history of drug and/or alcohol misuse (86%) and the link between their substance use and the crime committed was highlighted. Probation Officers commonly referred clients to appropriate services to address their alcohol and drug use.

Responses to alcohol and illegal drug use

Data from the National Drug Treatment Reporting System (NDTRS) indicated that during the period 2011–2020, some 8,608 cases of young people aged under 25 years received treatment due to their alcohol use and 27,569 for their drug use. The most common drugs for which treatment was received during that period were cannabis, opioids, and cocaine. Treatment for cocaine use increased substantially (171%) during the reporting period, while treatment for opiate use decreased.

Conclusion

Drinking behaviours are slowly changing with more young people delaying alcohol initiation or choosing not to drink at all. However, for many who do start drinking, a pattern of hazardous drinking emerges, often with harmful consequences. Although illegal drug use has plateaued, a change is evident in the increase in polydrug use and in use of stimulants, such as ecstasy and cocaine, along with an increase in the use of illegal drugs by young females.

The overview provides relevant and up-to-date information about the drug and alcohol situation among young people in Ireland, which is important for those who work with young people and for policymakers in order to respond effectively.

Anne Doyle

1 Doyle A, Sunday S, Galvin B and Mongan D (2022) *Alcohol and other drug use among children and young people in Ireland: prevalence, risk and protective factors, consequences, responses, and policies*. HRB Overview Series 12. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/36112/>

POLICY AND LEGISLATION

The cannabis policy debate

Cannabis for non-medical use (recreational use) is the subject of increasing policy debate across Europe. This debate reflects the complexity of the decisions to be made by policymakers and other stakeholders. While the penalties for using or possessing small amounts of cannabis for recreational use have been reduced in several European countries, recent developments in Luxembourg, Malta, and Germany suggest a more significant shift in policy trends in Europe (see Box 1).

To support an evidence-based debate and policy development process, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has produced a series of outputs on the topic. This article focuses on two of these outputs. First, a report on the experiences of the Americas in implementing policy change – *Monitoring and evaluating changes in cannabis policies: insights from the Americas* – and, second, discussions from a webinar held on Cannabis Control Approaches across Europe in October 2021.^{1,2}

It should be noted that this article is focused on cannabis for recreational use and not use for medical reasons or use as an ingredient in other products such as food or cosmetics. However, it is acknowledged that the new forms and emerging uses bring a complex set of challenges for European policy in this field.

Context – a more tolerant policy environment

The broader drug policy context is important when considering the changes in policy on recreational cannabis use. Support has been growing internationally for a move towards a more human rights and health-led approach to drug policy, away from the ‘war on drugs’ rhetoric of the more criminal-led approach. This is evident in key policy documents, including

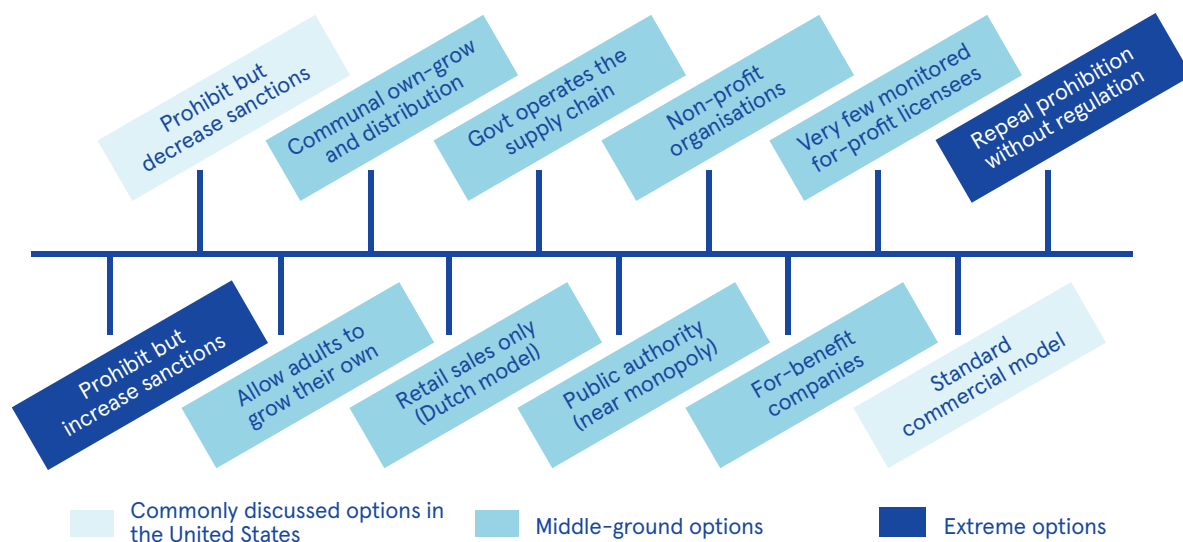
the European Union (EU) drugs strategy (2021–2025) and the outcome document of the United Nations (UN) General Assembly Special Session 2016.^{3,4} The harms caused by the prohibitionist approach to cannabis are well documented, as is its failure to reduce the prevalence of cannabis use. This has created a political environment which is increasingly accepting of adopting a less penalising model. This can take many forms along a continuum that includes depenalisation, decriminalisation, regulation, and legalisation.⁵

Developments in the Americas

The 2010s have seen the production and sale of cannabis for recreational use to adults legalised in Uruguay in 2013, Canada in 2018, and 18 states of the United States of America (USA), starting in 2012. Far from a homogenous shift in policy, the experience in the Americas has illustrated some of the wide variety of regulatory models that can be adopted and the complex nature of this policy debate. In January 2020, the EMCDDA published a technical report on *Monitoring and evaluating changes in cannabis policies: insights from the Americas*, as noted earlier.¹ The aim was to review the changes governing recreational cannabis policies in the Americas and the findings of any preliminary evaluations.

Implementing regulation in the Americas

The report highlights the heterogeneity in approaches adopted across the jurisdictions. Figure 1 (p. 13)¹ is used in the report to illustrate some of the alternatives to the status quo of prohibition of cannabis supply. While not the only option adopted in the US, the for-profit commercial model is common. However, Uruguay and Canada have adopted more restrictive models. They have created regulatory regimes with an intention to limit the power of private businesses in the market. Uruguay was the first country to operate a state-run dispensary system. The authors note that the options in Figure 1 are not mutually exclusive. For example, most jurisdictions allow both home production and commercial sales of cannabis. The overall message from this part of the report was that the motivations driving the policy change, the legislative frameworks, and the models implemented are varied and comparing their implementation and impact is complex.



Source: EMCDDA (2020),¹ Figure 3.1, p. 13. Originally sourced from JP Caulkins *et al.* (2015) *Considering marijuana legalization*. Santa Monica, CA: RAND Corporation.

Figure 1: Some alternatives to status quo cannabis supply prohibition

The cannabis policy debate continued

Impact of regulation

In the report, a literature review was carried out of studies that would provide preliminary evaluative evidence of the different models. Among the insights highlighted by the authors were that:

- The peer-reviewed literature on cannabis legislation is very new and there are conflicting results depending on the data and methods used.
- Applying causality to data such as those on emergency department admissions is problematic given the range of other factors that could be influencing reporting or measurement.
- There is a lack of reliable and adequate data for a before-and-after comparison of the introduction of regulation.

The overall message was that the evidence base was still ‘insufficient to comment with any certainty on the impact of the changes that are occurring in the Americas’ (p. 6).¹ Two years after publication, this continues to be the case.

Cannabis control in Europe

The EMCDDA’s webinar on cannabis control approaches in Europe brought together experts in the field to reflect on the current situation and possible future scenarios.² There was consensus that the policy landscape and attitudes towards cannabis have changed in Europe, in line with the more health-focused policy context outlined above. Malta, Luxembourg, and Germany (see Box 1) are key examples of where this shift is happening. While the webinar identified a wide variety of issues, there were three that dominated the discussion:

- The restrictive nature of international drug laws and agreements
- The challenges of monitoring and evaluating the impact of policy change
- The risk of ‘corporate capture’.

Restrictions of international drug laws/agreements

While European countries may have internal drivers for changes to their cannabis laws, there are external influences that put limitations on the changes that can be made. The situation is complicated by the existence of international drug laws or agreements. Signatories must be cognisant of the restrictions they place on an individual country’s options vis-à-vis their drug laws. Two of those relevant in the European context are:

- The 1961 UN Single Convention on Narcotic Drugs, to which all EU member states are signatories.⁶ Signatories commit to prohibit the production, manufacture, export and import of, and trade in scheduled drugs (which includes cannabis). It also limits their legal use to medical and scientific settings.
- The 2004 European Council Framework Decision (2004/757/JHA) allows for the possession and cultivation of cannabis for ‘personal consumption as defined by national law’ (Article 2.2).⁷ Anything beyond personal cultivation/consumption would be contrary to EU rules and regulations.

Therefore, any country that is a signatory of the UN convention and opens a regulated market is technically breaking international law, as is the situation with Uruguay, Canada, and certain US states. European countries would be breaking both agreements.

These restrictions have led to what was termed in the webinar as a ‘repetitious pattern’ in recent European policy. Some localities or whole countries propose sweeping changes to their cannabis laws, but as a result of international pressure modify their proposals to reflect more modest changes that sit within the 2004 EU Framework Decision (see Box 1).

Drug policy debates tend to be divisive and emotive. Tensions will inevitably arise within the EU if countries pursue models of regulation that violate these international agreements. Therefore, there is a need for constructive debate at European level to avoid tensions escalating among EU members over the changing policy landscape. It was argued that Europe is diverse and rules need to be made that respect that diversity.

At a more global level, it was noted that there is no appetite internationally to change the UN convention. However, as a group, countries that want to regulate cannabis could do so via a ‘late reservation’ to the convention. While this would be a challenging process, it presents an alternative to breaking international law. This was the approach successfully taken by Bolivia in relation to the cultivation and use of the coca leaf.

Monitoring the impact of policy change

Rigorous data and analysis are essential to be able to assess the impact of policy changes on the outcomes it sets to achieve. The webinar discussions illustrate that much work has yet to be done on developing this evidence base. For example, the European School Survey Project on Alcohol and Other Drugs (ESPAD), which collects comparable data on substance use among 15–16-year-old students to monitor trends within as well as between countries, was discussed. Among the key messages was that there is no simple correlation between a country’s cannabis-related penalties and its rates of lifetime or harmful use among young people. The relationship between a country regulating their cannabis market and the disappearance of the illicit market also needs further research. An overall message was that countries need to identify the outcomes they want to achieve by making changes to their cannabis laws and collect rigorous evidence to understand if these are being achieved and any unintended consequences of the changes.

Corporate capture

There was concern expressed by speakers about the corporate capture of regulated cannabis markets, as evidenced in the US and the increasing lobbying power of the industry globally. If not managed correctly, it was suggested that they would end up playing a similar role in the market and policy development as Big Tobacco and the alcohol industry. This would not be compatible with regulation models that have harm reduction at their core. In his closing remarks to the session, EMCDDA director Alexis Goosdeel argued that the needs of the user and the reduction of harms should be the drivers of policy decisions, not the interests of the cannabis industry.

Concluding comment

Changes in cannabis control are apparent in the Americas and more recently in Europe. These changes are not without their challenges. They have the potential to undermine the value of international laws and agreements more broadly. Where the motivation for changing policy is to reduce the harms caused by the status quo, the situation will need to be closely monitored and evaluated to ensure these outcomes are being achieved. Any unintended negative outcomes will also need to be monitored and minimised with the rollback or amendment of policies as necessary. A rigorous evidence base will be required to support these decisions. Reducing the harms will need to remain central to the policymaking and legislative process, and not be usurped by the business interests of the cannabis industry.

The cannabis policy debate continued

Recent developments in policy on non-medical (recreational) cannabis use in Europe

Malta

In December 2021, Malta became the first European country to legalise limited cultivation and possession of cannabis for personal use. The commercial cultivation and selling of cannabis for recreational use remains prohibited. Some of the key elements of Malta's Responsible Use of Cannabis Act are:

- Residents aged 18 and over are allowed to grow up to four cannabis plants per household and keep up to 50 g at home. Possession outside the home is limited to 7 g.
- Smoking cannabis in public or in front of a child are against the law and subject to fines.
- Anyone who has a criminal record for cannabis possession can request it to be removed.
- Cannabis associations are permitted through which members can access up to a maximum of 7 g of cannabis per day and 50 g per month.
- A new regulatory authority was created to oversee the cannabis sector – cannabis associations are required to register and report to the authority.

Luxembourg

The programme for government in Luxembourg for 2018–2023 outlined plans to establish a chain of production for cannabis and its sale under the control of the state for those aged 18 years and over, for recreational use. The proposed shift in policy was driven by aims including to move users away from the illicit market, to reduce the psychological and physical harms, and to tackle crime at the supply level. However, in June 2022, the government introduced to parliament a draft law that outlines a more restricted shift in their policy. It is understood that this was at least in part as a result of commitments to international laws and agreements. The draft legislation will legalise limited cultivation (four plants per household) and possession of cannabis for personal use for those aged 18 and over. Use in public will remain prohibited, subject to a fine. As of September 2022, the law had yet to be passed by the country's parliament.

Germany

Germany plans to take a more sweeping approach to regulating cannabis when compared with Malta and Luxembourg. The coalition government formed in September 2021 agreed to legislate for a regulated cannabis market that would allow for the licensed cultivation and sale of cannabis to adults aged 18 years and over from regulated stores. While the implementation structure of the new laws is the subject of ongoing discussion, it is expected that there would be regulated and taxed dispensaries and quality controls. Consultations with key stakeholders concluded in July 2022. A more detailed timetable for the introduction of the new legislation has yet to be confirmed but it is expected that a draft Bill will be forthcoming by the end of 2022. The implications for international laws and agreements remain unclear.

Lucy Dillon

- 1 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2020) *Monitoring and evaluating changes in cannabis policies: insights from the Americas. Technical report*. Luxembourg: Publications Office of the European Union. <https://www.drugsandalcohol.ie/31594/>
- 2 EMCDDA (2021) Cannabis control approaches across Europe [webinar]. 27 October 2021. Available online at: https://www.emcdda.europa.eu/media-library/emcdda-webinar-cannabis-control-approaches-across-europe_en
- 3 Council of the European Union (2020) *EU drugs strategy 2021–2025*. Brussels: Council of the European Union. <https://www.drugsandalcohol.ie/33750/>
- 4 United Nations Office on Drugs and Crime (UNODC) (2016) *Outcome document of the 2016 United Nations General Assembly Special Session on the world drug problem: our joint commitment to effectively addressing and countering the world drug problem*. Vienna: UNODC. Available online at: <https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf>
- 5 For a clear description of the distinction between depenalisation, decriminalisation, regulation, and legalisation, visit: https://www.emcdda.europa.eu/media-library/motion-graphic-what-decriminalisation-drugs_en
- 6 The 1961 UN Single Convention on Narcotic Drugs, as amended by the 1972 Protocol. Available online at: <https://www.unodc.org/unodc/en/treaties/single-convention.html?ref=menu#:-:text=Single%20Convention%20on%20Narcotic%20Drugs%2C%201961&text=First%2C%20it%20seeks%20to%20limit,to%20medical%20and%20scientific%20purposes>
- 7 Council of the European Union (2004) Council Framework Decision 2004/757/JHA of 25 October 2004. Brussels: Council of the European Union. Available online at: <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32004F0757&from=EN>

Overview of 65th session of Commission on Narcotic Drugs

The Commission on Narcotic Drugs (CND) is the governing body of the United Nations Office on Drugs and Crime (UNODC). The 65th session of CND was held in Vienna on 14–18 March 2022.

Background

CND is the central drug policymaking body of the UN. It aims to provide member states and civil society with the opportunity to exchange expertise, experiences, and information on drug-related matters and to develop a coordinated response to the drugs situation. Membership is made up of representatives from 53 UN member states, allowing for a spread of geographical representation. Ireland is not currently a member of CND.

Russian invasion of Ukraine

While not usually a forum for debate on wider geopolitical issues, the Russian invasion of Ukraine featured heavily at the session. Many members formally expressed their support for Ukraine and their unconditional condemnation of Russia's actions. The Russian delegation created unprecedented disruption by forcing a vote (which they lost) on an issue that has historically always been decided through consensus. They were blocked from becoming the representative of their region on the CND Bureau, which is the working group responsible for oversight of various budgetary and administrative functions of the UNODC. Their proposed resolution on the misuse of information technologies for illicit drug trafficking and money laundering also failed, after all European Union (EU) countries and others, including the United States and Canada, refused to negotiate Russia's proposal.

Resolutions and scheduling of substances

CND is the forum in which member states discuss the drugs situation and adopt relevant resolutions. At the 65th session, it adopted four resolutions by consensus on:

- Promoting alternative development as a development-oriented drug control strategy, taking into account measures to protect the environment
- Strengthening international cooperation to address the links between illicit drug trafficking and illicit firearms trafficking
- Promoting comprehensive and scientific evidence-based early prevention
- Intensifying efforts to address the diversion of non-scheduled chemicals frequently used in the illicit manufacture of drugs and proliferation of designer precursors.

CND also has the power to adopt proposals made by the World Health Organization (WHO) and the International Narcotics Control Board (INCB) to schedule, de-schedule or re-schedule substances under international control. At the 65th session, it agreed to do so for one cathinone/stimulant, two novel synthetic opiates, and three fentanyl precursors.

Overarching debate

Overall, debate at the plenary sessions of CND indicated an ongoing shift among many (although not all) member states for a move towards a more human rights and health-led approach to the drugs issue and away from the more criminal-led approach. There was a joint call to action by CND and UNODC with WHO and INCB to ensure availability and access to controlled substances for medical and scientific purposes. The need for a gender perspective in policies to reflect the specific needs of women also arose quite often.

Side events

As well as plenary sessions, there were over 120 side events held.¹ These side events were organised by member states, UN entities, and international or civil society organisations. They covered a wide range of topics related to the supply and demand reduction aspects of the drugs situation, including: cannabis regulation; gender perspectives; the needs of children of people who use drugs; links between drugs and development; prevention; trafficking; cultivation; human rights of people who use drugs; civil society's role in drug policy; links between drugs and the environment; the death penalty and drug offences; and drug policy and prisons.

Most of the sessions were recorded and are available to watch on YouTube and other fora. Readers are recommended to look through the schedule of events and contact the organisers for recordings and materials from sessions of interest.

Lucy Dillon

¹ The full schedule of side events at the 65th session is available at: https://www.unodc.org/unodc/en/commissions/CND/session/65_Session_2022/mon_14_march_side-event.html

RECENT RESEARCH

Gambling in Ireland: profile of treatment episodes from a national treatment reporting system

A new Health Research Board (HRB) study examines 3,000 cases treated for problem gambling in Ireland between 2008 and 2019.¹ The study published in May 2022 in the *Irish Journal of Psychological Medicine* is the first Irish national study using routinely gathered health surveillance data to describe treated problem gambling.

Background

Globally, problem gambling prevalence is estimated at between 0.1% and 5.8%.² Problem gambling can have many negative consequences, including impacts on physical and psychological health and social functioning. The most recent Irish figures from 2022 show that almost one-half of the population (49%) engage in gambling, while the prevalence rate for problem gambling among the general population is 0.3%, indicating there are 12,000 people with problem gambling in Ireland.³ Little is known about gambling behaviour in Ireland⁴ and there is a need to better understand treatment uptake, as only a small proportion of people with problem gambling seek treatment.⁵

Methods

An analysis of episodes treated for problem gambling collected by the National Drug Treatment Reporting System (NDTRS)⁶ was undertaken. The analysis was based on voluntary submission of data on problem gambling⁷ to the NDTRS. Included were episodes entering treatment between 2008 and 2019 (n=2999) where gambling was reported as a main or an additional problem.⁸ Variables of interest included service types accessed, demographics, socioeconomic information, referral and assessment details, current problems (up to five), and treatment history.

Key findings

- The majority of cases were male (93.8%).
- Just over one-half (52.7%) reported gambling as their sole problem, while 47.3% of cases were also associated with problem substance use.
- The median age entering treatment was 34 years.
- Just over one-third (35.4%) were in paid employment and more than one-half (53.8%) had completed secondary or third-level education.
- The majority (86.1%) lived in stable accommodation.
- The majority of cases were treated at inpatient settings (56.1%), followed by outpatient treatment (38.7%).
- The most common source of referral to treatment was self-referrals (46.3%) and referrals from family/friends (20%).

Referrals by health professionals were low: 6.9% were referred by general practitioners (GPs) and 4.4% by mental health professionals.

Gambling only and gambling along with substance use

Problem gambling frequently co-occurred with substance use (47.3%). The most common problem drugs reported alongside gambling were alcohol (85.6%), followed by cannabis (32.3%), cocaine (28%), and benzodiazepines (10.9%).

There were significant differences between those treated for gambling only and those treated for gambling and substance use.

- Cases treated for gambling only were more likely to be in employment, have completed secondary or third-level education, and be living with dependent children. They were more likely to receive outpatient treatment and be referred by GPs or health professionals.
- Cases treated for gambling and additional problem drug or alcohol use were more likely to have left school early, be unemployed, and 1 in 10 are likely to be homeless. They were more likely to attend inpatient services and be referred by another drug treatment service, outreach worker, or the legal system.

Discussion

Problem gambling affects not just those who gamble but also those around them. The potential impact of parental gambling on children is evident with 1 in 5 cases living with dependent children. Furthermore, one-half of cases started gambling before the age of 17 years. This study provides insights into treated problem gambling nationally and highlights the need for a national database on gambling treatment to be established. A systematic approach to collecting and analysing data about those who seek treatment for problem gambling over time would improve understanding about why people present for treatment, improve referral pathways, and inform policy and planning.

Ita Condon

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Gambling treatment in Ireland

continued

- 7 The primary purpose of the NDTRS is to capture data on problem drug and alcohol treatment. Service providers can voluntarily submit data where the main problem is a process addiction such as gambling, eating, spending, gaming/internet, sex or pornography.
- 8 The data reflect the number of entries into treatment in a calendar year, rather than the number of persons treated in that year.

Decline in alcohol use among young people: potential consequences for public health policy, legislation, and discourse

Background

Alcohol is the most commonly used drug by young people, with adolescents traditionally using alcohol as a rite of passage to adulthood. A key period for experimentation and risk-taking, it is also a particularly risky time to do so, not only because of the impact alcohol can have on the developing brain but also due to early alcohol initiation increasing the risk of hazardous and harmful drinking in the future.¹⁻⁴

Globally, in 2019, alcohol use ranked second for attributable disability-adjusted life-years (DALYs) among adolescents and young adults aged 10–24 years.⁵ Alcohol contributes to all the leading causes of death for young people: suicide, road traffic collisions, poisoning, and assaults, while long-term use is linked to seven different types of cancer, cardiovascular disease, and liver disease.^{6,7} Consequently, delaying and/or reducing alcohol use among young people has been key to the World Health Organization's (WHO) policies and recommendations and on which, here in Ireland, the components of the Public Health (Alcohol) Act 2018 are based.⁸⁻¹⁰

Given the devastating impact that alcohol can have not only on the individual and their family but also population-wide, it is a welcome finding that survey data from around the world, particularly high-income countries, indicate that youth drinking is in decline and that although some young people are still drinking, and drinking in risky ways, fewer young people overall are choosing to drink and those that do are starting later.¹¹⁻¹⁴

Possible explanations for decline in youth drinking

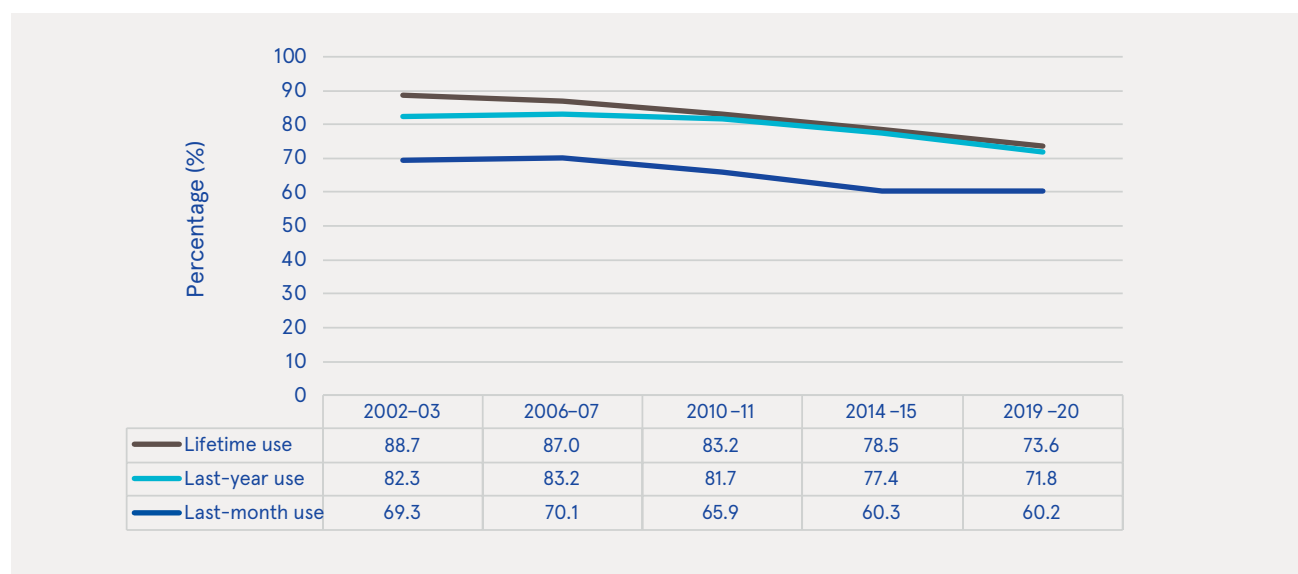
Several theories have been proposed to explain why more young people are deciding not to drink. Changes in parenting styles and relationships is one such theory. As parents become more aware of, and concerned about, protecting their children from alcohol-related harms, there is increased monitoring and control of alcohol use.¹⁵ The Irish Census, which indicated a 4.4% increase between 2011 and 2016 in adult children living at home with their parents, may conclude that declining alcohol use and the restraining effect of living at home are interrelated, extending adolescence and restricting independence.^{16,17} Also proposed is a byproduct of the digital revolution, where gaming and socialising among young people take place online.¹¹

Attitudes towards alcohol have also changed among young people themselves. They are deemed to be more conscientious about school and their physical and mental health and do not view alcohol as an important aspect of their social lives, with a resultant normalisation of non-drinking.^{11,13,14} Alcohol use is no longer uniformly seen as a rite of passage, there is less time going out with friends, peer pressure to drink has declined, and there is more room for individual choice as adolescents are spending more time cultivating the individual self.^{11,13,18} An adverse characteristic of millennials and Generation Z is the rise in poor mental health, the increasing uncertainties in employment and housing opportunities, and the additional burden of global matters such as eco-anxiety and war. Combined, these factors may also influence the decision not to use alcohol; rather they are more self-conscious and less inclined to consume any product excessively (e.g. meat, dairy, and alcohol).¹⁷

These cultural shifts as well as that of increasing immigration in many high-income countries from communities that do not drink alcohol have been proposed as factors in reducing overall drinking trends.¹⁹ Also influencing young people's behaviour are the competing activities in their lives that do not involve alcohol, such as schoolwork, competitive sports, and the aforementioned gaming and social media use.^{11,15} The successful public health campaigns and legislation introduced worldwide in reducing tobacco use may also be a factor in declining alcohol use. Traditionally, tobacco was seen as a 'gateway' to alcohol use, and the significant reduction in tobacco use may have unintentionally contributed to the decrease in alcohol use among young people.^{12,20}

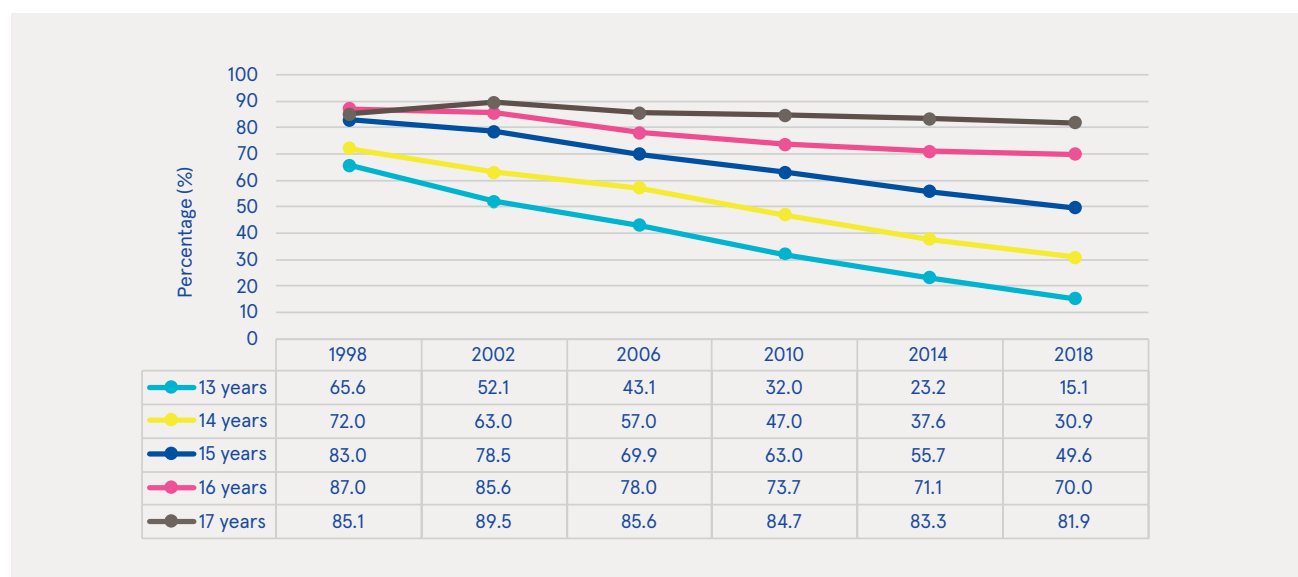
Although difficult to measure their exact impact, public health campaigns and government policies tackling alcohol use have also been attributed to the decline, especially those that focus on alcohol availability and affordability.

Decline in alcohol use among young people continued



Source: Mongan *et al.* (2021)²¹

Figure 1: Trends in alcohol consumption among young people aged 15–24 years, 2002–2020



Source: Gavin *et al.* (2021)²²

Figure 2: Trends in alcohol consumption among adolescents aged 13–17 years, 1998–2018

Does the international decline in youth drinking include Ireland?

In Ireland, alcohol use appears to have been declining among young people aged 15–24 years since the mid-2000s. Last-year alcohol use has steadily declined since the 2006–07 National Drug and Alcohol Survey (NDAS) (see Figure 1), reducing by 14% between that survey and the one carried out in 2019–20, meaning the number of teetotaler young people increased from 17% in 2006–07 to 28% in 2019–20.²¹ The decline in youth drinking is more pronounced among females than males; a 16% decrease in last-year drinking was noted among young females 15–24 years between 2006–07 and 2019–20 (82–69%) compared with a 12% decrease among young males (85–75%).

When examining a narrower age cohort, such as the Health Behaviour in School-aged Children (HBSC) survey, Figure 2 illustrates the decline in alcohol use among adolescents aged 13–17 years between 1998 and 2018, where the decline is particularly evident among those aged 13–16 years. The decline is less pronounced among 17-year-olds.²² Reports of lifetime drunkenness among HBSC adolescents have also declined among those aged 13–16 years with, for example, a 45% reduction in the number of 15-year-olds reporting lifetime drunkenness between 1998 (48%) and 2018 (26%). However, a less noticeable decline was noted among 17-year-olds reporting drunkenness, just 5% in the same period (from 65% to 62%).

Decline in alcohol use among young people continued

The decline in adolescent drinking was also observed in the European School Project on Alcohol and Other Drugs (ESPAD), where a 41% decline among 15–16-year-olds in last-month alcohol use was noted between 1995 (69%) and 2015 (36%). However, the downward trajectory reversed between 2015 and 2019 and a 14% increase in last-month alcohol use was noted; alcohol use in the last month had increased to 41% in 2019.²³

Is youth drinking definitively in decline in Ireland?

The data presented here indicate at first glance that alcohol consumption has decreased among young people in Ireland. However, when smaller age groups are examined, it appears that this overall decline is being driven by younger adolescents, particularly those less than 17 years. While it is indisputable that young people are delaying alcohol initiation, what appears to be happening is that once they do start drinking (on average at 16.6 years), hazardous drinking, including binge drinking, is commonplace.

By looking at wider age cohorts, such as 15–24 years, perhaps the true scale of youth drinking in decline is being disguised and, in fact, propped up by changing behaviours in 13–16-year-olds. The dramatic decrease in lifetime alcohol use over these years is a finding that would make researchers and policymakers alike believe that alcohol use among young people is a problem solved. However, it is important that public health actors do not get complacent and continue to pursue best practices when it comes to delaying and preventing alcohol use among young people.

Youth drinking in decline: implications for public health, public policy and public debate

A paper published in early 2022, ‘Youth drinking in decline: what are the implications for public health, public policy and public debate?’ considers how the decline in alcohol use among young people may evolve in the future and what it implies for public health, public policy, and public debate.²⁴

How will youth drinking trends develop in future?

It is too early yet to predict the impact that the Covid-19 pandemic will have on this overall decrease in youth drinking. However, surveys carried out during the pandemic indicated that, overall, young people were less likely to increase drinking due to the lockdowns.^{25,26} There is evidence that the decline in youth drinking is slowing and trends stabilising, although not reversing. Room *et al.* suggest that due to the large-scale, long-term structural and cultural shifts, the decline is likely to be sustained despite the availability and affordability of alcohol as well as the pervasive alcohol marketing and pleasures associated with alcohol use.²⁷

The fear, however, is that the decline in youth drinking, although welcomed, could result in complacency from public policy actors; encourage lowering of alcohol taxes; an easing of policies and practices in place; and less discourse of alcohol-related harms, along with a drive by the alcohol industry to act on this complacency to renew efforts to boost alcohol sales. Despite concerns, it is important to consider how the decline in youth drinking will translate into improvements in public health.

What will the decline mean for public health?

Reductions in early initiation of alcohol use among schoolchildren and the ensuing overall decline in alcohol use among young people is likely to result in public health benefits, from reductions in road traffic collision deaths, assaults, suicide, self-harm, poisonings, and dependence. However, establishing the potential impact on alcohol-attributable diseases will be more complex due to long latency periods as well as other competing health issues, such as drug use, smoking, and obesity.

Also to be considered is whether the decline is limited to certain sociodemographic groups, for example, females and/or those from lower socioeconomic groups who bear a disproportionate burden of harm from alcohol use, and whether the harm now becomes concentrated among older, heavier drinkers.

What will the decline mean for public debate and policy?

Holmes *et al.* consider two model scenarios that may result from the decline in youth drinking: the reinforcement scenario and the withdrawal scenario.²⁴

The reinforcement scenario

The reinforcement scenario is based on the prediction that as young people continue to abstain from alcohol into older adulthood and focus on healthier practices that alcohol-related harms reduce. Alcohol-related harm thus becomes viewed as a manageable problem resulting in governments no longer working in partnership with the alcohol industry, as they reap the political rewards of successful, evidence-based and popular public health alcohol control policies.

The reinforcement model is based on alcohol use replicating the tobacco experience, whereby increased negative attitudes towards smoking, multiple effective policies in place, and increased tobacco control reduced smoking. Typically, in public discourse, alcohol is not framed as a black-and-white issue in the way that smoking is. In practice, this means it is hard to form a public consensus against drinking, which in turn leads to challenges in getting public buy-in to alcohol policy interventions. This is particularly evident in relation to a lack of success in public health measures addressing youth drinking.

The withdrawal scenario

An alternative scenario, one that Holmes *et al.* consider more probable, is the withdrawal scenario that envisages a population that drinks less and is therefore unconcerned with alcohol-related problems. Motivation to address alcohol-related harm is reduced, particularly due to the emphasis on the economic consequences of restricting alcohol sales, which would see a lack of support from government for public health measures and a continuation of government and alcohol industry partnerships, reducing the effectiveness of restrictive policies, while focus (and resources) turn to other public health challenges.²⁸

The withdrawal scenario predicts an easing of alcohol restrictions and extended periods of fluctuating trends of alcohol use, as well as, potentially, global corporations using the apparent success of reducing youth drinking to partner with governments of low-income and middle-income countries in order to expand their markets and secure influence over government policymaking.²⁹

In recognition of the lack of policymakers’ support, public health actors may alternatively turn their attention to more focused alcohol issues that are deemed manageable, or those arguably less contentious, such as campaigns around short-

Decline in alcohol use among young people continued

term temperance like Dry January, calorie labelling, and no-alcohol or low-alcohol drinks. This approach may thus be viewed in a more favourable light as opposed to that of the reinforcement model or, indeed, the withdrawal scenario.

Conclusion

In the face of an improving public health trend, that of a decline in youth drinking, both scenarios illustrate the challenges presented for public health actors. The authors conclude by highlighting suggestions to consider, namely, to increase our knowledge of the reasons for the decline in youth drinking; to understand children's and young people's attitudes towards alcohol and alcohol policy to improve the effectiveness of future policies; for public health actors to continue to advocate for governments to address the weaknesses in existing alcohol policy environments; and, finally, for public health actors to consider their ultimate aim or end goal, especially if alcohol-related harms decline.

Anne Doyle

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Associations between mental health, alcohol consumption, and drinking motives during Covid-19 second lockdown in Ireland

Background

The Covid-19 pandemic, declared in March 2020, has had a profound impact on the lives of people worldwide, particularly on mental health, as lockdowns resulted in lost incomes, health fears, and isolation, all of which are risk factors for increased mental health problems and alcohol use. Alcohol use as a response to stressful life events increases an individual's risk of developing alcohol problems.¹ In addition, it weakens the immune system, which in turn reduces immunity to viral infections such as Covid-19.^{2,3} Studies carried out earlier in the pandemic indicated that older people were more likely to have increased their alcohol use, with stress and depression cited as reasons for the increase.^{4,5} A cross-sectional study in Ireland aimed to determine the drinking motives and changes in alcohol use later in the pandemic during the second lockdown, in October–December 2020, along with psychopathological symptoms.⁶

Methods

The online survey involved 713 adult participants. The Alcohol Use Disorders Identification Test–Concise (AUDIT–C) was used to measure alcohol use and patterns of use, and participants were asked to complete the survey based on what their normal drinking patterns were prior to the pandemic as well as during the last month (during the pandemic). To assess motives for drinking during the lockdown, the Drinking Motives Questionnaire–Revised (DMQ–R) was used, which asked participants to provide reasons for their drinking: enhancement, coping, social facilitation, or conformity motives. The Brief Symptom Inventory (BSI) assessed their level of anxiety, depression, and loneliness due to the Covid-19 situation, while the Global Severity Index (GSI) measured the participant's distress level. A Likert scale based on the *Report on the social implications of Covid-19 in Ireland* assessed their perception of the negative impact of Covid-19 distress.⁷

Results

The mean age of the participants was 35.77 years and the majority were female (68%). Comparing the AUDIT–C scores before and during the pandemic, the data indicated that the majority of participants decreased their alcohol use (65.8%), 19.6% remained unchanged, and 14.6% increased their alcohol use, with no gender differences identified.

Older age was associated with increased alcohol use, and the authors refer to evidence of older age alongside alcohol use weakening the immune system as both increasing

the individual's risk of Covid-19. In fact, the World Health Organization (WHO) specifically recommended that older adults reduce their alcohol intake.⁸

Drinking to cope with the impact of the pandemic to relieve negative mood/state (also referred to as 'self-medicating') was also associated with increased alcohol use. Those who indicated low social facilitation on the DMQ–R, i.e. those who were less likely to report social purposes for drinking prior to the pandemic, were also more likely to consume alcohol during the pandemic. Increased alcohol use as a response to stressful life events has been associated with the development of alcohol-related problems.

The study also reported that those with higher psychopathological symptoms during the Covid-19 lockdown, as measured by the GSI, were more likely to report depression, loneliness, and anxiety attributed to the pandemic. In particular, depression scores and hostility (e.g. anger or frustration), as measured using the BSI, were the strongest predictors of drinking to cope.

Conclusion

The authors conclude by highlighting the vulnerability of older people in a vicious cycle of drinking during the pandemic to reduce anxiety, and yet noting that alcohol has depressogenic effects. This vulnerable group are also at increased risk of Covid-19 and thus are a group that would benefit from interventions aimed at enhancing their coping skills.

Anne Doyle

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Exploring serious and organised crime across Ireland and the UK

In March 2021, the Azure Forum for Contemporary Security Strategy, with the support of the British Embassy in Dublin, launched a report examining serious and organised crime in Ireland and the United Kingdom (UK).¹ The aim of this report was to conduct a qualitative assessment of information that was publicly available about serious and organised crime to determine how criminality occurs across and between Ireland and the UK. The report considers methods and activities that make up serious and organised crime along with the wider criminal markets where criminal behaviour takes place. It focuses on three issues: human trafficking, drug trafficking, and economic crime.

Methodology

Over 300 documents from a range of sources, such as journals, book chapters, speeches, presentations, expert blogs, and researcher blogs were identified in the literature review. Additionally, reports published by government departments, law enforcement agencies, and advisory bodies were included along with reports published by charities, non-governmental organisations, and think tanks. Due to the transnational nature of criminality in the UK and Ireland, the author also drew on European and international literature related to serious and organised crime. In order to get further insight into serious and organised crime in these jurisdictions, semi-structured interviews were carried out with law enforcement practitioners (n=15) from An Garda Síochána (AGS) and the Police Service of Northern Ireland (PSNI).

Key findings

Cross-cutting criminal enablers

Four 'cross-cutting' enablers that made different types of serious and organised crime possible across Irish and UK jurisdictions were identified and examined.

- Digital technology:** Use of technology has become the most significant enabler of serious and organised crime. As acknowledged by the European Commission, approximately 85% of all crimes are considered to have a digital component.² Secure communications platforms that avail of end-to-end encryption, such as WhatsApp and Telegram, have contributed to a changed landscape which is resilient in the face of law enforcement takedowns.
- Exploitation of national borders:** While criminality online has increased, exploiting national borders remains essential for all types of serious and organised criminal activity; for example, in the movement of drugs, people, firearms, and cash. The land border between Northern Ireland (NI) and Ireland has provided many layers and facets in the facilitation of criminal activity, influencing how offenders and markets operate on the island of Ireland and within the Common Travel Area. Moreover, cross-border cooperation between organised crime groups (OCGs) in NI and Ireland is well-known, as are groups that commit crime in both jurisdictions.¹

- Professional and public sector corruption:** OCGs count on the involvement of 'active or passive' corrupt individuals working in professional and public sectors (p. 20).¹ Fortunately, corruption within Irish law enforcement and justice agencies is rare but remains a risk for both Ireland and the UK.
- Criminal use of firearms:** In the main, illegal firearm possession and use in Ireland and the UK remains low when compared with international standards. However, there is evidence of more firearm seizures alongside drug seizures and more firearm-related violence among OCGs involved in drug trafficking in Ireland when compared with similar groups in the UK.

Modern slavery and human trafficking

While slavery and human trafficking is closely linked to serious and organised crime, it is not straightforward but more 'complicated and nuanced' (p. 23).¹ The author examined the relationship between human trafficking and human smuggling and stressed how victims may move between both several times on their journey. Typically, human smuggling ends when the victim arrives at their destination; however, often the victim is exploited en route or at their final destination or both. The main markets, methods, and offenders involved are considered in the report. Trafficking is centred on three markets: criminal exploitation, labour exploitation, and sexual exploitation.¹ In Ireland, sexual exploitation is prominent, followed by labour exploitation and then criminal exploitation. Victims of trafficking are exploited in the drugs trade; for example, in the cultivation of cannabis where they are used for supervising plant growth, drying out their leaves, removing buds, and packing bags for onward transportation and sale.¹

Drug trafficking

The UK and Ireland are considered 'highly lucrative markets' for criminal networks involved in the importation and supply of illicit drugs (p. 30).¹ Trafficking methods that are frequently used include air; maritime via roll-on/roll-off ferries and foot passengers; and the postal system via regular mail or courier services. The report explored supply and retail trades in cannabis, cocaine, heroin, and synthetic drugs. The movement of drugs into and within Ireland and the UK displayed similar features. However, divergences were also evident, particularly in the amphetamines market and in the retail supply of heroin and crack cocaine, which for now is only evident in the UK. Due to the close proximity and relationship between Ireland and the UK, the Common Travel Area, the 'all-island nature' of the drugs trade in Ireland and NI (p. 37), the author has called for vigilance as changes in trends in one country will likely influence the other.

Economic crime

Due to the similarities between the British and Irish economies, both countries are vulnerable to illicit asset laundering from overseas and/or domestic criminality. However, there are differences between both jurisdictions: in the UK, 'a sophisticated laundering infrastructure' has been documented and threatens the existing financial system (p. 43).¹ In contrast, in Ireland, the targeting of domestic criminal finance has presented a challenging environment for OCGs involved in money laundering, who lean more towards cash. Overseas illicit financial movement is currently underdeveloped in Ireland as is the use of cryptocurrencies for laundering purposes.

Exploring serious and organised crime across Ireland and the UK

continued

Limitations of study

The author acknowledged several limitations in the report. For example, while the literature review was extensive it relied on publicly available data and did not include sensitive intelligence that would normally be included in organised threat assessments. Nor were insights from network analyses or interviews with offenders themselves included. Due to the thematic focus of the report, it was not possible to include other types of information. Time constraints also resulted in the prioritisation of some topics over others. The broad geographic area of Ireland and the UK resulted in the loss of information that might have been gleaned at a local and regional level.

Recommendations

Several recommendations were put forward by the author, as follows.

- 1 There should be increased drug market monitoring.
- 2 Comprehensive research projects funded by Irish and UK justice agencies should map the nature and scale of human trafficking between the island of Ireland and the UK.
- 3 UK and Irish agencies should consider harmonising data collection and analysis on human trafficking.
- 4 The Irish Department of Justice should consider establishing an independent 'technology futures' research advisory group.
- 5 A joint research programme should explore and monitor the role of crypto-assets in serious and organised crime.
- 6 There should be a bilateral research project on corrupted transport workers.
- 7 Joint projects between AGS, the National Crime Agency, Europol, and Dutch and Belgian authorities should be considered to actively monitor any changes in drug flows to the UK from the Netherlands and Belgium regarding nature and scale of displacement to UK and/or Irish ports.
- 8 The Department of Justice and Central Bank of Ireland should review the threat to the Irish economy from the laundering of illicit finance from overseas.
- 9 The Department of Justice and AGS should consider the production of regular strategic threat assessments on serious and organised crime in Ireland based on all-source reporting from across all State agencies.
- 10 Civil society organisations and research institutions across Ireland and the UK should explore practical, collaborative mechanisms to promote independent analysis of serious and organised crime.

Conclusion

This report is a valuable first step at bringing together existing publicly available knowledge and information and has provided a partial snapshot of organised and serious crime across Ireland and the UK. As acknowledged by the author, there were several limitations mainly due to lack of research in serious and organised crime in the Irish context. Some of the inferences made in this report were informed by the *Drug markets and crime national reports*, published by the Health Research Board, who is the Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).³ The EMCDDA monitors drug-related activities across Europe.

Ciara H Guiney

- 1 Chance A (2022) *Exploring serious and organised crime across Ireland and the UK: towards a shared understanding of a shared threat*. Dublin: The Azure Forum for Contemporary Security Strategy. <https://www.drugsandalcohol.ie/35946/>
- 2 European Commission (2020) *Communication from the Commission: a counter-terrorism agenda for the EU: anticipate, prevent, protect, respond*. COM(2020) 795 final. Brussels: European Commission. Available online at: <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52020DC0795&from=EN>
- 3 Health Research Board (2022) *National reports*. Dublin: Health Research Board. https://www.drugsandalcohol.ie/php/annual_report.php

Global Burden of Disease – what the data tell us and how to address it

Background

Alcohol consumption in Ireland is high. It is approximately 35% higher than the Health Service Executive (HSE) low-risk drinking guidelines¹ and is associated with a considerable burden of health and social harm, with the the Health Research Board's National Drug-Related Deaths Index (NDRDI) reporting three alcohol-related deaths daily in 2017.² Effective policy decision-making relies on robust evidence of the health impact of alcohol, and one source of such evidence is the Global Burden of Disease (GBD) study.

Global Burden of Disease

The GBD captures premature death and disability from more than 350 diseases and injuries in over 200 countries worldwide and can be used to understand the alcohol-related burden on mortality and morbidity. In 2018, the *Lancet* published a report using GBD data to estimate the years of life lost (YLLs) and the years lived with a disability (YLDs), which when combined contributes to disability-adjusted life-years (DALYs).³

Alcohol-attributable deaths in Ireland

Using the GBD data to examine alcohol-related mortality in Ireland, a study commissioned by Alcohol Action Ireland found that in 2019 there were 1,543 deaths attributable to alcohol, representing 5% of all deaths.⁴ This equates to 62,237 DALYs attributable to alcohol and four deaths per day, more than that previously reported. There were approximately 750 alcohol-attributable deaths among older people (70 years and over) and approximately 260 deaths among those in the 15–49-years age group.

Causes of alcohol-related deaths

The study examined the main causes of alcohol-related deaths and found that 274 deaths in 2019 resulted from liver cancer, cirrhosis, and other chronic liver disease combined. Alcohol was attributed to 27% of suicide and self-harm deaths that year.

Trends in alcohol-related deaths

Using GBD data, the authors investigated the trend in alcohol-related deaths in Ireland between 1990 and 2019 and found that deaths correlated with per capita consumption rates that followed policy changes, economic fluctuations, and lifestyle and behaviour changes, such as the move to home drinking as opposed to on-trade consumption during that period.

Alcohol-related cancer

As a Group 1 carcinogen, alcohol has been linked to seven different types of cancer: oesophagus, larynx, upper throat, mouth, bowel, liver, and female breast.¹ During the period 2012–2017, there were 55,097 discharges from Irish hospitals due to partially alcohol-attributable cancers, according to Hospital In-Patient Enquiry (HIPE) scheme data reported by the HRB.² A *Lancet Oncology* study published in 2021 found that approximately 1,000 cancer diagnoses in Ireland in 2020 were alcohol attributable⁵ and a further study indicated that 1 in 8 breast cancer diagnoses are alcohol related.⁶

The authors note that cancer care has improved, greatly impacting cancer mortality rates, although knowledge of the link between alcohol use and breast cancer remains low, as indicated by the 2016 Healthy Ireland survey findings.⁷

Policy implications

The Public Health (Alcohol) Act 2018 in Ireland is grounded in the World Health Organization (WHO) 'Best Buys' that identify alcohol price, marketing, and availability as the principal factors driving alcohol consumption and subsequent harms.^{8,9} Several components of the Act are already in place, including structural separation; minimum unit pricing (MUP); measures around advertising in the vicinity of children; the prohibition of advertising in sports grounds for events where most competitors or participants are children, or directly on a sports area for all events; and measures around sale and supply of alcohol. However, despite the Act being signed into law in 2018, a number of sections have yet to be commenced: section 13 restricting the content of alcohol advertisements; section 18 limiting advertising in print media; section 19 providing a watershed on alcohol advertising; and section 12, labelling on alcohol products providing neutral public health information.

Recommendations

The authors of the report recommend that the remaining sections of the Act be immediately commenced and make a further recommendation that the public health response to alcohol-related harm be considered similar to that of the Road Safety Authority. Its successful multifaceted approach to reducing road traffic fatalities is a best-practice example that could also be applied to alcohol-related harm.

Anne Doyle

- 1 For further HSE information about alcohol consumption, visit: <https://www2.hse.ie/alcohol/>
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- 3 Griswold MG, Fullman N, Hawley C, *et al.* (2018) Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet*, 392(10152): 1015–1035. <https://www.drugsandalcohol.ie/29555/>
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- 6 Stewart BW and Wild CP (2014) *World cancer report 2014*. Lyon: International Agency for Research on Cancer. <https://www.drugsandalcohol.ie/28525/>
- 7 Ipsos MRBI (2016) *Healthy Ireland Survey 2016: summary of findings*. Dublin: Stationery Office. <https://www.drugsandalcohol.ie/26278/>
- 8 Office of the Attorney General (2018) Public Health (Alcohol) Act 2018. <https://www.drugsandalcohol.ie/33698/>
- 9 World Health Organization (2017) *Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases* (No. WHO/NMH/NVI/17.9). Geneva: World Health Organization. Available online at: <https://apps.who.int/iris/handle/10665/259232>

PREVALENCE AND CURRENT SITUATION

Drug treatment in Ireland, 2015–2021

Published in June 2022, the latest National Drug Treatment Reporting System (NDTRS) report presents trends in treated problem drug use (excluding alcohol) for the seven-year period from 2015 to 2021.^{1,2}

Key findings

Over the period, some 69,450 cases treated for problem drug use (excluding alcohol) were reported to the NDTRS.³ The number of treated cases recorded increased from 9,892 in 2015 to 10,769 in 2021 (see Table 1). Between 2019 and 2020, the number of treated cases decreased by 9%, from 10,664 cases to 9,702 cases, increasing to 10,769 cases in 2021.

The overall drop in the number of cases entering drug treatment in 2020 is in part the result of temporary service closures and measures introduced to comply with Covid-19 restrictions and does not necessarily indicate a real decline in demand for treatment.^{4,5}

New cases (never previously treated) accounted for 37.8% of cases in 2015 and 39.1% in 2021. Previously treated cases accounted for 59.2% of cases in 2015 and 56.6% in 2021.

In 2021, the majority of cases (70.3%) were treated in outpatient facilities as in previous years, while 12.9% of cases were treated in inpatient facilities, 8.5% in low-threshold services, 6.1% in prisons, and 2.2% by general practitioners (GPs) (see Table 2).⁶

Between 2019 and 2020, the number of cases treated in residential settings decreased by 24.3%, from 1,571 cases to

1,190 cases, rising to 1,394 cases in 2021. The reduction in residential case numbers in 2020 can in part be attributed to temporary closures and measures introduced to comply with Covid-19 restrictions.

Main problem drug

Opioids, mainly heroin, remain the main problem drug reported over the period. As a proportion of all cases treated, opioids decreased year-on-year from 47.8% in 2015 to 33.7% in 2021 (see Table 3).

Cocaine was the second most common main problem drug reported in 2021. There was a threefold increase in the proportion of cases treated for cocaine as a main problem, rising from 10.4% in 2015 to 30.2% in 2021. In 2021, for the first time, the NDTRS recorded more cocaine (n=3248) than heroin (n=3168) cases among those treated for drugs as a main problem.

Cannabis was the third most common main problem drug reported in 2021. The proportion of cases treated for cannabis as a main problem decreased from 28.2% in 2015 to 21.3% in 2021.

In 2021, as in 2020, cocaine remained the most common main problem drug among new entrants to treatment (see Table 3). Cocaine replaced cannabis as the most common main problem drug among new entrants in 2020. In 2021, cocaine accounted for 38.4% of new cases, followed by cannabis (35.2%) and opioids (12.6%). Among new cases, cocaine increased from 13.7% in 2015 to 38.4% in 2021.

Polydrug use

Over the period, the majority of cases (57.8%) reported polydrug use, i.e. problem use of more than one substance. The proportion of cases that reported polydrug use decreased from 60.9% in 2015 to 53.4% in 2018, then increased to 58.2% in 2021 (see Table 4).

Table 1: Number of cases treated for drugs as a main problem, by treatment status, NDTRS 2015–2021

	2015		2016		2017		2018		2019		2020		2021	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
All cases	9892		9227		8922		10274		10664		9702		10769	
New cases	3742	37.8	3526	38.2	3257	36.5	3962	38.6	3979	37.3	3796	39.1	4206	39.1
Previously treated cases	5855	59.2	5335	57.8	5242	58.8	5872	57.2	5927	55.6	5441	56.1	6090	56.6
Treatment status known	295	3.0	366	4.0	423	4.7	440	4.3	758	7.1	465	4.8	473	4.4

Table 2: Number of cases treated for drugs as a main problem, by type of service provider, NDTRS 2015–2021

	2015		2016		2017		2018		2019		2020		2021	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
All cases	9892		9227		8922		10274		10664		9702		10769	
Outpatient	5818	58.8	5481	59.4	5610	62.9	6715	65.4	6946	65.1	6806	70.2	7568	70.3
Inpatient*	1779	18.0	1885	20.4	1757	19.7	1384	13.5	1571	14.7	1190	12.3	1394	12.9
Low threshold	1197	12.1	886	9.6	792	8.9	887	8.6	948	8.9	870	9.0	918	8.5
Prison	827	8.4	737	8.0	651	7.3	1082	10.5	848	8.0	754	7.8	652	6.1
General practitioner	271	2.7	238	2.6	112	1.3	206	2.0	351	3.3	82	0.8	237	2.2

* Includes any service where the client stays overnight, e.g. inpatient detoxification, therapeutic communities, respite, and step-down.

Drug treatment in Ireland, 2015–2021 continued

Table 3: Main problem drug excluding alcohol reported in 30 days prior to treatment, NDTRS 2015–2021

	2015		2016		2017		2018		2019		2020		2021	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
All cases	9892		9227		8922		10274		10664		9702		10769	
Opioids	4732	47.8	4341	47.0	4016	45.0	4349	42.3	4133	38.8	3559	36.7	3629	33.7
Cocaine	1026	10.4	1138	12.3	1500	16.8	2254	21.9	2560	24.0	2619	27.0	3248	30.2
Cannabis	2786	28.2	2439	26.4	2200	24.7	2358	23.0	2502	23.5	2120	21.9	2299	21.3
Benzodiazepines	873	8.8	897	9.7	868	9.7	999	9.7	1082	10.1	1097	11.3	1218	11.3
Z-drugs*	154	1.6	103	1.1	82	0.9	48	0.5	72	0.7	72	0.7	80	0.7
Amphetamines	63	0.6	55	0.6	40	0.4	57	0.6	59	0.6	53	0.5	77	0.7
NPS**	85	0.9	72	0.8	51	0.6	48	0.5	63	0.6	43	0.4	49	0.5
MDMA (ecstasy)	51	0.5	53	0.6	44	0.5	34	0.3	47	0.4	31	0.3	12	0.1
Volatile inhalants	15	0.2	11	0.1	6	0.1	10	0.1	6	0.1	6	0.1	~	~
Other	107	1.1	118	1.3	115	1.3	117	1.1	140	1.3	102	1.1	152	1.4
New cases	3742		3526		3257		3962		3979		3796		4206	
Opioids	971	25.9	950	26.9	809	24.8	719	18.1	676	17.0	550	14.5	530	12.6
Cocaine	513	13.7	568	16.1	748	23.0	1232	31.1	1258	31.6	1359	35.8	1615	38.4
Cannabis	1693	45.2	1452	41.2	1272	39.1	1505	38.0	1506	37.8	1338	35.2	1479	35.2
Benzodiazepines	340	9.1	353	10.0	290	8.9	345	8.7	340	8.5	392	10.3	418	9.9
Z-drugs	46	1.2	41	1.2	22	0.7	17	0.4	24	0.6	27	0.7	26	0.6
Amphetamines	33	0.9	24	0.7	19	0.6	34	0.9	37	0.9	28	0.7	47	1.1
NPS	53	1.4	36	1.0	21	0.6	25	0.6	22	0.6	26	0.7	23	0.5
MDMA (ecstasy)	31	0.8	39	1.1	29	0.9	18	0.5	38	1.0	21	0.6	8	0.2
Volatile inhalants	6	0.2	8	0.2	~	~	8	0.2	~	~	~	~	~	~
Other	56	1.5	55	1.6	42	1.3	59	1.5	73	1.8	52	1.4	55	1.3

* Z-drugs are non-benzodiazepine hypnotic sedative drugs, e.g. zolpidem and zopiclone.

** NPS: New psychoactive substances.

~ Cells with five cases or fewer.

Table 4: Polydrug use in cases treated for drugs as a main problem, NDTRS 2015–2021

	2015		2016		2017		2018		2019		2020		2021	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
All cases	9892		9227		8922		10274		10664		9702		10769	
One drug only	3872	39.1	3524	38.2	3816	42.8	4787	46.6	4803	45.0	4019	41.4	4501	41.8
Two or more drugs	6020	60.9	5703	61.8	5106	57.2	5487	53.4	5861	55.0	5683	58.6	6268	58.2

In 2021, cannabis (42%) was the most common additional substance reported by cases with polydrug use, followed by cocaine (35.9%), benzodiazepines (35.8%), and alcohol (35.8%).

Risk behaviour

The proportion of all cases that had ever injected decreased from 33.7% in 2015 to 21% in 2021. Among cases that had ever injected, the proportion currently injecting, i.e. in the 30 days prior to treatment, decreased from 36.7% in 2015 to 32.7% in 2021.

Sociodemographic characteristics

The following sociodemographic characteristics of the cases were noted:

- Seven in 10 cases (73.0%) reported over the period were male.
- The median age of cases when entering treatment increased from 30 years in 2015 to 32 in 2021.
- Under 18s accounted for 5.5% of cases in 2021.
- Cases recorded as homeless increased in proportion from 9.2% in 2015 to 12.5% in 2021.

Drug treatment in Ireland, 2015–2021 continued

- The proportion of cases with an Irish Traveller ethnicity increased from 2.9% in 2015 to 3.4% in 2021.
- A large proportion of cases (58.8%) were unemployed in 2021, as in previous years.
- The proportion of cases in paid employment increased from 8.9% in 2015 to 20.5% in 2021.
- In 2021, 1 in 6 cases (15.8%) treated for problem drug use were residing with children aged 17 or younger.

Sociodemographic characteristics – cocaine as main problem

The following sociodemographic characteristics of cases with cocaine as a main problem were noted:

- Eight in 10 cases (78.4%) reported over the period were male.
- The proportion of female cases increased from 1 in 5 cases (19.2%) in 2015 to 1 in 4 cases (25.2%) in 2021.
- The median age of cases when entering treatment rose from 30 years in 2015 to 31 years in 2021.
- Under 18s accounted for 1.9% of cocaine cases in 2015 and 0.9% in 2021.
- The proportion of cases in paid employment increased from 24.3% in 2015 to 34.2% in 2021.
- Cases with polydrug use decreased in proportion, from 70.9% in 2015 to 62.7% in 2021.
- In 2021, the most common additional substances were cannabis (53.3%), alcohol (52.1%), and benzodiazepines (30.5%).

Ita Condrón

- 1 The NDTRS is the national epidemiological surveillance system that reports on treated problem drug and alcohol use in Ireland. Established in 1990, the NDTRS is maintained by the National Health Information Systems (NHIS) of the Health Research Board (HRB) on behalf of the Department of Health.
- 2 Kelleher C, Condrón I and Lyons S (2022) *National Drug Treatment Reporting System: 2015–2021 drug treatment data*. HRB StatLink Series 8. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/36071>
- 3 The data reflect the number of entries into treatment in a calendar year, rather than the number of persons treated in that year.
- 4 The capacity and functionality of treatment services were impacted by Covid-19 restrictions. The NDTRS surveyed participating services to estimate the impact of the restrictions on treatment data for 2020, with a response rate of 80%. Around 40% of services surveyed expressed some impact on their ability to provide returns, while around 50% expected some impact on numbers (unpublished data).
- 5 To comply with European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) requirements and enable services to accurately reflect their activities in response to Covid-19 restrictions, the NDTRS added functionality to the LINK database to record treatment provided over the telephone or internet (teleworking).
- 6 Coverage of services was 70% for 2021. The number of services participating in the NDTRS varies annually, making small fluctuations in the numbers of cases difficult to interpret. Coverage for most service types ranges between 86% and 100%; the main reason for the shortfall is the poor participation of GPs who provide opioid substitution treatment (OST). In 2021, only 45% of eligible GPs participated in the NDTRS. In addition, the NDTRS receives counselling data but no OST data from the Irish Prison Service. This means that the number of OST cases are underrepresented in the NDTRS.

Adolescent Addiction Service report, 2022

The Adolescent Addiction Service (AAS) of the Health Service Executive (HSE) provides support and treatment in relation to alcohol and drug use for young people and families from the Dublin suburbs of Ballyfermot, Clondalkin, Palmerstown, Lucan, and Inchicore. Services provided include advice, assessment, counselling, family therapy, professional consultations, and medications if required. In 2022, AAS published a report detailing referrals for 2021.¹

Referrals

In 2021, AAS worked with 50 young people and their families, with a mean age of 15.5 years (range: 13–18 years). This figure includes new referrals, re-referrals, and continuances. The majority of young people were male (70%), while 6% were non-Irish nationals. In terms of referral areas, the greatest numbers of referrals were from Clondalkin followed by Lucan and Ballyfermot.

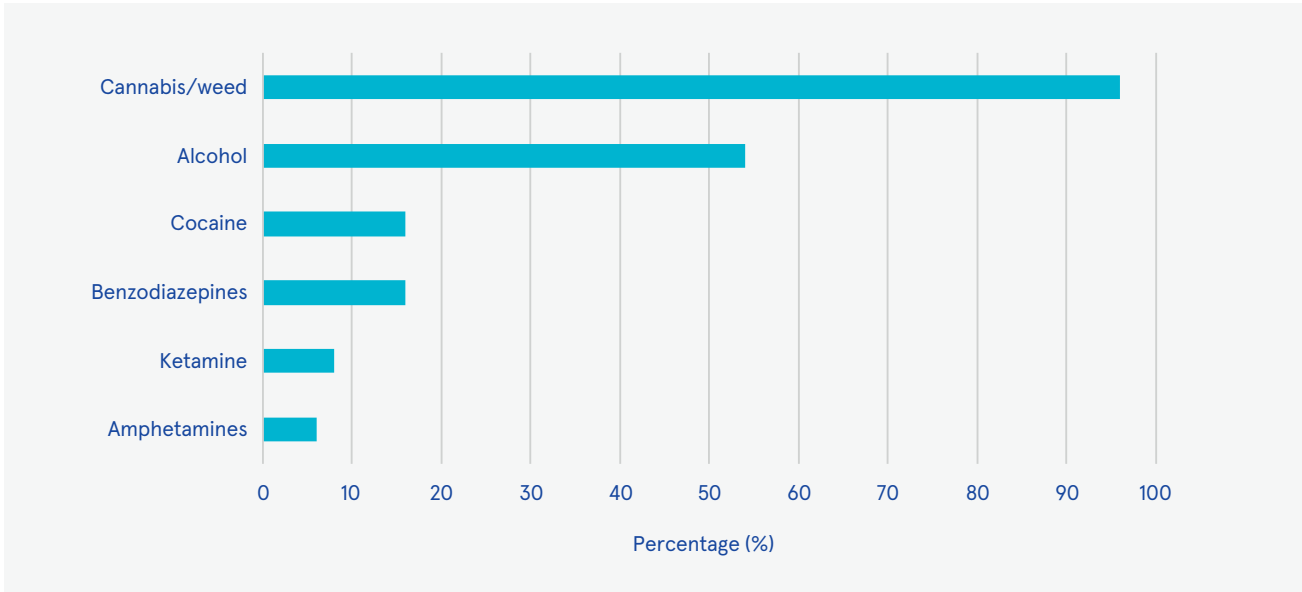
Drug and alcohol use

Cannabis (weed) continued to be the main substance used by clients, with an overall use rate at 96%, while alcohol use was at 54% (see Figure 1). Other substances of use included cocaine (16%), benzodiazepines (16%), ketamine (8%), and amphetamines (6%). Solvents and head-shop-type products did not feature among young people's substance use in 2021. However, 8% admitted to taking nitrous oxide on occasion.

Other issues

Other issues that presented related to absconding, indebtedness, and holding, distributing or dealing drugs. Some young people had social work involvement and 34% had been assigned a juvenile liaison officer at some stage. The majority of young people (90%) were seen by a family therapist only, with 10% having a psychiatric assessment. Some 4% of clients were prescribed medication within the service in 2021.

Adolescent Addiction Service report, 2022 continued



Source: HSE AAS (2022)

Figure 1: Main substances used by AAS clients, 2021

Conclusions

The report authors noted that, as in previous years, most young people had established patterns of substance use prior to referral and, as a consequence, some struggle to maintain a drug-free status. Nevertheless, most achieve stability and several remain abstinent. They concluded that there is a need for parents and non-parental adults to identify young people within risk groups at an early stage and to elevate concern for them.

Seán Millar

- 1 Adolescent Addiction Service (AAS) (2022) *Adolescent Addiction Service report 2022*. Dublin: Health Service Executive. <https://www.drugsandalcohol.ie/35606/>

An Garda Síochána annual report, 2020

In January 2022, An Garda Síochána (AGS) published their annual report for 2020.¹ This article first reports on activities related to national policing, followed by national security and intelligence, community safety, and finally statistics for detections of incidents related to the sale and supply of drugs and Garda drug seizures for 2020.

National policing

Gardaí work in various units to fight crime across Ireland. What follows is a brief outline of a selection of the work undertaken by some of these units.

National Criminal Intelligence Unit

The National Criminal Intelligence Unit (NCIU) works with national and local investigation units with the aim of finding, stopping, and dismantling organised crime groups. The main point of contact within NCIU is the National Criminal

Intelligence Officer (NCIO). Its role is to provide other CIOs within AGS with information and intelligence on incidents as they arise.

Garda National Drugs and Organised Crime Bureau

Table 1 provides a breakdown of seizures relating to operations carried out by the Garda National Drugs and Organised Crime Bureau (GNDOCB) in 2020.

Operation Thor

Operation Thor, AGS's national anti-burglary operation, commenced in November 2015. Since then, there have been 14,487 arrests and 404,693 checkpoints. Burglary incidents in residential and non-residential settings have decreased by 42% and 33%, respectively.

Garda National Protective Services Bureau

The Garda National Protective Services Bureau (GNPSB) targets suspects involved in sexual crime, online child exploitation, child protection, domestic abuse, and human trafficking.

- The dedicated Child Sexual Abuse Reporting (CSAR) phonenumber provided by AGS received 111 calls in 2020. Callers are referred to a specially trained detective in the Sexual Crime Management Unit within GNPSB.¹

AGS annual report, 2020 continued

Table 1: Summary of seizures by Garda National Drugs and Organised Crime Bureau

Category	2020	Total since March 2015
Illicit drugs	€36,695,244	€205,002,465
Firearms	23	132
Rounds of ammunition	2131	5511
Cash	€7,827,938	€18,660,931
Threat-to-life operations	2	75*

Source: AGS annual report (2022), p. 21

* 75 relates to threat-to-life operations carried out since the murder of David Byrne at the Regency Hotel, Dublin on 5 February 2016.

* The statistics provided relate to operations undertaken involving participation by GNDOCB; they do not include seizures made by local Garda units other than by GNDOCB.

- In 2020, Divisional Protective Service Units (DPSUs) were established in all Garda Divisions with the aim of providing consistent and professional approaches in the investigation of crime involving victims.
- In 2020, some 38 victims of human trafficking were reported to AGS, which represented a 9.5% decrease from 2019. The Organised Prostitution Investigation Unit completed two investigations in 2020.
- The Missing Persons Unit (MPU) offered support and advice to families of missing persons. In 2020, some 8,483 missing person incidents were recorded on PULSE; 3,331 persons were reported missing one or more times. At the end of 2020, there were 34 missing persons. The MPU also supported the United Kingdom's (UK) National Crime Agency and UK police on a historical missing person case.
- Domestic Abuse Intervention and Policy Unit/Domestic Homicide Review Team: Coercive control became a criminal offence in January 2019 under provisions of the Domestic Violence Act 2018. In February 2020, the first conviction was made and resulted in a sentence of 21 months.

Garda National Economic Crime Bureau

The Garda National Economic Crime Bureau (GNECB) targets criminal organisations involved in cybercrime. In 2020, the GNECB arrested 17 suspects under provisions of the Criminal Justice Act 2006 as amended. Operation Omena targeted an organised crime group operating in Ireland and the other European Union (EU) countries with links to Romania. Investigations have resulted in several arrests and convictions in relation to money laundering, possession, and using false instruments.

Garda National Cyber Crime Bureau

The Garda National Cyber Crime Bureau (GNCCB) assisted in several enquiries: child abuse images/child exploitation (n=160), theft and fraud offences (n=56), data retrieval (n=35), murder (n=16), and sexual assault/rape (n=15). It provided technical support on several operations. For example, forensic examiners identified over 10 victims of child sexual exploitation and helped bring the perpetrators to justice.

Criminal Assets Bureau

In 2020, the Criminal Assets Bureau (CAB) continued to target 'high ranking' criminals along with mid and lower-level tiers

involved in organised crime gangs with the aim of 'disrupting' their advancement within these organisations. CAB also extended its work with international agencies, for example, Interpol, Europol, and Joint Investigation Teams.²

Operational support services

AGS has several operational support units to support its work: the Garda Air Support Unit (GASU), Garda Dog Unit, Garda Mounted Unit, and Garda Water Unit.

- **GASU:** In 2020, GASU carried out 1,350 flights resulting in 1,221 hours flown. Overall 2,320 incidents were attended, 214 suspects detained, 29 missing persons located, and 52 vehicles located.
- **Garda Dog Unit:** The unit carried out 1,442 searches in 2020 to find missing persons, drugs, firearms, explosive substances, and stolen property. Dogs also identified the location of €1.5 million of drugs and cash.
- **Garda Mounted Unit:** The aim of this unit is mainly crime prevention. Overall, there are 14 mounts. They responded to 5,340 deployment requests, such as public order, crowd control, and VIP protection.
- **Garda Water Unit:** In 2020, this unit carried out person-related searches and recovered 11 remains.

National security and intelligence

Security and intelligence

The Garda National Crime and Security Intelligence Service cooperates and shares intelligence with European and international agencies and maintains ongoing surveillance of threats to Ireland from terrorists and organised crime groups. The threat level remains unchanged since 2018, where it was 'moderate', indicating that 'an attack is possible but not likely' p. 31. Table 2 highlights some of the work carried out by this service.

AGS annual report, 2020 continued

Table 2: Actions taken by the security and intelligence section to keep Ireland safe

Unit	Activities during 2020
Special Detective Unit (SDU)	<ul style="list-style-type: none"> Conducted several intelligence-led counterterrorism operations which led to seizures of explosives, firearms, munitions/ammunitions, and the subsequent prosecution of individuals involved Initiated several terrorist finance investigations in 2020 which lead to arrests and convictions for money laundering and terrorist financing Provided security for numerous official state visits Carried out searches in August 2020, along with local Garda personnel and Regional Armed Support Units, as part of a PSNI operation to combat activities by the New IRA Supported Department of Justice in conducting security screening of 164 refugees as part of Irish Refugees Relocation Programme Undertook intelligence-led operations to target groups and individuals involved in violent extremism
Special Tactics and Operations Command (STOC)	
National Negotiation Unit	<ul style="list-style-type: none"> Trained Garda negotiators dealt with 93 incidents in 2020 The Dublin Metropolitan Region reported the highest number (n=42) of incidents, followed by the Eastern Region (n=22)
Emergency Response Unit	<ul style="list-style-type: none"> Provided close protection to high-risk protectees, including visiting dignitaries, heads of state, and protected witnesses Conducted 80 firearms operations in 2020, including 36 high-risk searches
Armed Support Unit	<ul style="list-style-type: none"> Conducted 177 planned searches in support of frontline policing Provided an overt presence at four special events related to the Covid-19 pandemic

Source: AGS annual report (2022), pp. 32–33

PSNI: Police Service of Northern Ireland; IRA: Irish Republican Army.

Liaison and protection

In addition, AGS continued to work closely with agencies outside Ireland. Its activities included:

- Interpol:** Members of AGS participated in several Interpol-led projects in relation to cybercrime, financial crime, and fugitives. Gardaí seconded to Interpol participated in international operations that targeted financing of terrorism, cybercrime, and fraud.
- Europol:** AGS supported several European Joint Action Days, such as cyberattacks, human trafficking, and cocaine trafficking. In addition, they contributed to Europol's Organised Crime Threat Assessment, the Internet Organised Crime Threat Assessment, and reports on terrorism in the EU.
- Schengen Information System (SIS II) and SIRENE Bureau:** In 2020, the SIS Project team delivered operational, technical, and training elements needed for Ireland to join SIS. The SIRENE Bureau was established and will act as the single point of contact for exchanging information and coordinating activities related to SIS alerts
- International Coordination Unit (ICU):** The ICU continued to oversee the National Internal Security Fund Project within AGS. The aim of this project is to fight crime and to manage risk and crisis. The unit also coordinated AGS participation in EU research as part of the Horizon 2020 programme.
- National Major Emergency Management (MEM) office:** MEM expanded its remit in 2020 to include chemical, biological, radiological and nuclear incidents, policy, and training. It became responsible for An Garda Síochána Covid-19 Coordination Unit in March 2020.

Community safety

Community engagement is at the heart of the work of AGS. Several activities were carried out in 2020, such as crime prevention campaigns (e.g. burglary prevention, online safety, public safety and harm reduction, rural safety, bicycle theft/safety and smartphone safety). For example, in early 2020 the It's Your Choice campaign was launched for teenagers, informing them of the impact of addiction and assault and how to stay safe online. With the aim of increasing engagement and

AGS annual report, 2020 continued

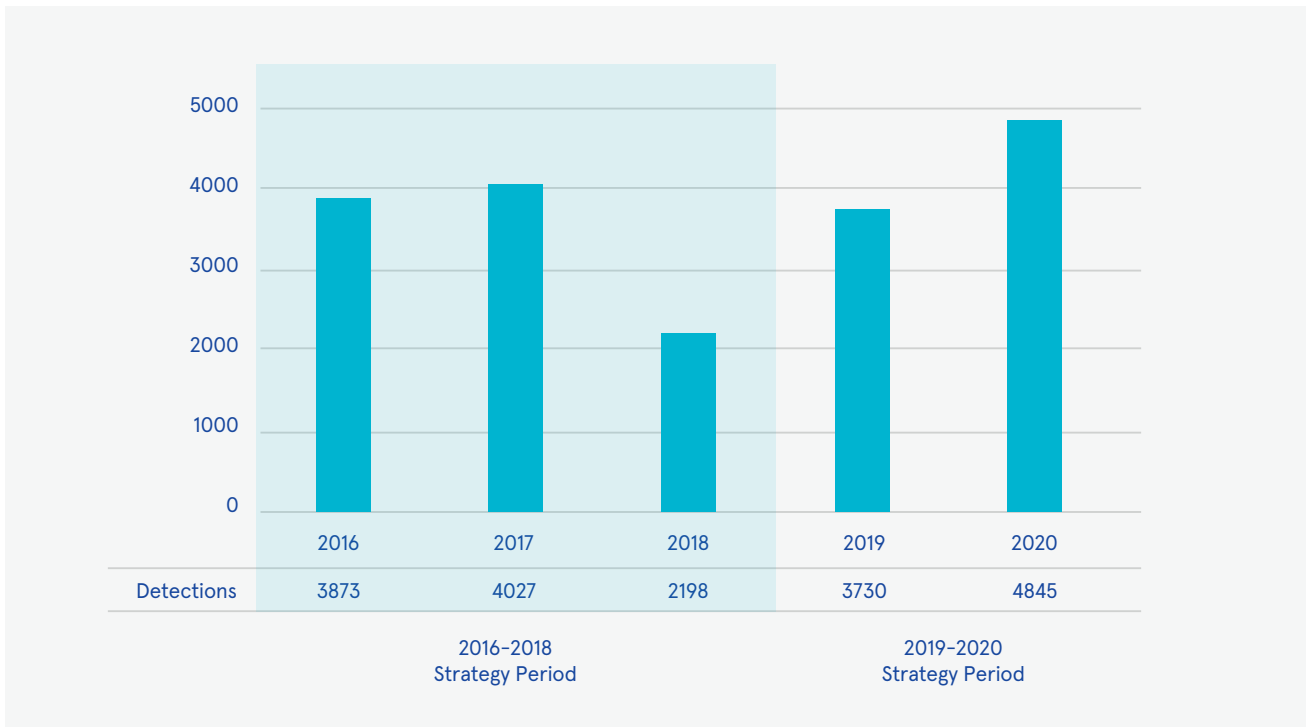
community assurance, a National Community engagement day was held in January 2020.²

Statistics: sale and supply of drugs
Incidents of sale and supply of drugs marked as detected
 Figure 1 shows the number of sale and supply incidents detected between 2016 and 2020. Between 2016 and 2018, there was on average 281 incidents per month. Between 2019 and 2020, there was on average 357 incidents per month. The report stated that the detection figures should be interpreted

with caution as the PULSE system used to record detections was upgraded to PULSE 7.3 in February 2018. Hence, detections before and after the upgrade cannot be compared.

Garda-only drug seizures, 2020

Drug seizures are submitted to Forensic Science Ireland (FSI) for analysis. Overall, it was estimated that the value of drugs seized by Gardaí in 2020 was €31,406,368. As illustrated in Table 3, the most prominent drugs seized in Ireland with values greater than €1 million were cocaine, cannabis herb, diamorphine, cannabis plants, and phenethylamines. While cannabis plants were ranked fourth, it is likely that this figure is higher, as not all plants are sent to FSI for analysis.



Source: Operational PULSE data ICCS types: 1011, 1012, 1021, AGS annual report (2022), p. 83

Figure 1: Detected sale and supply of drugs incidents, 2016–2020

Table 3: Garda drug seizures, 2020

Category	Grams/mls/plant	Tbls/sqr/caps	Value
Cocaine	137,806	10	€9,646,455
Cannabis herb	368,602		€7,372,035
Diamorphine	41,411		€5,797,575
Cannabis plants*	7,204		€5,763,200
Phenethylamines**	28,410	31,924	€1,129,040
Benzodiazepines	714	471,403	€726,858
Cannabis resin	70,250		€421,501
Hallucinogens	5,046	2,821	€319,829
Sleeping tablets		70,713	€141,425
Mixing agents	102,249	421	€51,125
Cathinones	386	2,813	€19,289
Synthetic cannabinoids	408	108	€8,162

AGS annual report, 2020 continued

Category	Grams/mls/plant	Tbls/sqr/caps	Value
Opioids other	11,239	151	€4,338
Solvents	3,967		€3,966
Anabolic steroids		1,921	€1,153
New psychoactive substances	5	20	€252
Piperazine		33	€165
			€31,406,368***

Source: AGS annual report (2022), p. 86

* Cannabis plants are calculated based on figures recorded on PULSE as not all plants seized are routinely sent to Forensic Science Ireland (FSI).

** Phenethylamines include ecstasy (MDMA) and other similar related drugs.

*** This total figure is based on Garda only seizures as recorded by FSI and PULSE. The Garda National Drugs and Organised Crime Bureau (GNDOCB) figure may differ for a number of reasons, such as the inclusion of seizures outside of the remit of FSI and PULSE; GNDOCB report based on seizure date and FSI based on analysis date; the weights/quantities may differ once confirmed by FSI.

Conclusion

Garda Commissioner Drew Harris acknowledged that 2020 was an 'unprecedented year' for Ireland that needed an 'exceptional response' from AGS to help keep people safe during the pandemic (p. 4). AGS and its personnel acted swiftly to reassure and provide support to the public; appreciation of these actions was illustrated in independent surveys which found high levels of public confidence, support, and trust in how AGS operated at this time. While lessons were learned from the responses to the many challenges 2020 brought to AGS as an organisation, the progress made would not have been possible without Garda personnel who consistently illustrated their 'dedication to duty' and to protecting Ireland and its people (p. 5).²

Ciara H Guiney

- 1 An Garda Síochána (2022) *An Garda Síochána: annual report 2020*. Dublin: An Garda Síochána. <https://www.drugsandalcohol.ie/34969/>
- 2 An Garda Síochána (2022) Garda National Protective Services Bureau (GNPSB). Available online at: <https://www.garda.ie/en/about-us/organised-serious-crime/garda-national-protective-services-bureau-gnpsb-/>

European Drug Report, 2022

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published the *European drug report 2022: trends and developments*¹ on 14 June 2022. The purpose of this report is to provide an overview and summary of the European drug situation up to the end of 2021. The Health Research Board (HRB) provides the Irish data and research for the EMCDDA report.

Hazardous new psychoactive substances

New psychoactive substances (NPS) continue to appear in Europe at the rate of one per week, posing a public health challenge. In 2021, some 52 NPS were reported for the first time through the European Union (EU) Early Warning System (EWS), bringing the total number of NPS monitored by the EMCDDA to 880. In 2021, some 15 new synthetic opioids, six synthetic cathinones, and six new synthetic cannabinoids were reported for the first time. Despite the 2022 Taliban ban on the production, sale, and trafficking of illicit drugs in Afghanistan, poppy cultivation appears to continue. Following controls on synthetic cathinones in China, most bulk quantities of these

substances trafficked to Europe in 2020 originated in India, reflecting market adaptation to legal controls and supply disruptions.

Drug types

The situation in Europe with regard to various drug types is summarised below.

Cocaine

The availability and use of cocaine in Europe remains high, and reports indicate that crack cocaine use may be increasing among vulnerable drug users. A record 213 tonnes of cocaine were seized in the EU in 2020 and 23 laboratories were dismantled.

- In the EU, surveys indicate that nearly 2.2 million 15–34-year-olds (2.2% of this age group) used cocaine in the last year.
- In 2020, some 14,000 people entering treatment for the first time sought treatment for cocaine use. At 15%, this was the second most common problem drug for first-time entries.
- In 2020, there were 7,500 entries to treatment for crack cocaine use, with just five EU countries accounting for 90% of the total treatment cases.

European Drug Report, 2022

continued

- Cocaine, mostly in the presence of opioids, was implicated in 13.4% of drug poisoning deaths in Europe in 2022.
- The purity of cocaine has been on an upward trend over the past decade, and in 2019 reached a level 57% higher than the index year of 2009, while the retail price of cocaine has remained stable.

Cannabis

Developments in the cannabis area are creating new challenges for policymakers and services responding to its use. Cannabis products are becoming increasingly diverse, including extracts and edibles – high tetrahydrocannabinol (THC) content – and cannabidiol (CBD) products (low THC content). In 2020, the average THC content of cannabis resin was 21%, almost twice that of cannabis herb (11%), reversing the trend seen in recent years, when herbal cannabis was typically of higher potency.

- Cannabis is the most commonly used illicit drug in Europe, across all age groups.
- The EMCDDA estimates that last-year cannabis use among EU inhabitants aged 15–34 years is at 15.5%.
- Among EU inhabitants aged 15–24 years, an estimated 19.1% (9.0 million) used the drug in the last year and 10.4% (4.9 million) in the last month.
- In 2020, around 80,000 people entered specialised drug treatment in Europe for problems related to cannabis use (35% of all treatment demands); of those, about 43,000 were entering treatment for the first time.

Opioids (mainly heroin)

While heroin injecting is in decline, there are concerns around the injecting of a broader range of substances, including amphetamines, cocaine, synthetic cathinones, prescribed opioids, and other medicines. Drug-induced deaths continue to be driven by opioids and other drugs. An estimated 5,800

overdose deaths, involving illicit drugs, occurred in the EU in 2020. Most of these fatalities were associated with polydrug toxicity, which typically involves combinations of illicit opioids, other illicit drugs, medicines, and alcohol.

- There were an estimated one million high-risk opioid users in Europe in 2020.
- In 2020, use of opioids was reported as the main reason for entering specialised drug treatment by 66,000 clients, or 28% of all those entering drug treatment in Europe. Of these, almost 11,200 were first-time entrants.
- Toxicology reports from suspected drug-induced deaths reported that opioids were found in an estimated 74% of fatal overdoses reported in the EU, often in combination with other drugs.

New psychoactive substances and stimulants

- At the end of 2021, the EMCDDA was monitoring around 880 NPS, 52 of which were first reported in Europe in 2020.
- A total of 224 new synthetic cannabinoids have been detected in Europe since 2008.
- In 2021, some 15 new synthetic opioids, six synthetic cathinones, and six new synthetic cannabinoids were reported for the first time.
- The 73 new synthetic opioids detected between 2009 and 2021 include six first reported in 2021.
- Surveys in European countries show that 1.9 million young adults (15–34 years) used MDMA in the last year (1.9% of this age group). Prevalence estimates for those aged 15–24 years are higher, with 2.2% (1.0 million) estimated to have used MDMA in the last year.

Brian Galvin

- 1 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2022) *European drug report 2022: trends and developments*. Luxembourg: Publications Office of the European Union. <https://www.drugsandalcohol.ie/36441/>

Drug and alcohol misuse among people on probation supervision

On 11 November 2021, Minister for Justice Helen McEntee TD launched the report *Informing and supporting change: drug and alcohol misuse among people on probation supervision in Ireland*.^{1,2,3} The report was written by Dr Louise Rooney of University College Dublin.² The study built on research examining alcohol and drug misuse in individuals referred for probation supervision in 2011/12.⁴ The aim of the current research was to examine the prevalence of alcohol and substance misuse in similar subjects with the view to developing best practice and to help manage and prioritise Probation Service resources.²

Methodology

This study used a cross-sectional quantitative design. Probation officers from community-based supervision teams (n=218) were invited to complete a survey for clients on their caseload who were subject to a probation order, supervision order, adjourned supervision, or supervised temporary release. The response rate was 81%. Clients on community service orders or those referred for pre-sentence reports were excluded from this survey. Survey questions addressed four main areas: background details; details of drug use; details of alcohol use; and gateways–influences context. An extensive analysis was conducted using Statistics Package for the Social Sciences (SPSS) software.

Results

Demographics

Overall, 3,096 surveys were completed by probation officers, of which a 4:1 gender ratio was shown (male = 2566; female = 522). The majority of the sample were categorised as 18–24 years, 25–34 years, and 35–49 years, 24%, 34%, and 27%, respectively. Clients were categorised as mainly White Irish (80%) and Irish Traveller (11%).²

Drug and alcohol misuse among people on probation supervision

continued

Drug and alcohol misuse prevalence

The majority of clients indicated that they had misused drugs or alcohol at some stage during their lifetime (81%), of which 67% misused drugs and 64% misused alcohol. Clients who reported drug and alcohol misuse combined accounted for 50% of the sample.² Clients aged between 25 and 34 years were considered most at risk. The highest level of no substance misuse was recorded in Young Persons Probation (22%) and Irish Travellers (18%).²

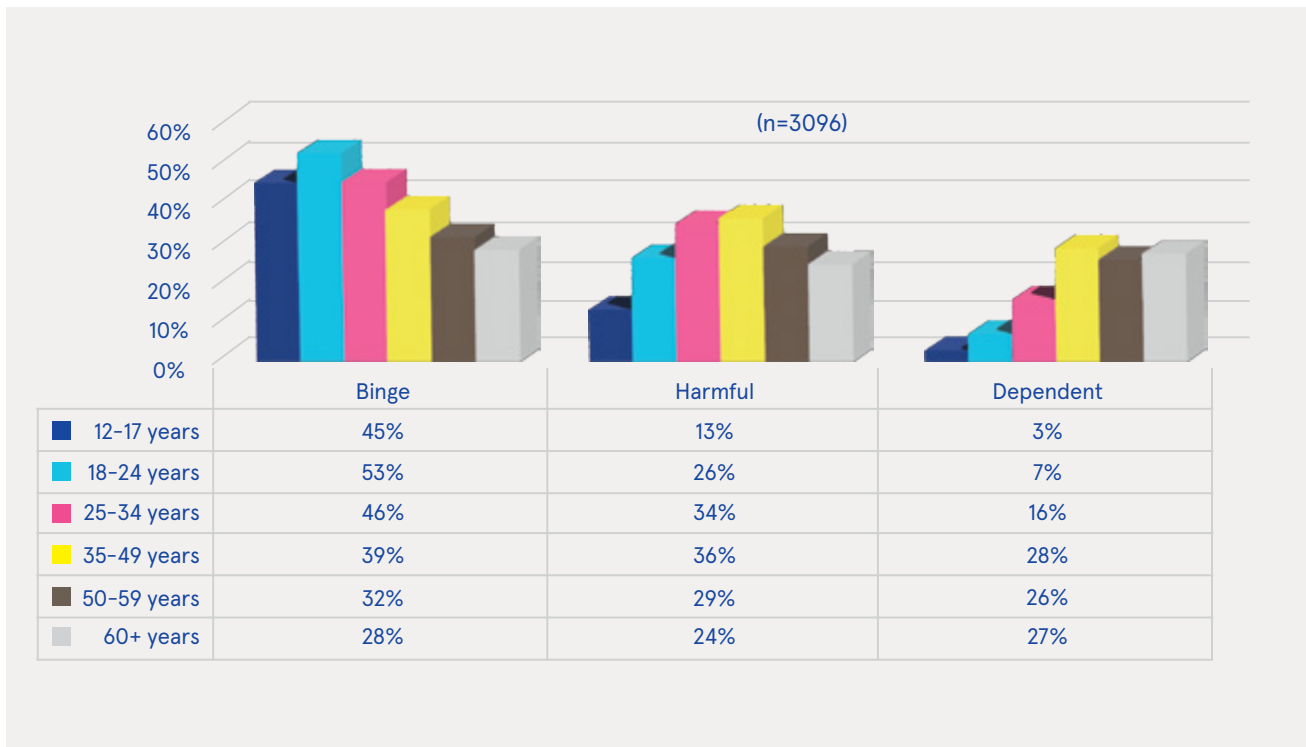
Nature and frequency – alcohol misuse

While no gender differences were found for alcohol dependence, males were more likely to participate in binge (56%) and harmful (38%) drinking than females (binge 36%; harmful 27%). Figure 1 presents a breakdown of type of alcohol misuse by age. Binge drinking was highest in clients aged 18–24 years (53%), followed by those aged 25–34 years (46%) and 12–17 years (45%). Harmful drinking was highest in those aged 35–49 years (36%), followed by those aged 25–34 years (34%). High levels of dependency were shown in clients aged 35–49 years (28%), followed by those aged 60+ (27%) and 50–59 years (26%).

Nature and frequency – drug abuse

Several key findings emerged from the analysis.²

- Cannabis (84%) was the most common substance used by probation clients, followed by benzodiazepines (55%), cocaine (48%), and heroin (41%).
- 21% of drug misusers reported the misuse of two substances, while 20% reported the misuse of three substances.
- Cannabis misuse was highest among 18–24-year-olds (65%).
- Benzodiazepine misuse was highest among 18–24-year-olds (41%).
- Cocaine misuse was most prevalent among 25–35-year-olds (41%).
- Ecstasy misuse was highest among 25–43-year-olds (23%).
- Heroin misuse was most prevalent among 35–49-year-olds (42%).
- Males were more likely to misuse cocaine, ecstasy, and cannabis than females. Alternatively, females were more likely to misuse heroin than males.
- 5% of probation clients reported history of a drug overdose.
- 7% of probation clients reported intravenous drug misuse.
- Over one-half of intravenous drug misusers (52%) began injecting drugs between the ages at 18–24 years, 18% at 12–17 years, and 15% at 25–34 years.²



Source: Rooney (2021), Figure 4.17, p. 47

Figure 1: Type of alcohol misuse by age

Drug and alcohol misuse among people on probation supervision

continued

Substance misuse and offending behaviour

Table 1 provides an outline of the key findings for alcohol and drug abuse.

Table 1: Key findings for alcohol and drug misuse behaviour

Alcohol	Drugs
<ul style="list-style-type: none"> A link between alcohol and current offence was reported for 53% of the sample. 	<ul style="list-style-type: none"> A link between drug misuse and current offence was reported for almost one-half of the sample (48%).
<ul style="list-style-type: none"> Males (42%) had a significantly higher rate of alcohol-related offending than females (32%). 	<ul style="list-style-type: none"> No differences in drug-related offending behaviour were observed across males and females.
<ul style="list-style-type: none"> Irish Travellers (49%) were reported as having a significantly higher rate of alcohol-related offending than White/Black Irish (40%) and clients from other ethnicities (39%). 	<ul style="list-style-type: none"> Cannabis (56%) and benzodiazepines (37%) were the most frequently misused substances by participants, with a reported link between their current offence and drug misuse.
<ul style="list-style-type: none"> The highest rate of alcohol-related offending behaviour was observed for binge drinkers (61%), followed by harmful alcohol misusers (50%) and participants who were alcohol dependent (35%). 	<ul style="list-style-type: none"> A link between drug misuse and current offence was three times more likely among people who misused cannabis.
	<ul style="list-style-type: none"> White/Black Irish (54%) were involved in a higher rate of drug-related offending than Irish Travellers (40%) and clients from other ethnicities (36%).
	<ul style="list-style-type: none"> Almost one-half of the sample (43%) had been convicted of an offence under the Misuse of Drugs Act 1977.
	<ul style="list-style-type: none"> 79% of participants with a conviction under the Misuse of Drugs Act 1977 were convicted of possession, whereas 51% had a conviction for possession, sale and supply less than €13,000.
	<ul style="list-style-type: none"> Of those who had a Misuse of Drugs Act 1977 conviction, 20% were presently on probation supervision for possession for personal use.

Source: Extracted from Rooney (2021), p. 66

Limitations of study

Several methodological limitations were identified by the authors of the study.

- 1 Surveys completed by probation officers were centred on information in case files and not from clients directly.
- 2 The level of information contained in the case files would have been influenced by the length of time the client received probation supervision and how well they engaged with supervision.
- 3 Hence, there were gaps in the information provided.

Recommendations

Based on the findings of this research, several recommendations were put forward that will inform future policy and practice in the Probation Service.

- **Interagency cooperation:** Synergies should continue to be strengthened with other Government agencies, the Health Service Executive, and other community services.
- **Service mapping:** The misuse of drug and alcohol in Probation Service clients is a problem across Ireland. Hence, a needs analysis should be conducted to identify and address gaps in service supports and interventions.
- **Service review:** Probation Service-funded projects providing specialist supports and interventions should be reviewed to examine their alignment and interconnectedness with the national drugs strategy.

Drug and alcohol misuse among people on probation supervision

continued

- **Substance misuse and mental illness:** Collaboration with multidisciplinary and out-of-reach services should address the needs of individuals that experience substance misuse alongside mental illness.
- **Information technology (IT) development:** The current IT system should be modernised and updated to ensure that policy and practice is evidence based and data driven. Developing online platforms that are based on existing research would enhance probation supervision and provide substance misuse supports and interventions, thus increasing service access.
- **Research and evaluation:** To ensure that policy and practices are evidence based, a structured method of research should analyse Probation Service data and evaluate existing services and training. The findings should be disseminated and collaboration with key stakeholders conducted to progress recommendations.
- **Policy development:** The Probation Service should continue its commitment to maintaining a progressive, current policy that is informed by international best practice.
- **Training:** Probation officers should receive training to enhance their knowledge and skills in responding to clients that present with substance misuse problems, to work in partnership with service providers, and to maintain best practice standards.²

Conclusion

This research was welcomed by Minister McEntee and the Minister of State Frank Feighan TD. Minister McEntee acknowledged that ‘high quality research’ is critical to enhancing greater

understanding of the issues so that ‘stronger evidence based policies’ and interventions are developed.¹ While the Minister of State believed that the findings are aligned with the promotion of a public health approach to the drug use objective on the national drugs strategy,⁵ he acknowledged the importance of promoting alternatives to coercive sanctions for individuals committing drug-related offences and highlighted the need for more community services targeting this group. Director of the Probation Service, Mark Wilson, stated that a ‘detailed work plan to address the needs and key recommendations outlined in the study’ will be developed.¹

Ciara H Guiney

- 1 The Probation Service (2021) Minister for Justice Helen McEntee, Minister of State, Frank Feighan and Director of the Probation Service Mark Wilson welcome the publication of Research Report on Drugs and Alcohol Misuse [Press release]. 11 November 2021. Dublin: The Probation Service. Available online at: <http://www.probation.ie/EN/PB/WebPages/WP21000023>
- 2 Rooney L (2021) *Informing and supporting change: drug and alcohol misuse among people on probation supervision in Ireland*. Dublin: The Probation Service. <https://www.drugsandalcohol.ie/35133/>
- 3 Rooney L (2021) Substance misuse and supervision: an examination of drug and alcohol misuse among probation service clients. *Irish Probation Journal*, 18 (October): 137–158. <https://www.drugsandalcohol.ie/35227/>
- 4 The Probation Service (2012) *Drug and alcohol misuse among adult offenders on probation supervision in Ireland: findings from the Drugs and Alcohol Survey 2011*. Navan: The Probation Service. <https://www.drugsandalcohol.ie/18746/>
- 5 Drugs Policy Unit, Department of Health (2019) *Reducing Harm, Supporting Recovery: progress 2018 and planned activity 2019*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/30660/>

RESPONSES

IDPC e-course on decriminalisation

The International Drug Policy Consortium (IDPC) is a global network of 192 non-governmental organisations.¹ It focuses on issues related to drug production, trafficking, and use, promoting objective and open debate on the effectiveness, direction, and content of drug policies at national and international levels. The network supports evidence-based policies that are effective at reducing drug-related harm.

The IDPC has developed an e-training course on drug decriminalisation, an approach that sets out to reduce the harms caused by criminalisation on health, wellbeing, and rights of people who use drugs.² This is a free-to-access online learning course that is open to anyone interested in the topic. The aim of the course is to support and equip those interested in advocating for the decriminalisation of drug use and personal possession. The IDPC recognises that this approach ‘can sometimes be difficult to advocate for as it runs counter to decades of public and political messaging from a global “war on drugs”’.²

The course was created in 2021 by the IDPC in partnership with Mainline, Health[e]Foundation, and Frontline AIDS.^{3,4,5} It contains seven modules which can be taken individually or collectively. Each module should take between one and two hours to complete:

- 1 Introduction, definitions and support for decriminalisation
- 2 Existing models of decriminalisation
- 3 Making the case for decriminalisation
- 4 Designing a decriminalisation model
- 5 Thresholds and defining drug possession for personal use
- 6 Designing decriminalisation: sanctions and intrusiveness
- 7 The ‘gold standard’ for decriminalisation.

Lucy Dillon

- 1 For further information on the IDPC, visit: <http://idpc.net>.
- 2 Access to the e-course can be found at: <https://idpc.net/alerts/2021/07/introducing-the-drug-decriminalisation-e-course>
- 3 For further information on Mainline, visit: <https://english.mainline.nl/>
- 4 For further information on Health[e]Foundation, visit: <https://healthefoundation.eu/>
- 5 For further information on Frontline AIDS, visit: <https://frontlineaids.org/>

DOVE Service, Rotunda Hospital annual report, 2020

The Danger of Viral Exposure (DOVE) Service in the Rotunda Hospital, Dublin was established to meet the specific needs of pregnant women who have or are at risk of blood-borne or sexually transmitted bacterial or viral infections in pregnancy. Exposure may also occur through illicit drug use. Figures from the service for 2020 were published in the hospital's annual report in 2021.¹

Clinical activity

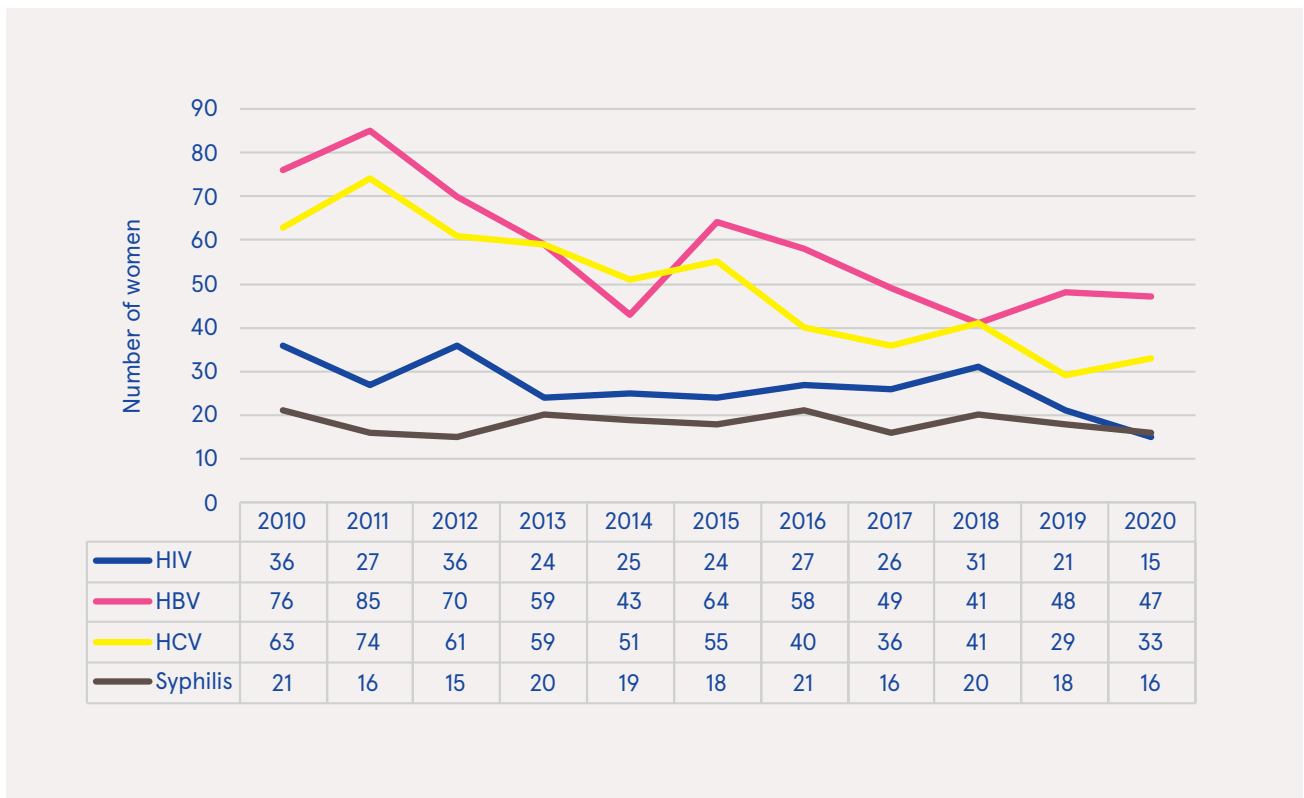
Figure 1 shows the number of women who booked into the DOVE Service for antenatal care each year during the period 2010–2020. It also shows the diagnosis of viral disease for these women. During 2020, some 157 women booked into the DOVE Service for antenatal care.

Of these:

- 15 (13%) women were positive for HIV infection.
- 47 (43%) women were positive for hepatitis B (HBV) surface antigen.
- 33 (30%) women were positive for hepatitis C (HCV) antibody.
- 16 (14%) women had positive treponemal serology (syphilis).

In addition to the figures presented above, a number of women attended the service for diagnosis and treatment of human papillomavirus (HPV), herpes simplex virus, chlamydia, and gonorrhoea.

It should be noted that these numbers refer to patients who booked for care during 2020. Table 1 summarises the outcome of patients who actually delivered during 2020. Of these patients, 12 were HIV-positive, 37 were HBV-positive, 23 were HCV-positive, and 18 had syphilis. During 2020, some 98 women were referred to the drug liaison midwife (DLM) service, including 37 women who had a history of opioid addiction and were engaged in a methadone maintenance programme. There was a total of 56 deliveries to mothers under the DLM service in 2020, of which 30 were on prescribed methadone programmes.



Source: The Rotunda Hospital (2021)

Figure 1: DOVE Service bookings by year, 2010–2020

DOVE Service annual report, 2020 continued

Table 1: Deliveries to mothers attending the DOVE Service who were positive for HIV, HBV, HCV or syphilis, or who were attending the drug liaison midwife, 2020

Mother's status	HIV-positive	HBV-positive	HCV-positive***	Syphilis-positive	DLM
Total mothers delivered	12	37	23	18	56
Total mothers delivered <500 g (including miscarriage)	0	0	0	0	0
Total mothers delivered >500 g	12	37	23	18	56
Live infants	13*	37	23	18	55
Miscarriage	0	0	0	0	0
Stillbirth	0	0	2	0	1
Infants <37 weeks' gestation	3	4	6	2	13
Infants >37 weeks' gestation	10	33	17	16	43
Caesarean section	5	13	10	10	18
HIV, HBV, HCV or syphilis-positive infants	0	0**	0**	0	14
Maternal median age	31	33	34	30	-

Source: The Rotunda Hospital (2021)

* One set of twins.

** Final serology test not yet available for all infants.

*** The difference in the numbers in the table is because one section is "bookings" and one is "births" (the bookings will deliver in 2020 and 2021) and the births will have booked in 2019 and 2020.

DLM: drug liaison midwife.

Seán Millar

- 1 The Rotunda Hospital (2021) *The Rotunda Hospital Dublin annual report 2020*. Dublin: The Rotunda Hospital. <https://www.drugsandalcohol.ie/35998/>

Prison visiting committees annual reports, 2020

A visiting committee is appointed to each prison in Ireland under the Prisons (Visiting Committees) Act 1925 and the Prisons (Visiting Committees) Order 1925. Members of the 12 visiting committees are appointed by the Minister for Justice for a term not exceeding three years. The function of prison visiting committees is to visit, at frequent intervals, the prison to which they are appointed and hear any complaints that may be made to them by any prisoner. They report to the Minister for Justice regarding any abuses observed or found, and any repairs which they think are urgently needed. Prison visiting committee members have free access, either collectively or individually, to every part of the prison to which their committee is appointed. Information from prison visiting committee reports relating to drug use in prisons for 2020 is summarised below.¹

Mountjoy Prison, Dublin

In its report, the Mountjoy Visiting Committee noted that many prisoners have come from a background of intergenerational deprivation, neglect, and poor health, and that the increased

use of illegal substances in society is mirrored in the prison. Families, communities, staff, and individual prisoners may be targeted to take part in the supply, distribution or use of drugs. The committee observed that support and protection of vulnerable groups inside the prison and in the community requires further development and that a review of staffing resources in the health and drug counselling services in Mountjoy is recommended to enable a greater focus on infectious disease and substance abuse treatment.

Dóchas Centre, Dublin

The Dóchas Visiting Committee stated that based on its size the Dóchas Centre has a high number of cases presenting with psychosis, schizophrenia, and addiction. However, through the course of 2020, the consumption of illegal drugs was reduced considerably in the Dóchas Centre. The committee noted that this is likely in part because of the Covid-19 restrictions and also as a consequence of the more structured regime. Nevertheless, it was observed that overall there has been a noticeable decrease in the presence of drugs and the problems associated with drugs in the prison, which is a positive development.

Wheatfield Prison, Dublin

The Wheatfield Place of Detention Visiting Committee's report observed that during the early days of the Covid-19 pandemic, there was a reduction in drugs getting into the

Prison visiting committees continued

prison and that prisoners reported feeling less stressed and that some prisoners saw it as an opportunity to live without drugs. However, drugs have since reappeared; the Wheatfield yards are large spaces covered with netting, yet it is a struggle to prevent drugs and objects being thrown over the perimeter wall. The committee felt very strongly that this issue should be tackled as an emergency, given that the pressure on prisoners to be involved in the supply of illegal drugs within the prison is a considerable burden and that prisoners should be protected from drug gangs whose driving force is to make money off the backs of prisoners and their families.

Cloverhill Prison, Dublin

In its report, the Cloverhill Visiting Committee noted that the amount of drugs circulating in the prison was considerably reduced during the peak time of the Covid-19 pandemic. This was partly due to the difficulties in landing drugs from the perimeter wall in the exercise yard of the prison, the reduced and manageable prison population, reduction in committal prisoners, and also from the practice of quarantine or isolation of new prisoners on presentation in Cloverhill. The committee also observed that despite the challenges of operating within the pandemic restrictions, the Addiction Counselling Service reported that service provision in 2020 had been successful; the service adjusted to the restrictions, offering sessions throughout the year. There was a slight increase in client engagement, with an average of six more sessions per month in 2020. The committee heard that clients and counsellors adapted well to video calls, reflecting the deep commitment of counsellors in keeping the service operative.

Arbour Hill Prison, Dublin

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

Loughan House, Co. Cavan

The Loughan House Visiting Committee heard that face-to-face addiction and counselling sessions were suspended due to Covid-19 restrictions in 2020. However, counselling staff made themselves available via a telephone-based service. This was coupled with the fact that prisoners in Loughan House are permitted their own mobile phone, meaning that Merchants Quay Ireland addiction team specialists remained fully accessible throughout the year.

Shelton Abbey Prison, Co. Wicklow

The Shelton Abbey Visiting Committee's report noted that a full-time addiction counsellor was appointed in 2017, who is respected by offenders and regarded as a trusted listener, and who continues an induction/awareness meeting with all new committals. All prisoners are assessed to see if they have current or previous addiction issues and are offered one-to-one addiction counselling if required.

Midlands Prison, Co. Laois

The Midlands Prison Visiting Committee was informed that a general practitioner (GP) addiction specialist holds weekly sessions as part of the drug treatment service within the prison. In addition, the addiction counselling service in the prison is supported by Merchants Quay Ireland and includes one-to-one counselling and assessments.

Seán Millar

- 1 Department of Justice (2022) *Prison Visiting Committee annual reports 2020* [Arbour Hill Prison, Castlerea Prison, Cloverhill Prison, Cork Prison, Dóchas Centre, Limerick Prison, Loughan House, Midlands Prison, Mountjoy Prison, Portlaoise Prison, Shelton Abbey Prison, Wheatfield Prison]. Dublin: Department of Justice. <https://www.drugsandalcohol.ie/35807/>

AcoRN webinar: alcohol availability – research design and data

Background

The UK-Ireland Alcohol Research Network (AcoRN) held the third in a series of webinars on 13 April 2022 examining alcohol availability. Previous webinars focused on alcohol marketing (November 2021) and alcohol and policymaking (February 2022). The event was chaired by Dr Sheila Gilheany of Alcohol Action Ireland and the three speakers gave an insight into alcohol availability both in Ireland and in the United Kingdom.

Alcohol policy and legislation in Ireland and Northern Ireland

Dr Joanna Purdy of the Institute of Public Health (IPH) in Ireland outlined the role the IPH has played in alcohol policy both in Ireland and Northern Ireland. The policy and legislation that govern alcohol were summarised and the similarities between the Northern Irish drug and alcohol strategy *Preventing Harm, Empowering Recovery*¹ and Ireland's *Reducing Harm, Supporting Recovery*² were noted. It was argued that in Northern Ireland, the Licensing and Registration of Clubs (Amendment) Act 2021 has to a certain extent liberalised alcohol sales through extended opening hours, although other measures within the Act have restricted alcohol sales and availability.³

In order to facilitate policymakers' and other concerned stakeholders' understanding of the relationship between outlet density and alcohol-related harms, a mapping exercise of alcohol outlet density in Northern Ireland was conducted

AcoRN webinar continued

there by the Department for Communities. The report has implications for licensing policy and consideration of public health in the licensing process.⁴

Alcohol availability in Ireland was considered in the context of legislation, reports, and publications. Availability is a key part of the Public Health (Alcohol) Act 2018⁵ as well as the Sale of Alcohol Bill, which aims to simplify and streamline alcohol licensing laws, but also to reduce alcohol-related harms, especially among young people.⁶ It is key too in the *Report of the Night-Time Economy Taskforce*,⁷ the aim of which is to create a vibrant night-time economy based on international models of best practice and stakeholder engagement. Although welcomed, especially as we emerge from the Covid-19 pandemic, concern was raised about the lack of a public health voice to contribute to the taskforce. A number of useful resources were referenced: the alcohol county profiles that detail alcohol-related harms by county⁸ and a report compiled by the National Community Action on Alcohol Network, which details how to object to or appeal a decision regarding alcohol licensing.⁹

The first session closed with a reminder that it is necessary to closely monitor the changes in both the temporal and spatial availability of alcohol and the impact on alcohol-related harm, and that there are currently no time series analysis or sophisticated mapping of outlet density and alcohol-related harms in Ireland or Northern Ireland.

Association between neighbourhood-level alcohol availability and related harm

Professor Niamh Shortt of the University of Edinburgh stated that to address the challenges of public health, we need to change our toxic environments, and that a variety of alcohol-related interventions (based on alcohol availability, promotion, and price) are required to achieve this objective. The environment we live in greatly influences our behaviours and the increased availability of alcohol results in more competitiveness among retailers, reduced prices, and thus increased consumption. The evidence indicates that alcohol availability tends to be higher in areas of social deprivation, and as deprivation increases so too does alcohol availability.^{10,11}

Alcohol density appears to affect those in the lowest income groups more than those in higher income groups, suggesting a socially differentiated vulnerability to such environments. Evidence of the association between outlet density and inequalities, increased crime, domestic violence, road traffic collisions, mortality, and morbidity was outlined and how these need to be considered in licensing policy.

Having a sound knowledge base to better understand the influence of alcohol availability and its association with alcohol use and harm, children's exposure to alcohol, and the social and spatial inequalities that exist informs researchers and policymakers. To date, there are inconsistent data available, and examples of mechanisms for collecting similar data were given. Ideally, a consistent, well-managed database with comprehensive information about licensing should be developed.

Exploring study design to evaluate policy changes in licensing and availability

Professor Niamh Fitzgerald from the University of Stirling provided an overview of the diversity of evaluation study designs, methods, and study sizes that can be used to advance our understanding of the impact of availability policy from a public health perspective. The licensing system in Scotland was described and how public health stakeholders have a statutory role in the system and can object to the granting of a licence on the grounds that it would breach the objectives or the local statement of licensing policy. Several studies that have looked at alcohol licensing and how this engagement of public health practitioners has helped or hindered were examined. One such study, *Exploring the Impact of Alcohol Premises Licensing in England and Scotland (ExLEnS)*, examines the impact of public health stakeholders' engagement in alcohol premises licensing.¹²

A mixed-methods study, *Evaluating Later or Expanded Premises Hours for Alcohol in the Night-time Economy (ELEPHANT)*, was described and how it aims to understand and evaluate the contribution of changes in trading hours for bars and clubs in Glasgow and Aberdeen to harms, services, and economic costs in the local night-time economy.¹³ This study aims to build on international research, suggesting several risks of later opening hours (increased intoxication, assaults, injuries, or use of services).

However, not all studies found such robust evidence of harms and/or were methodologically weak, and/or out-of-date, and the importance of robust and up-to-date evidence was emphasised.

As well as a variety of methods and potential research questions that can be used to build on our understanding of alcohol availability and its impact on health, crime, and economics, a number of methods was proposed. These include observations in late-night premises, ambulance call-outs, time series analysis, and qualitative interviews with diverse stakeholders.

Conclusion

The webinar closed by concluding that to understand the impact of alcohol availability and policies that affect availability, it is crucial that we have consistent longitudinal data on alcohol-related outcomes and access to data on exposure to availability.

Anne Doyle

- 1 Department of Health (Northern Ireland) (2021) *Preventing harm, empowering recovery: a strategic framework to tackle the harm from substance use (2021–31)*. Belfast: Department of Health. <https://www.drugsandalcohol.ie/34827/>
- 2 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/27603/>
- 3 Licensing and Registration of Clubs (Amendment) Act (Northern Ireland) 2021. Available online at: <https://www.legislation.gov.uk/nia/2021/7/contents/enacted>
- 4 Institute of Public Health in Ireland (2015) *Using alcohol licensing data in public health research and policy: proceedings of a knowledge exchange forum hosted by the North South Alcohol Policy Advisory Group*. Dublin/Belfast: Institute of Public Health in Ireland. <https://www.drugsandalcohol.ie/27683/>

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- 5 Office of the Attorney General (2018) Public Health (Alcohol) Act 2018. <https://www.drugsandalcohol.ie/33698/>
- 6 Department of Justice (2021) Sale of Alcohol Bill. Available online at: <https://www.justice.ie/en/JELR/Pages/SaleAlcohol%20Bill>
- 7 Night-Time Economy Taskforce (2021) *Report of the Night-Time Economy Taskforce*. Dublin: Department of Tourism, Culture, Arts, Gaeltacht, Sport and Media. <https://www.drugsandalcohol.ie/34846/>
- 8 For access to the 26 alcohol county profiles for 2019 published by the Health Service Executive in collaboration with the Alcohol Forum, visit: <https://alcohol.iph.ie/?p=407>
- 9 Tracey S and National Community Action on Alcohol Network (2017) *A community guide to alcohol licensing in Ireland*. Donegal: Alcohol Forum. <https://www.drugsandalcohol.ie/28432/>
- 10 Shortt NK, Rind E, Pearce J, *et al.* (2018) Alcohol risk environments, vulnerability and social inequalities in alcohol consumption. *Ann Am Assoc Geogr*, 108(5): 1210–1227.
- 11 Trangenstein PJ, Curriero FC, Jennings JM, *et al.* (2019) Methods for evaluating the association between alcohol outlet density and violent crime. *Alcohol Clin Exp Res*, 43(8): 1714–1726.
- 12 Fitzgerald N, Egan M, de Vocht F, *et al.* (2018) Exploring the impact of public health teams on alcohol premises licensing in England and Scotland (ExLEnS): protocol for a mixed methods natural experiment evaluation. *BMC Med Res Methodol*, 18: 123. Available online at: <https://exilens.stir.ac.uk/>
- 13 For further information on the ELEPHANT study, visit: <https://www.stir.ac.uk/research/hub/contract/1399293>





National Drugs Library

UPDATES

Recent publications

PREVALENCE/CURRENT SITUATION

Gambling in Ireland: profile of treatment episodes from a national treatment reporting system

Condron I, Lyons S and Carew AM (2022) *Irish Journal of Psychological Medicine*, Early online. pp. 1-8.
<https://www.drugsandalcohol.ie/36419/>

This is the first Irish national study using routinely gathered health surveillance data to describe treated problem gambling. Results will inform service policy and planning.

This study provides insights into treated problem gambling nationally. Monitoring and surveillance can play a crucial role in measuring the successful efforts and help inform planning and treatment. The findings may have implications for treatment pathways.

Consensus recommendations for opioid agonist treatment following the introduction of emergency clinical guidelines in Ireland during the COVID-19 pandemic: a national Delphi study

Durand L, Keenan E, Boland F, et al. (2022) *International Journal of Drug Policy*, 106: 103768.
<https://www.drugsandalcohol.ie/36471/>

The objectives of this study are to (1) identify changes introduced to OAT [opioid agonist treatment] clinical guidelines in Ireland during the pandemic; and (2) develop consensus on whether the new recommendations should be retained beyond the pandemic, using a national Delphi consensus methodology.

A wide range of stakeholders involved in the delivery and receipt of OAT agreed on 16 clinical guidance statements for inclusion in OAT clinical guidelines as we move beyond the pandemic, rather than reverting to pre-pandemic guidelines. The agreed statements relate to facilitating safe access to OAT with minimal waiting time, supporting patient-centred care to promote health and well-being, and preventing drug overdose. Notably, consensus was not achieved for OAT drug dosage and frequency of urine testing during the stabilisation and maintenance phase of care.

Locked in and locked out: sequelae of a pandemic for distressed and vulnerable teenagers in Ireland

McLoughlin A, Abdalla A, Gonzalez J, et al. (2022) *Irish Journal of Medical Science*, Early online.
<https://www.drugsandalcohol.ie/36511/>

The aim of this study is to investigate the impact of the coronavirus pandemic on teenage psychiatry referrals following crisis presentation to the adult emergency department (ED) of an Irish tertiary hospital. In doing so, this study will specifically examine the effect of COVID-19 on self-injurious behaviour, suicidality and substance use among older adolescents (age 16/17 years).

Presentation of increased numbers of under-18s for psychiatry assessment at the adult ED/general hospital indicates a deepening chasm between available and aspirational emergency (adolescent-specific) psychiatric care in the community. Mobilising resilience factors and maximising coping skills for at-risk youth will inform tailored intervention and support strategies along with adequate resourcing of services for vulnerable adolescents in the community.

Homelessness duration and stability: a typology of emergency accommodation usage patterns in Dublin

Bairéad C and Norris M (2022) *Cities*, 127: 103735.
<https://www.drugsandalcohol.ie/36263/>

This article presents an analysis of data on the use of emergency accommodation (EA) by single homeless people in Dublin, Ireland between 2016 and 2018. The objective is to reflect on, test and critique the use of administrative data in research on homelessness heretofore in Ireland and internationally.

Applying this design to our dataset on EA usage in Dublin between 2016 and 2018 reveals four clear EA usage patterns – short stay, medium stay, long stay inconsistent and long stay stable. We believe that this four-part typology more accurately represents patterns of EA use in Dublin in recent years.

Recent publications continued

Dynamic associations between anxiety, depression, and tobacco use in older adults: results from The Irish Longitudinal Study on Ageing

Monroe DC, McDowell CP, Kenny RA and Herring MP (2021) *Journal of Psychiatric Research*, 139: 99–105.
<https://www.drugsandalcohol.ie/36031/>

This study quantified associations between smoking and smoking cessation on prevalent and incident generalised anxiety disorder (GAD) and major depression (MDD) in a nationally representative sample of Irish older adults.

Current smokers did not have higher odds of incident MDD (OR = 1.399, 0.984–1.990; $p = 0.065$) or GAD than non-smokers (1.039, 0.624–1.730; $p = 0.881$). Findings may have important implications for interventions designed to curb tobacco abuse, which tend to be less successful among those with anxiety and depression.

RESPONSES

The Greentown Project: building evidence to inform intervention design for juveniles caught-up in local criminal networks

Naughton CM, Redmond S and O'Meara Daly E (2022) *International Journal of Offender Therapy and Comparative Criminology*, Early online.
<https://www.drugsandalcohol.ie/36200/>

The current paper, based on findings from a comparative analysis, builds on a multi-step research design process to provide evidence-based knowledge to inform the design of a new targeted intervention.

An initial social network analysis of national crime and intelligence data produced localized basic criminal network maps illustrating co-offending and intelligence relationships between adults and juveniles in specific Police sub-districts (Part 1). These network maps then provided an enquiry frame for interviews with members of the police forces in three case study locations (Part 2). A comparative analysis of the three studies (Part 3) identified diversity in network structure and inherent resilience. The analysis also identifies core similarities in juveniles' vulnerabilities and risks to recruitment. These factors are important considerations for an intervention seeking to disrupt networks and create safe 'exit' environments for juveniles.

Developing Ireland's first National Student Mental Health and Suicide Prevention Framework for Higher Education

Surdey J, Byrne D and Fox T (2022) *Irish Journal of Psychological Medicine*, Early online.
<https://www.drugsandalcohol.ie/36032/>

This article focuses on the development of Ireland's first National Student Mental Health and Suicide Prevention Framework for Higher Education.

The Framework is informed by international evidence and was the product of a collaborative cross sector and cross disciplinary team including health professionals, government representatives, educators, students, policy makers, community organizations, researchers and clinicians.

Melanotan II user experience: a qualitative study of online discussion forums

Gilhooley E, Daly S and McKenna D (2021) *Dermatology*, 237(6): 995–999.
<https://www.drugsandalcohol.ie/36115/>

The aim of this study was to qualitatively examine MT II [Melanotan II] use, as portrayed on online forums, and to explore the motivations for its use and side effect profile.

Motivations for MT II use included the pursuit of a tanned appearance, often in anticipation of sun holidays and fitness/body building competitions. Clinicians should be aware not only of the potential risks in relation to pigmented skin lesions, but also remain cognisant of the other medical hazards associated with the use of this substance, namely transmission of infectious diseases, use of potentially contaminated products, polypharmacy, and sunbed exposure.

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