

Focal Point Ireland: national report for 2016 - Prevention

Health Research Board. Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction

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0. Summary

National profile

Prevention of problem drug use is one of five pillars in the *National Drugs Strategy (interim) 2009–2016* (Department of Community 2009). The stated objectives of the Prevention pillar are to:

- develop a greater understanding of the dangers of problem drug/alcohol use among the general population
- promote healthier lifestyle choices among society generally, and
- prioritise prevention interventions for those in communities who are at particular risk of problem drug/alcohol use.

The strategy set out to develop a framework for prevention activity structured around universal, selective and targeted prevention interventions. Young people and their families are the main target groups for drug prevention activities, which consist mainly of universal and selective prevention, with much less of a focus on targeted prevention.

While environmental prevention interventions are not specifically identified in the national strategy, relevant activities include alcohol and tobacco control policies and legislation.

The drugs.ie website targets the general population and contains information on the risks and consequences of misusing alcohol and drugs. It also contains a recently improved directory of services and support mechanisms that includes a range of prevention interventions.

Universal prevention interventions in primary and post-primary schools are delivered through the Social, Personal and Health Education (SPHE) programme. SPHE aims to help students understand the social influences that impact on decision-making and helps them to develop life skills to improve their self-esteem, develop resilience, and build meaningful and trusting relationships. The quality of SPHE programme delivery is regularly assessed through school inspections, which involve observations of lessons, reviews of lesson materials, self-evaluations by teachers and surveys among students.

In the community, prevention programmes are delivered in various settings, such as youth clubs and youth cafés, and by means of diversion activities provided by the statutory, voluntary and community sectors.

There is ongoing support for programmes that target those who have left school early or are at risk of doing so.

Families are targeted through a range of initiatives, including the Strengthening Families Programme and Functional Family Therapy.

Trends

Policy and practice in drug prevention have changed little over the past 10 years; the key policy objectives are to develop awareness of and resistance to the risks and consequences of misusing substances. Interventions have remained focused on delivering information, developing knowledge and awareness, and providing life skills to improve resilience. Diversionary programmes have sought to promote healthy choices and behaviour through sport and recreation and to support those at risk of early school leaving. There have been sporadic attempts to deliver psychosocial interventions to young people, but these are poorly documented. Increasingly restrictive alcohol and tobacco control policies and legislation have also been introduced.

New developments

There has been little in the way of new developments around policy and practice in drug prevention in the past year. However, in a broader policy context, the objectives and actions of the National Drugs Strategy (NDS) are linked to a number of other strategies including the *National Youth Strategy 2015–2020* and the *National Strategy on Children and Young People's Participation in Decision-Making, 2015–2020*. The *National Youth Strategy* has a blend of universal and selective

goals targeting young people aged 10–24; the strategy is designed to target the general population of young people but also includes a specific focus on young people experiencing, or at risk of experiencing, the poorest outcomes. The goal of supporting young people to pursue an active and healthy lifestyle mirrors the objectives and actions of the NDS in promoting a healthy lifestyle and providing sports and recreational activities through youth work settings. The goal of supporting young people to connect and contribute to their community mirrors the actions in the NDS that seek to prioritise at-risk communities and improve social bonding in these same communities.

The *National Strategy on Children and Young People's Participation in Decision-Making, 2015–2020* provides a framework for young people to become directly involved in the design, development, implementation and evaluation of services that are delivered under the actions of the NDS. This is a welcome strategic development that is designed to allow young people to play an active role in designing and delivering services that are 'fit for purpose' and directly meet their needs.

The policy landscape around young people is well equipped with strategies and action plans but is somewhat lacking in thorough and detailed evaluation of such policy mechanisms and their outcomes.

A new National Drugs Strategy is planned for 2017. While it is not yet confirmed whether this will include alcohol, alcohol was included under the definition of 'drug' used for the public consultation process as part of the new strategy's development.

1. National profile

1.1 Policy and organization

1.1.1 Main prevention-related objectives of national drug strategy

As reported on in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), drug use prevention of problem drug use is one of five pillars in the *National Drugs Strategy (interim) 2009–2016* (Department of Community 2009). The stated objectives of the Prevention pillar are to:

- develop a greater understanding of the dangers of problem drug/alcohol use among the general population
- promote healthier lifestyle choices among society generally, and
- prioritise prevention interventions for those in communities who are at particular risk of problem drug/alcohol use.

The strategy identifies three levels on which prevention measures can be delivered: universal, selective and targeted. However, the vast majority of measures continue to be delivered at the universal and selective levels, targeting young people and their families.

A new National Drugs Strategy is expected to be in place at the beginning of 2017 (see section 3.1 in Policy workbook). While it is not yet confirmed whether this will include alcohol, alcohol was included under the definition of 'drug' used for the public consultation process as part of the new strategy's development.

1.1.2 Organisational structure responsible for the development and implementation of prevention interventions

The lead agencies for developing and delivering prevention-related actions under the NDS continue to be the Department of Health, with support from the Health Service Executive (HSE), Department of Education and Skills, Department of Children and Youth Affairs, An Garda Síochána, drugs task forces and service providers. The last category includes non-governmental organisations (NGOs).

1.1.3 Funding system underlying prevention interventions

The bulk of funding is provided by the statutory sector with some small assistance from philanthropists.

1.1.4 Optional national action plan for drug prevention in schools

There is no specific national action plan for drug prevention in schools in Ireland. Rather, school is one of the environments covered under the Prevention pillar of the *National Drugs Strategy (interim) 2009–2016* (Department of Community 2009). There are two actions under the strategy that deal specifically with prevention within the school setting:

To improve the delivery of Social and Personal Health Education (SPHE) in primary and post-primary schools through:

- the implementation of the recommendations of the SPHE evaluation in post-primary schools, and
- the development of a whole-school approach to substance use education in the context of SPHE.

To ensure that substance use policies are in place in all schools and are implemented, and monitor the effectiveness of the implementation of these policies in schools through the whole-school evaluation process and the inspectorate system, and ensure that best practice is disseminated to all schools.

See section 1.2.2 of this workbook for a description of current activities in school settings

1.2 Prevention interventions

1.2.1 Environmental prevention interventions and policies

Environmental prevention interventions in Ireland are focused around increasingly restrictive alcohol and tobacco controls. However, some approaches to developing strategies at a local level are also focusing on changing the environment in which substance use takes place, rather than just on the 'problem users'. For example, see section 4.1 of this workbook for a report on a pilot project to implement community mobilisation measures to tackle alcohol-related harm in high-risk local communities.

Alcohol

As reported on in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), there are a number of measures in place to control alcohol use. In summary:

- Tax on alcohol, including excise duty and value-added tax (VAT) remains high, although it was not increased in the most recent national budget (2016).
- It is illegal to drive with a blood alcohol concentration (BAC) of above 50 mg for all drivers, or 20 mg for learner, newly qualified or professional drivers.
- While there is no national legislation prohibiting drinking in public spaces, each local authority is entitled to pass bye-laws prohibiting the consumption of alcohol in public spaces within its area.

It is an offence to

- buy alcohol if you are under the age of 18
- pretend to be 18 or over in order to buy or consume alcohol
- sell alcohol to anyone under the age of 18, and
- buy alcohol for anyone under the age of 18.

- Children (anyone under the age of 18) are only allowed on licensed premises between 10.30 am and 9.00 pm, although 15- to 17-year-olds may remain after 9.00 pm if at a private function.

If implemented, the Public Health (Alcohol) Bill 2015 would have major implications for environmental prevention activity in Ireland. The Bill addresses alcohol as a public health issue for the first time and it aims to reduce alcohol consumption in Ireland to 9.1 litres of pure alcohol per person per annum by 2020 and to reduce alcohol-related harm. See section 3.1 of the Policy workbook for a detailed update on its progress since the 2015 workbook. In summary, the main provisions of the Bill include:

- Minimum unit pricing to tackle the sale of cheap alcohol, particularly in the off-trade sector
- Compulsory health labelling of alcohol products
- The regulation of advertising and sponsorship of alcohol products. Advertising would be banned near schools, early years services, playgrounds and around public transport. Advertising would also be prohibited in sports grounds for events where the majority of competitors or participants are children, and merchandising of children's clothing would be restricted.
- The structural separation of alcohol products in mixed-trading outlets
- Promotions whereby alcohol products are sold at a reduced price or free of charge would be restricted or banned.

Since the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), there has been ongoing Government support for the Bill in Ireland. In the new administration's Programme for Government, launched in May 2016, there was an explicit commitment to enact the Public Health (Alcohol) Bill 2015. However, the Bill is facing a number of delays at the European level. See section 3.1 of the Policy workbook for more detail.

Tobacco

In May 2016, the new government renewed its commitment to making Ireland tobacco free by 2025 (Government of Ireland 2016); in other words, reducing the prevalence rate of smokers to less than 5%. Therefore, national policy on tobacco control continues to be guided by the 2013 report *Tobacco Free Ireland* (Tobacco Policy Review Group 2013). The report has two key themes: protecting children and de-normalising smoking. As reported in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), the most recent prevalence estimate suggests that in 2014, 19.5% of the population reported smoking one or more cigarettes each week. This represents a steady decline from an estimated 28.2% of the population who reported smoking one or more cigarettes each week in 2003 (Hickey P and Evans DS 2014).

The tobacco control measures outlined in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016) continue to be in place. In summary:

- Smoking is illegal in all enclosed workplaces, for example offices, shops, bars, restaurants and factories.
- Smoking in motor vehicles in which a person under the age of 18 is present is banned.
- The sale of tobacco products to anyone under the age of 18 is illegal.
- The sale of cigarettes in packs of fewer than 20 is banned.
- All point-of-sale advertising of tobacco products is banned.
- Tobacco products must be stored out of sight of the customer.
- Tax on tobacco has increased since the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), with an additional 50 cent being added to a packet of 20 in the 2016 Budget (the cost of a

packet of 20 cigarettes is now €10.50 for the most popular brands), with a pro rata increase on other tobacco products, including rolling tobacco.

There have also been some developments in the packaging of tobacco products since the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016).

The Public Health (Standardised Packaging of Tobacco) Act 2015

The Public Health (Standardised Packaging of Tobacco) Act 2015 has faced some challenges since being reported on in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016). This Act aims to outlaw all forms of branding for tobacco products. Only the brand name will be allowed on packaging, and it will need to be presented in a uniform typeface for all tobacco products – any alternative fonts, colours or embossing will be removed. All products will have to use the same neutral colour for the packaging, except for the mandatory health warnings that are to be included on all product packaging.

The aim is to make tobacco packaging less attractive and to make health warnings more prominent. If this Act is enacted, it will mean Ireland's standardised packaging will be more restrictive than that of the EU 'Tobacco Products Directive (TPD) (2014/40/EU), which allows packaging to retain branded fonts and colours. Recent research among young people in Ireland found that this more restrictive packaging was less attractive to them (Babineau and Clancy 2015) (see section 4.1). However, amendments to the Act are to be made under the Health (Miscellaneous Provisions) Bill 2016, initiated in January 2016.

These amendments set out further provisions for retail packaging of tobacco products, some of which are of a technical and practical nature and some of which seek to provide basic information to the consumer. However, given the delay in forming a government in Ireland in early 2016, this Bill has been delayed. Furthermore, a legal challenge to the Public Health (Standardised Packaging of Tobacco) Act 2015 has been initiated on behalf of Japan Tobacco International Ireland Limited. The Department of Health envisages that more challenges to this legislation will arise in 2016 (Department of Health 2016a). In the meantime, the Minister for Health signed the regulations transposing the Tobacco Products Directive (2014/40/EU) into Irish law on 20 May 2016

1.2.2 Universal prevention interventions

A range of universal prevention programmes are run at both local and national levels. These include online resources, whole-school prevention programmes and out-of-school substance misuse awareness campaigns.

Online awareness

Drugs.ie is a government-funded website. Its mission is 'to help individuals, families and communities prevent and/or address problems arising from drug and alcohol use'. It is the main delivery mechanism for substance use information for the **general** public. During 2015, the site received almost 1.5 million unique visits, 151,446 of which were Irish visits (Department of Health 2016b). It provides information on drugs and alcohol, and in the past year it has further developed an online directory of related services. Other elements include:

- an online drug self-assessment and brief intervention resource
- information campaigns as a response to emerging drug trends
- a live chat helpline, and
- an e-bulletin on drug-related issues and research.

Universal prevention in education

Social, Personal and Health Education (SPHE)

Little has changed in the area of school prevention education since the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and

Drug Addiction 2016). The Social, Personal and Health Education (SPHE) programme continues to be the main vehicle through which substance use prevention is delivered in both primary and post-primary schools. The programme is a mandatory part of the primary and post-primary (Junior Cycle) school curriculum, and supports the personal and social development, health and well-being of students through 10 modules, including a module on substance use. The themes and content of modules are built around helping students to understand the nature of social influences that impact on their development and decision-making, and helping them to develop adequate life skills to improve their self-esteem, develop resilience and build meaningful and trusting relationships. The 'Walk Tall' and 'On My Own Two Feet' programmes, which are substance misuse prevention programmes, have been integrated into the SPHE curriculum for primary and post-primary schools respectively.

There have been no new published reports on the implementation of the SPHE programme in primary or post-primary schools since the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016). As reported then:

- The overall quality of teaching and learning through SPHE in primary schools was found to be 'good' or 'very good'. The majority of parents surveyed (96%) agreed that the school helped their child's social and personal development, although a sizeable proportion (24%) did not know how the school dealt with bullying (Department of Education and Skills 2013b).
- The vast majority of post-primary schools were complying with the curriculum requirement to timetable SPHE for at least one period per week. The deployment of staff to deliver SPHE was considered 'good' or 'very good' in over 80% of schools visited. Schools were encouraged to promote a whole-school approach to the provision of SPHE, i.e. personal and social development of students is supported through an integrated and structured set of initiatives such as anti-bullying and positive mental health interventions. The inspectors reported that in 90% of the schools visited the quality of the whole-school approach was 'good' or 'very good' (Department of Education and Skills 2013a).

The key updates since the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016) are:

- The Walk Tall programme for primary schools has been updated and revised. While it continues to be focused on substance use, it has been amended to address all the strand units of the SPHE curriculum. The strand units are those within the three top-level strands: 'Myself', 'Myself and Others' and 'Myself and the Wider World'. In addition, the materials, stories and resources have been updated, and the methodologies now better reflect the active learning methodologies that are recommended for the broader SPHE programme (personal communication Professional Development Service for Teachers, 2016).
- The revised Walk Tall programme is being made available to schools through national professional development seminars in the academic year 2016/2017. Seminars will be targeted at training teachers who will be delivering the revised programme. Web resources and school support will also be available to further embed practice (Department of Health 2016b).
- It has been agreed that from 2017 onwards, SPHE will be incorporated into a new area of learning for secondary-school pupils called 'Wellbeing', which will be compulsory for schools to offer. Three hundred hours will be devoted to the 'wellbeing' area from 2017 to 2020 (over the course of three years); from 2020, this will be increased to 400 hours over the course of three years. This will represent the equivalent of one-seventh of a student's learning time. 'Wellbeing' consists of SPHE, physical education (PE) and civic, social and political

education (CSPE), and schools can design their own wellbeing programme (National Council for Curriculum and Assessment 2016).

- Analysis of the Lifeskills Survey 2015 (forthcoming) indicates that 95% of post-primary schools now have, or are progressing, a substance misuse policy (Department of Health 2016b). This is an improvement on the 90% of post-primary schools reported on in last year's workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016) as having a substance misuse policy in place (Department of Education and Skills 2014).

The third national Lifeskills Survey is due for publication in late 2016. This survey will provide data on a number of important lifeskills-related issues within schools, including aspects of SPHE and substance use. Findings from the second Lifeskills Survey were reported on in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016) (Department of Education and Skills 2014).

Garda Schools Programme

The Garda Schools Programme is delivered in both primary and secondary schools. Substance use is addressed as part of a much broader programme focusing on educating young people about the role of the Gardaí and promoting responsible behaviour. The content focuses on drug information and was designed and developed in conjunction with the Department of Education and the SPHE syllabus. The programme consists of a series of presentations given to the school children by their local Gardaí on the role of the Garda, road/cycle safety, bullying, vandalism, personal safety, drugs, crime prevention and respectful online communication. Coordination of the programme's delivery is handled on a local basis, with local Gardaí undergoing two days training to be able to deliver the programme. While the programme is aiming to achieve national coverage, the current level of coverage is unclear. While the number of schools in which the programme has been delivered is monitored centrally by the Garda Schools Programme Office, it is not publicly available (personal communication, Garda Schools Programme Office, September 2016).

The National Educational Psychological Service (NEPS)

The National Educational Psychological Service (NEPS) works with primary and secondary schools to support the development of academic, social and emotional competence and well-being of all children (Department of Education and Skills 2016). Its stated mission is 'to work with others to support the personal, social and educational development of all children through the application of psychological theory and practice in education, having particular regard for children with special educational needs'. In the current National Drugs Strategy, NEPS was identified as a programme that, while not specifically included in the earlier *National Drugs Strategy (interim) 2001–2008*, had supported the delivery of the Prevention pillar during that period by providing 'supports to children at risk' (Department of Community 2009) (p29).

NEPS delivers 'a consultative, tiered service delivery model to schools, in line **with** international best practice for the effective and efficient delivery of educational psychological services' (Department of Education and Skills 2016) (p 245). At a whole-school level, NEPS aims to build schools' capacity to meet the needs of their pupils through universal, evidence-based approaches and early intervention to promote academic, as well as social and emotional, competence and well-being for all. At the individual pupil level, NEPS works with teachers and parents to enable them to intervene effectively to meet the pupil's needs. NEPS will also work directly with pupils where necessary.

Profile of service users

While NEPS is particularly focused on children with special educational needs (SENs), they also work with those groups of children at risk of marginalisation (for example, socioeconomically disadvantaged groups, immigrant/migrant, and Traveller populations) and children and young

people with social, emotional or behavioural difficulties. In the 2014–2015 school year the primary reasons for referrals were:

- Learning difficulties: 63%
- Social/emotional/behavioural difficulties: 20%
- Review: 8%
- Irish exemption/poor attendance/school exclusion/other: 7%
- Placement advice: 2%.

There is no further detail available on the outcomes of the work with these young people. However, NEPS provides some limited universal prevention interventions.

NEPS ‘Incredible Years’ and ‘FRIENDS’ programmes

Of relevance to universal prevention in schools is the training NEPS that psychologists provide for teachers to implement evidence-based programmes and practices that promote resilience and social and emotional competence in children and young people. The service has prioritised the delivery of two programmes in particular: the Incredible Years Teacher Classroom Management Programme (IYTCM) and the FRIENDS programmes.

The IYTCM programme is a classroom-based prevention and early-intervention programme designed to reduce conduct problems and promote children’s pro-social behaviour. NEPS has 140 psychologists who are accredited trainers. In 2014–2015, they delivered 20 IYTCM programmes to 400 teachers (Department of Education and Skills 2016). IYTCM has been evaluated in several Irish contexts and has been found to lead to improvements in the classroom environment, including an increase in pro-social behaviour among students, an increase in teachers’ sense of efficacy in terms of classroom management, and a reduction in teacher-reported stress and negative classroom management strategies (Davenport and Tansey 2009); (McGilloway, *et al.* 2011).

The FRIENDS programmes are school-based anxiety prevention and resilience-building programmes that enable children to learn effective strategies to cope with and manage all kinds of emotional distress, such as worry, stress, change and anxiety. Eighty NEPS psychologists are certified to train and support teachers in the delivery of the extended range of FRIENDS programmes at all levels from primary to post primary. In 2014–2015 they delivered 50 programmes to 1,250 teachers (Department of Education and Skills 2016). In 2004, the World Health Organization cited FRIENDS for Life as the only evidence-based programme for anxiety in children that is effective at all levels of intervention (World Health Organization Dept. of Mental Health and Substance Abuse and Prevention Research Centre of the Universities of Nijmegen and Maastricht 2004). Research findings for the delivery of the FRIENDS for Life programme in post-primary schools in Ireland have been positive. They demonstrate significant reductions in anxiety levels following participation in the FRIENDS for Life programme. Positive gains in young people’s emotional well-being reported in previous Irish and international research were confirmed by students and their parents. This was the case in both universal and small-group settings in post-primary schools geographically distributed across the country (Henefer and Rodgers 2013).

Universal prevention interventions in the community

The interventions reported on in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016) continue to be delivered (e.g. youth cafes, recreational arts and sports-related activities) but no new evaluations on specific interventions or programmes of interventions have been published. However, there have been a number of new strategic developments, which are outlined in section 3.1 of this workbook; in particular, the implementation of the first *National Youth Strategy 2015–2020* (Department of Children and Youth Affairs 2015a).

Universal prevention interventions in families

The Strengthening Families Programme (SFP) and the Community Reinforcement Approach (CRA) continue to be delivered in some regions – the findings from evaluations of both programmes were included in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016) (section 1.2.2). There have been no project or programme evaluations published in this area since the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016).

1.2.3 Selective prevention interventions

A range of selective interventions reported on in the 2015 workbook continue to be delivered; for example, those delivered by the Regional and Local Drug and Alcohol Task Forces and the Young People's Facilities and Services Fund. However, there is no new evidence to report on the outcomes achieved by these programmes.

Prevention interventions in education centres outside mainstream schooling

A number of prevention programmes are delivered to those attending centres of education that are outside mainstream schooling. For example, Youthreach is a Department of Education and Skills official education, training and work experience programme for early school leavers aged 15 to 20. It offers young people the opportunity to identify options within adult life and provides them with opportunities to acquire certification. Each Youthreach site has staff trained in the Substance Abuse Prevention Programme that they implement. Youth Encounter Projects provide non-residential educational facilities for children who have either become involved in, or are at risk of becoming involved in, minor delinquency. The projects provide the young people with a lower pupil-teacher ratio and a personalised education plan. SPHE (see section 1.2.2 of this workbook) is included in the range of subjects offered by these projects (Department of Health 2016b).

Youth Employability Initiative

The Youth Employability Initiative was launched at the end of 2015. It aims to increase young people's employability, enhance their acquisition of employability skills and aid their preparation for and progression to employment, education or training through engagement with youth work programmes provided by the voluntary youth work sector. It is open to voluntary youth organisations or services that are already in receipt of funding under a number of schemes administered by the Department of Children and Youth Affairs, including the Local Drugs Task Force Scheme.

The Youth Employability Initiative targets young people aged 15 to 24 who are, or who are at risk of not being in employment, education or training (NEET), for intensive support to enhance their 'soft' skills and competencies, i.e. their 'employability skills'. Funding will be made available for the delivery of projects using youth work methodologies that increase young people's employability skills and competencies. These projects must be additional to the programmes already being delivered by the youth service. The grant is available for programmes that have been run before and have been proven to be effective, or for new and innovative programmes. Projects were being delivered throughout 2016 and were taking place in out-of-school settings.

Prevention interventions targeting educational disadvantage

As outlined in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), Delivering Equality of Opportunity in Schools (DEIS), the Action Plan for Educational Inclusion is the Department of Education and Skills' policy instrument to address educational disadvantage. It aims to improve attendance, participation and retention in designated schools located in disadvantaged areas. The School Completion Programme (SCP) targets those most at risk of early school leaving as well as those who are already outside of the formal educational system. This includes in-school, after-school and holiday-time supports. In the 2015–2016 school year, there were 836 schools (targeting around 169,500 pupils) participating in the DEIS Programme (personal communication, Social Inclusion

Unit, Department of Education and Skills, 2016). Under DEIS, a range of supports are provided to help address early school leaving (ESL) and the retention of students in schools. These include:

- a lower pupil-teacher ratio (PTR) in DEIS Band 1 schools
- appointment of administrative principal on lower enrolment
- additional funding based on level of disadvantage
- access to Home School Community Liaison Scheme and the SCP
- access to the School Meals Programme, and
- access to literacy and numeracy supports.

A review of existing evaluations of the programme, as well as other relevant Irish and international research, was published in 2015 (Smyth, *et al.* 2015). It provides an overview of the impact of DEIS and identifies the lessons that can be learned for future policy development. A key limitation of the evaluations reviewed was that they did not use a control group; therefore, the authors note that it is difficult to establish with certainty whether any improvements were due to the programme or to improvements that were happening across all schools. With this in mind, some of the key findings in terms of programme outcomes included that:

- Planning for teaching and learning and in setting targets for achievement has improved over time in DEIS schools.
- There was a significant improvement over the period from 2007 to 2013 in the reading and mathematics test scores of primary students in DEIS schools. Improvements were greater in reading than in mathematics. These improvements needed to be seen in the context of information from a 2014 assessment which showed an improvement in reading and mathematics scores across *all* primary schools, most likely reflecting the impact of a national literacy and numeracy strategy. This means that DEIS schools had kept pace with improvements in other schools but the gap in achievement had not narrowed.
- The most disadvantaged schools, urban Band 1 primary schools, had the lowest reading and mathematics scores. Students in rural DEIS schools had higher test scores than those in urban DEIS schools.
- Absenteeism rates declined over time in urban Band 1 primary schools; for example, 20.7% of students were absent for 20 days or more over the school year 2011–2012 compared with 24.4% of students in 2005–2006.
- The gap between DEIS and non-DEIS schools in terms of the proportion of students completing junior and senior cycle narrowed over time. Among those who entered post-primary education in 1995, the gap in retention rates between DEIS and non-DEIS schools was 22%, but this gap had declined to 10.5% for the cohort who entered in 2008.
- At post-primary level, there had been a slight narrowing of the gap in overall Junior Certificate grades between DEIS and non-DEIS schools.

The Department of Education and Skills is currently undertaking a review of the DEIS programme. This review will consider all aspects of the DEIS programme in order to inform policy development in the area of educational disadvantage.

Selective prevention targeting at-risk young people

Functional Family Therapy

A report of Functional Family Therapy (FFT) being implemented in Ireland has appeared for the first time in the *National Drugs Strategy 2009–2016 Progress Report to End 2015* (Department of Health 2016b). An evaluation of this approach in the Irish context was published in 2014 (Carr, *et al.* 2014). Overall, it found FFT to be an effective way of dealing with adolescent behaviour problems in the Irish context. The Archways Families First service was established in Dublin to provide a service for families of adolescents with behavioural problems who were at risk of involvement in the juvenile

justice system. The first phase of the study (a retrospective archival survey of 118 family cases) found that for FFT to be effective, therapists had to prevent families from dropping out of treatment and implement FFT with a high degree of treatment fidelity, closely adhering to treatment procedures specified by the FFT clinical practice model. The second phase of the study (a prospective randomised controlled trial of 97 family cases; 42 receiving FFT and 55 as controls) produced a number of results, including:

- There was a low drop-out rate from the intervention group (7%), indicating that families engaged with the service.
- Compared with the control group, families who participated in FFT reported significantly greater improvement in adolescent behaviour problems and family adjustment.
- Improvements shown immediately after treatment in the intervention group were sustained at the three-month follow up.
- What were termed 'clinical recovery rates' after treatment were significantly higher in the FFT group (50%) than in the control group (18.2%). Clinical recovery rates were determined by calculating the percentage of cases scoring below the clinical cut-off point on the Strength and Difficulties Questionnaire (SDQ) for the difficulties scales after treatment.

Multi-agency parents drug-education initiative

The Western Region Drug and Alcohol Task Force (WRDATF) have developed a multi-agency drug education initiative for parents. The initiative began in 2009 for parents of children aged between 12 and 18. The programme is delivered by the WRDATF, An Garda Síochána, the HSE and the Department of Education and Skills (SPHE Regional Manager). There are two strands to the programme: first, the agencies deliver an information evening to inform parents and teachers about the effects and consequences of drug use and the services available; second is a follow-up parents' programme developed in collaboration between the agencies and delivered over two to three evenings by an Education Support Worker. It covers a number of areas, including motivations and consequences of drug use; prevalence rates; risk and protective factors; positive parenting scenarios; principles of positive parenting; and dealing with an emergency.

An evaluation of the initiative was carried out in 2013 (Kinlen 2013). The evaluation was largely descriptive and focused on formative rather than summative elements; impact and outcomes for parents and young people were not explored. It found that between 2009 and 2013, 2,633 parents had attended information evenings and 1,061 had attended the series of drug education workshops. Satisfaction levels were high amongst the schools and parents for the planning, content and delivery of the programme. It identified a number of challenges for delivery, primarily those related to multi-agency working, including challenges in ensuring consistency in the messages being delivered by different stakeholders; differing views on the time required for pre-planning; logistical challenges in organising meetings for various agencies covering such a large geographical area; securing support for the programme at all levels within delivery agencies; and linking with existing school-based programmes, particularly SPHE.

A more recent summary report (Western Region Drug and Alcohol Task Force 2015) of the initiative described it as having been 'very successful' in terms of the demand from schools for the programme to be delivered and the interagency working involved. However, the report did not present any empirical evidence base to back up this claim.

Hidden Harm Project

The needs of children living with, and affected by, parental substance misuse continue to be the target of the National Hidden Harm Project. As reported on in the 2014 national report and the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre

for Drugs and Drug Addiction 2016), the project was established by State Agencies to inform service planning and improve services for these children. Since the 2015 workbook, a draft of the strategic statement *Seeing through Hidden Harm to Brighter Futures* was compiled by the *National Steering Group*. The statement was amended to reflect feedback provided by key stakeholders, and it lays out the national standard upon which all hidden harm work should be measured. 'The actions for 2016 are to activate three 'practice change' sites to develop a 'National Practice Change Guideline' to include agreed protocols regarding thresholds and care pathways' (www.hse.ie). No further information on this project has been published since the 2015 workbook.

1.2.4 Indicated prevention interventions

Child and Adolescent Mental Health Services (CAMHS)

As described in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), Child and Adolescent Mental Health Services (CAMHS) teams are the first line of specialist mental health services for children and young people. The service is provided by multidisciplinary teams, including psychiatrists, psychologists, nurses, social workers, speech and language therapists and occupational therapists. There has been no updated annual report for CAMHS since the 2015 workbook; however, some top-level data on two key issues can be found in the *Health Service Performance Report* (Health Service Executive 2016):

- Admission of children to Child Adolescent Acute Inpatient Units versus adult units: Between January and November 2015, 331 young people received acute inpatient mental health care. Of these, 241 (73%) were admitted to Child and Adolescent Acute Inpatient Units directly and 90 (27.2%) were initially admitted to an adult unit. Of the 90 initially admitted to an adult unit, eight (8.9%) were aged 16 or younger. Of the 82 who were 16 or 17 years old, 37 (45%) were discharged either the same day or within three days and 59 (71%) within a week. Looking at a longer timeframe, in 2008, only 25% of children who received acute inpatient mental health care were admitted to Child and Adolescent Acute Inpatient Units, compared with 72.8% in November 2015. The remainder were admitted to approved Adult Mental Health Inpatient Units.

Waiting lists: In November 2015, there were 1,177 children and adolescents waiting longer than three months for a first appointment; of these, 207 children or adolescents were waiting longer than 12 months. There is a waiting list initiative under way that focuses resources on addressing the over-12-month waiting list.

1.3 Quality assurance of prevention interventions

1.3.1 Overview of the main prevention quality assurance standards, guidelines and targets Standards for volunteer-led youth work

As reported in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), standards in the overall youth work sector are underpinned by the *National Quality Standards Framework (NQSF) for Youth Work* (Office of the Minister for Children and Youth Affairs 2010). The related initiatives continue to be implemented and are an element of the *National Youth Strategy 2015–2020* (Department of Children and Youth Affairs 2015a). To support this process, in 2015 three Quality Standards Officers from the City of Dublin Education and Training Board were co-located to the Department of Children and Youth Affairs. Their role is to ensure better cohesion between national youth policy and practice. A strategic review of the NQSF's implementation is planned for 2016; this will determine its future role and format (Department of Health 2016b).

Also, as reported on in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), there are government-published quality standards for volunteer-led youth groups (Department of Children and Youth Affairs 2013). The standards are based on three core principles: young person centred, the safety and well-being of young people, and a focus on developmental and educational services for young people.

2. Trends

2.1 Main changes in prevention interventions in the last 10 years

As reported in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016), drug policy focusing on prevention has changed little over the past 10 years. The two objectives of the Prevention pillar in the *National Drugs Strategy 2001–2008* (Department of Tourism 2001) were to:

- create greater societal awareness about the dangers and prevalence of drug misuse, and
- equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.

In the *National Drugs Strategy (interim) 2009–2016* (Department of Community 2009), the Prevention pillar objectives are to:

- develop a greater understanding of the dangers of problem drug/alcohol use among the general population
- promote healthier lifestyle choices among society generally, and
- prioritise prevention interventions for those in communities who are at particular risk of problem drug/alcohol use.

The common threads running through these objectives over the past 15 years are increasing awareness and improving understanding in the general population of the dangers and problems related to using drugs, as well as promoting positive health choices. This objective is closer to the universal public health model, which targets human agency and rationality as the primary mechanism of change. The objectives also contain continuing recognition that certain groups and communities may be at a higher risk than the general population, and therefore may require additional resources and supports. This type of thinking is more resonant of selective prevention, which prioritises groups and communities according to certain at-risk criteria.

The types of interventions delivered as part of drug prevention have remained much the same over the past 10 years. Interventions delivered in schools have been based on the social influence model and have provided life skills training to bolster self-development, decision-making and resistance in students. Interventions have also included a mix of information and awareness sessions to inform students about the risks of drug use. Interventions delivered in non-school settings have comprised a mix of information and awareness measures and diversionary initiatives (youth work, youth cafés, outdoor sport and recreation, and measures targeting early school leaving). There have been sporadic attempts at psychosocial interventions in out-of-school settings, but these have not been consistently employed and there is little empirical evidence on such interventions. A new National Drugs Strategy will come into existence in 2017. To date, it is unclear what form any new Prevention pillar may take. However, prevention is a particular focus of the consultation process being carried out as part of the development of this new strategy.

3. New development

3.1 Notable new or innovative developments since last workbook

New Programme for Government

As outlined in detail in section 3.1 of the Policy workbook, in May 2016 a new Programme for Government was published and, for the first time, a Minister of State for Communities and the National Drugs Strategy was appointed. Some elements of the Programme for Government are of particular relevance to prevention. For example, the Programme for Government committed to:

- enacting the Public Health (Alcohol) Bill 2015
- strengthening the regulation restricting advertising alcohol to children
- supporting the expansion of Local Drug and Alcohol Task Force projects and the Garda Diversion Programme, and funding an expansion of youth services targeting early school leavers and other young people.

The new Minister of State for Communities and the National Drugs Strategy is responsible for leading the development of the new strategy, due to be in place at the start of 2017 (see section 3.1 of the Policy workbook). Prior to her appointment, the new Minister expressed views of relevance to the prevention agenda, which may impact on the forthcoming strategy:

- While she gave her backing to all elements of the Public Health (Alcohol) Bill 2015, she argued strongly against any alcohol sponsorship of sporting events (Byrne 2014, 18 June), (Byrne 2011, 1 December), and she would like the Bill to be more restrictive on this issue (Byrne 2014, 18 June).
- She has sought changes to school-based drug and alcohol education programmes, although the details of the changes sought are unclear (Byrne 2015, 9 July).

Developments in youth strategy

There have been a number of developments in terms of related government strategy. *Better Outcomes, Brighter Futures: The National Policy Framework for Children & Young People, 2014–2020* (Department of Children and Youth Affairs 2014b) was reported on in the 2014 national report and also in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016). It was Ireland's first national policy framework for children and young people aged 0 to 24 years. This policy framework captures all children and youth policy commitments across all Government Departments and agencies in relation to five outcome areas and six key transformational goals, which were set out in the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016) (T1.2.2). The objectives and actions of the NDS are linked to two other youth strategies that have been published since the 2015 workbook: *The National Youth Strategy 2015–2020* (Department of Children and Youth Affairs 2015a) and *The National Strategy on Children and Young People's Participation in Decision-Making, 2015–2020* (Department of Children and Youth Affairs 2015b).

The *National Youth Strategy 2015–2020* (Department of Children and Youth Affairs 2015a) was launched in October 2015. It is Ireland's first-ever national youth strategy and sets out the Government's aims and objectives for young people aged 10 to 24 years, and is a blend of universal and selective goals. The goals of the strategy are to support young people to be active and healthy, achieve their full potential in learning and development, be safe and protected from harm, have economic security and opportunity, and be connected to and contributing to their community. The strategy focuses particularly on young people experiencing, or at risk of experiencing, the poorest outcomes. It identifies some 50 actions to be delivered between 2015 and 2017 by Government Departments, State Agencies and others, including voluntary youth services. The actions include

providing access to online youth mental health services, developing a national obesity policy and action plan, developing youth entrepreneurship initiatives in schools and youth work settings, and providing opportunities for young people who are the furthest from the labour market. Overall, it sets out to ensure that young people, particularly those who are vulnerable, have access to quality, effective programmes that respond to their needs and are designed to secure good outcomes for them. It has been presented by the Government as the key policy mechanism within which the Department of Children and Youth Affairs will implement the recommendations of the *Value for Money and Policy Review of Youth Programmes* (Department of Children and Youth Affairs 2014a) reported on in section 1.2.3 of the 2015 workbook (Health Research Board and Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction 2016).

The *National Youth Strategy 2015–2020* identifies five areas where specific outcomes will be pursued, including ‘active and healthy, physical and mental well-being’, under which one of the actions is to ‘pursue the actions set out in the *National Drugs Strategy 2009–2016* to ensure that young people receive comprehensive education and information, and have access to appropriate prevention interventions and treatment services’ (Department of Children and Youth Affairs 2015a)(p. 24). The *National Youth Strategy 2015–2020* (Department of Children and Youth Affairs 2015a) also commits to implementing *Tobacco Free Ireland*. This goal of supporting young people to pursue an active and healthy lifestyle mirrors the objectives and actions of the National Drugs Strategy in promoting a healthy lifestyle and providing sports and recreational activities through youth work settings. The goal of supporting young people to connect and contribute to their community mirrors the actions of the National Drugs Strategy that seek to prioritise at-risk communities and improve social bonding in these same communities.

The *National Strategy on Children and Young People’s Participation in Decision-Making, 2015–2020* (Department of Children and Youth Affairs 2015b) provides a framework for young people to become directly involved in the design, development, implementation and evaluation of services that are delivered under the actions of the National Drugs Strategy. Its action plan includes the following commitments:

- Young people will be centrally involved in the development and management of drug and alcohol-free venues and programmes for young people (e.g. youth cafés, alcohol-free music and dance venues, and sports venues), with an emphasis on those most at risk.
- The Health Service Executive (HSE) will develop mechanisms, including consultation and feedback mechanisms, for the participation of service users, families and carers in the decision-making processes of mental health services for young people at local and national levels.
- Children and young people will be consulted by services seeking to respond to parental substance misuse or substance misuse in families as targeted by the ‘Hidden Harm’ initiative.
- Children and young people will be included in consultations with communities to inform the development of Primary Care Services.

This is a welcome strategic development which is designed to allow young people to play an active role in designing and delivering services that are fit for purpose and that directly meet their needs.

The policy landscape around young people is well equipped with strategies and action plans, but lacks thorough and detailed evaluation of such policy mechanisms. The information available tends to come primarily from administrative sources such as Government Departments and State Agencies, and concerns issues such as the number and type of services available, the profile of people using the services and the human and financial resources related to services. While these

process elements may be indicators of the State's commitment to providing services for young people, they do not provide evidence as to the effectiveness of these services to improve people's life opportunities. For example, the recent National Youth Strategy identified the need to support young people who were experiencing, or were at risk of experiencing, the poorest outcomes. An evaluation plan to assess to what extent the actions of the National Youth Strategy can improve outcomes for at-risk young people would be a welcome addition to the policy landscape of youth development.

4. Additional information

4.1 Additional studies

Tobacco packaging and young people

Babineau and Clancy (2015) carried out a study to measure young people's perceptions of proposed changes to tobacco packaging according to two pieces of legislation: the EU Tobacco Products Directive (TPD) (2014/40/EU) and Ireland's Public Health (Standardised Packaging of Tobacco) Act 2015. The Public Health Act aims to outlaw all forms of enhanced branding on tobacco products. The Act stipulates that only the brand name would be allowed and it would need to be presented in a uniform typeface for all tobacco products – all font, colour and embossing would be removed. All products would have to use the same neutral colour for packaging, except for the mandatory health warnings, which are to be included on all products packaging (Babineau and Clancy 2015). The method used in this study was a cross-sectional survey of a representative sample (n=1,378) of secondary school students aged 16–17 in Ireland.

Three levels of tobacco packaging were considered:

- Current: The branded packs that existed at the time of the study, which included a written warning on one side and a pictorial warning on the other. Branded fonts and colours were retained.
- EU: The proposed packs as per the Tobacco Products Directive (TPD) (2014/40/EU), which included larger, dual-sided text and pictorial health warnings covering 65% of the pack. Branded fonts and colours were retained.
- Standardised Irish: As mentioned above, standardised packs with brand identifiers, including font, colour and embossing, removed. Packs of a brown matte colour and containing dual-sided text and pictorial warnings covering 65% of the pack.

Young people were asked to consider the EU and standardised Irish packs and respond to three main outcome measures:

- Attractiveness: 'Which, if either, of the cigarette packs do you think is more attractive?'
- Health risk: 'Which, if either, of the cigarettes do you think carries less of a health risk?'
- Attributes of a typical smoker: 'Which, if either, of the cigarettes do you think is typically smoked by someone who is popular or well-liked?'

The study found that removal of brand identifiers, including colour, font and embossing, reduced the perceived appeal of cigarette packs for young people across the brands tested. Packs standardised according to the proposed Irish legislation were perceived to be less attractive, carry more of a health risk and be smoked by less-popular people than packs that conformed to the Tobacco Products Directive (TPD) (2014/40/EU) guidelines.

Adolescents' exposure to alcohol marketing

Research has been carried out on the extent and nature of Irish adolescents' exposure to alcohol marketing and to determine the relationship between exposure to alcohol marketing and alcohol drinking behaviour (Fox, *et al.* 2015). The study population comprised 686 secondary-school children aged 13 to 17 years (52.6% boys, 47.4% girls) from 16 schools in counties Galway, Dublin and Cork. Respondents were recruited through their schools. Response rates were relatively low – 32.7% of invited schools took part in the research study – and within those schools, 61% (686) of invited students (n=1,124) completed the questionnaire, while 31.4% (353) returned diaries.

There were two strands of data collection. The first was a questionnaire, which collected data on demographic variables, drinking intentions, and exposure to alcohol marketing. Exposure to alcohol marketing was assessed in the questionnaire using the following items:

- the estimated number of alcohol advertisements seen or heard in the previous week and through which marketing channels these advertisements were heard
- whether the last sports and music events attended by the participant were sponsored by an alcohol brand
- if the participant was ever invited to 'like' an alcohol brand or event or to attend an event sponsored by an alcohol brand via social media
- whether the participant had ever seen an online pop-up alcohol advertisement or received an online quiz about alcohol or drinking via social media.

The second strand was an alcohol marketing diary to record all alcohol marketing participants encountered during one weekday and one weekend day. They were asked to note the alcohol brand being advertised, the media channel through which it was presented, where and when it was seen or heard and how appealing the advertisement was to them.

Results

Almost two-thirds of the students reported that they had ever consumed alcohol (62.5% of boys and 65.4% of girls). This was more common among 16- to 17-year-olds (74.6%) than among 13- to 15-year-olds (53.5%). Among those who had ever drunk alcohol, 18.7% of 13- to 15-year-olds and 50.2% of 16- to 17-year-olds reported to have been 'binge drinking' in the past 30 days. 'Binge drinking' was defined as 'having five or more alcoholic drinks in a row'.

Girls were more likely than boys to report online exposure to alcohol advertising (Table 3.4.1). In the previous week, 72% saw an online advertisement or pop-up for an alcohol product, 15.4% received an online quiz about alcohol or drinking, 35% were invited to 'like' an alcohol brand, 29.7% were invited to 'like' an event sponsored by an alcohol brand, and 21.4% were invited to attend an event sponsored by an alcohol brand. There was little difference in online exposure rates between young people aged 15 and younger and their older peers. Boys were more likely than girls to report that the last sports event they attended was sponsored by an alcohol brand and also more likely to own alcohol-branded merchandise.

Table 3.4.1 Percentage of students reporting exposure to various types of alcohol marketing

	Online exposure	Non-online exposure	Alcohol-branded merchandise ownership	Last sports event attended was sponsored by an alcohol brand	Last music event attended was sponsored by an alcohol brand
All students	77.2	90.9	61.2	18.3	16.1
Boys	74.0	90.5	71.4	22.8	15.4
Girls	80.8	91.3	50.0	13.2	16.9

	Online exposure	Non-online exposure	Alcohol-branded merchandise ownership	Last sports event attended was sponsored by an alcohol brand	Last music event attended was sponsored by an alcohol brand
13- to 15-year-olds	74.9	90.7	63.9	18.6	14.6
16- to 17-year-olds	79.6	91.0	58.5	18.0	17.6

Logistic regression analysis showed that increased exposure to alcohol marketing increased the risk of children engaging in the drinking behaviours examined (drinking alcohol, binge drinking, drunkenness, intention to drink in the next year). In general, the higher the number of exposures (alcohol advertisements), irrespective of the type of marketing, the more common the drinking behaviours became. The researchers found that the more intense the exposure, the greater the risk of drinking alcohol and engaging in 'risky' drinking behaviours, such as binge drinking. Owning merchandise, which may be described as engagement with alcohol brands beyond passive exposure, was the strongest predictor of alcohol behaviours. Merchandise included items such as key rings, rugby or football sports jerseys, mobile phone/iPod covers or accessories, items of clothing, or any other promotional items/merchandise with a branded logo on them. Unfortunately, the authors do not comment further on this finding specifically, other than to say it is consistent with findings in the international literature.

Conclusions

The authors concluded that the current regulatory system in Ireland does not protect children from exposure to alcohol marketing, and this failure is associated with increased alcohol consumption. While they recognise that in the absence of a complete ban, it is extremely difficult to prevent young people from being exposed to alcohol advertising, they make some suggestions for intervention. For example, as digital alcohol marketing – in particular that on social media – needs to be regulated, they suggest prohibiting the use of games and user-generated material in branded social media sites and an independent age-verification system.

Evaluation of community mobilisation and local alcohol action plans

As part of the National Substance Misuse Strategy, the remit of the Regional and Local Drug Task Forces was expanded in 2014 to include alcohol. To support the Task Forces in meeting the demands of this expanded remit, the National Community Action on Alcohol Pilot Project (NCAAPP) was established. The aim of this project was to reduce alcohol-related harm by supporting Task Forces in developing a 'community mobilisation approach' that would inform the development of policies to address the issue of alcohol use in their area. The project was delivered by the Alcohol Forum in partnership with the Drug Programmes and Policy Unit of the Health and the Wellbeing Division of the Health Services Executive. A process evaluation of the project has been carried out (Galligan 2015).

Community mobilisation

A community mobilisation approach is a priority theme cited in the *Steering group Report On a National Substance Misuse Strategy* (Department of Health 2012):

'Communities should be supported to develop the evidence-based skills and methodologies to implement community mobilisation programmes with a view to increasing public awareness and discussion of alcohol problems, and to build community capacity to respond to alcohol problems at local level.' (Department of Health 2012)(p. 23).

The report describes community mobilisation as a public health approach to reducing alcohol-related harm. It is an approach designed to change the context in which alcohol use occurs rather

than focusing solely on the 'problem drinker'. Community mobilisation is also a process through which communities work together to take action and bring about change. In this model, a community works with a range of stakeholders from the public, statutory, and private sectors to identify the changes they want to bring about in their area. Based on the best evidence available they work together to make a plan to bring about these changes. The community then implements the plan and monitors its progress in reducing alcohol-related harm.

(Galligan 2015) reviews the literature on community mobilisation and shows how it has been used elsewhere as a way of working that has effectively reduced alcohol-related harm. The author found a number of key elements that contributed to positive results when working in this way, including establishing well-functioning coalitions; getting wider community buy-in to the process and its aims; changing the policy context; taking an evidence-based approach; giving the project adequate time to get established and deliver on outcomes (in excess of three years); taking a multi-strategy approach; and using the media to support interventions.

Findings of the pilot project

Drawing any conclusions about the effectiveness of the NCAAPP on reducing alcohol-related harm was beyond the scope of this evaluation. Instead, the report explored the effectiveness of the *process* put in place to deliver on community mobilisation and, in turn, to establish local alcohol action plans. Five Task Forces were selected to take part in the project, each of which identified a project lead and established an alcohol sub-committee with responsibility for delivering on this project in their area. Each sub-committee sent a representative on five one-day formal training sessions held in Dublin. These covered a range of topics, including community mobilisation, data collection, research and evaluation methods, logic models, alcohol-related harm, using the media, and effective policy measures to address alcohol harm. They then received tailored on-site support to develop their local plans, as well as access to follow-up support in the form of phone calls, emails, one-on-one meetings, and some on-site group training. One individual from the Alcohol Forum had responsibility for delivering this programme of training and support.

Broadly speaking, the goals of the project were to train stakeholders on alcohol-related harm, raise awareness of policy measures, support community engagement, and develop local action plans. The evaluation found that, overall, the project was successful in these areas. The training and support delivered was of a high quality and was delivered by a highly dedicated trainer. Participants improved their knowledge of alcohol-related harm as well as available networking opportunities, and the centralised training sessions were seen as beneficial. The training also impacted on a change in work practices; for example, a public health approach to alcohol issues was adopted, evidence-based measures were applied, and a community mobilisation model was used. At the core of the project was the production of local alcohol action plans. Four of the five Task Forces completed local alcohol action plans by the end of the project and the fifth had outlined a plan. All of the completed action plans included monitoring, review and self-evaluation measures.

A number of critical barriers were identified in the course of the project's delivery. The process was most effective when led by a community coalition; this meant gaining wider community buy-in from a wide range of stakeholders to be active participants in the process. Some Task Forces found this challenging, and a longer lead-in time before training started was identified as a possible solution to this problem. There was also a need for leadership at a local level to support the process. (The Task Forces that progressed the most had strong local leadership who were committed to the process). Limited resources were also identified as a problem, and the absence of sufficient resources presented hurdles to making and delivering a plan. Local policy changes needed to be reinforced by a Government-level commitment to adopting policies shown to lower alcohol-related harm, such as regulating advertising alcohol through sports and alcohol product placement in shops. The author

recommended that the Public Health (Alcohol) Bill 2015 be enacted, as it would be a key component in creating a supportive environment for community mobilisation.

It is unclear whether this approach to developing local alcohol action plans is going to be rolled out across the remaining Local and Regional Task Forces.

5. Notes and queries

5.1 Recent relevant changes in tobacco and alcohol policies

The Regulations transposing the Tobacco Products Directive (2014/40/EU) were signed into Irish law on 20 May 2016. Additionally, implementation of the more stringent Public Health (Standardised Packaging of Tobacco) Act 2015 continues to be pursued despite potential legal challenges.

5.2 Recent research on aetiology and/or effectiveness of prevention interventions

See the findings of the first two studies described in section 4.1. The first on tobacco packaging and young people (Babineau and Clancy 2015), the second on adolescents' exposure to alcohol marketing (Fox, *et al.* 2015). Both studies illustrate the influence of advertising and marketing on young people's experiences of tobacco and alcohol products. In particular, Fox *et al.* (2015) illustrate how increased exposure to alcohol marketing is linked to increases in what can be termed 'risky' alcohol use among young people.

6. Sources, methodology and references

6.1 Sources

Houses of the Oireachtas (Parliament): www.oireachtas.ie

Central Statistics Office: www.cso.ie

Department of Health (including the Drugs Policy and Social Inclusion Unit and the Tobacco and Alcohol Control Unit): www.health.gov.ie

Irish legislation: www.irishstatutebook.ie

6.2 Methodology

Babineau K and Clancy L (2015) Young people's perceptions of tobacco packaging: a comparison of EU Tobacco Products Directive & Ireland's Standardisation of Tobacco Act. *BMJ Open*, 5(6): e007352 <http://www.drugsandalcohol.ie/24349/>

This was a within-subject experimental cross-sectional survey of a representative sample of secondary-school students. The researchers used a school-based pen-and-paper survey. It was carried out in 27 secondary schools across Ireland, randomly stratified for size, geographic location, gender, religious affiliation and school-level socioeconomic status. A total of 1,378 fifth-year secondary-school students aged 16–17 took part.

Carr A, Hartnett D, Sexton T and Graham C (2014) *Putting families first: an evaluation of Functional Family Therapy in an Irish context* [Electronic version]. Dublin: Archways Families First <http://www.drugsandalcohol.ie/25743/>

Carr *et al.* (2014) carried out a research programme between 2010 and 2014 to evaluate the effectiveness and implementation of FFT at Archways Families First in Dublin. The research involved a retrospective archival survey covering the period from 2007 to 2010. The researchers assessed 118 cases, 98 treatment completers and 20 dropouts. Given the limitations associated with such an approach, the authors also carried out a prospective randomised controlled trial covering the period from 2012 to 2014; 42 cases were randomised to the FFT group and 55 to a waiting-list control group – these families continued to receive 'treatment as usual'.

Fox K, Kelly C and Molcho M (2015) *Alcohol marketing and young people's drinking behaviour in Ireland*. Dublin: Alcohol Action Ireland <http://www.drugsandalcohol.ie/24854/>

This study is based on self-reported data on exposure to alcohol marketing and alcohol-related behaviours. A cross-sectional design was used and data were collected using a self-administered questionnaire and an alcohol marketing diary. The target population was 13- to 17-year-olds attending post-primary schools in Ireland. Of 49 schools approached, only 16 agreed to take part; 686 young people completed the questionnaire (individual-level response rate of 61%) and 353 returned a valid diary (response rate of 31.4%).

Galligan C (2015) *National community action on alcohol pilot project 2015: external evaluation report*. Ireland: Department of Health; Alcohol Forum and Health Service Executive <http://www.drugsandalcohol.ie/25098/>

Galligan (2015) undertook a multi-strategy process evaluation and collected data using a mixed-methods approach. The author primarily used qualitative approaches, including focus groups, interviews and structured observation, but also used some quantitative methods to gather data in relation to the numbers participating and other monitoring data. Galligan employed survey and observation instruments such as Likert scales and open-ended questions to collect data. All data from face-to-face sessions and qualitative data from questionnaires were recorded and transcribed, and organised thematically (coded) according to the evaluation objectives. Data were further coded to reveal patterns within these themes, and Microsoft Excel was used to assist in the coding process.

Kinlen L (2013) *Western Region Drugs Task Force Multi-agency Parents Initiative: Programme Evaluation*. Galway: Western Region Drugs Task Force <http://www.drugsandalcohol.ie/21606/>

Kinlen (2013) used both quantitative and qualitative methods for this evaluation. Parents and schools completed evaluation questionnaires; there was also a series of in-depth interviews with a range of stakeholders who were responsible for the delivery of the initiative. The author used observation methods for the parenting evenings. She carried out documentary analysis on programme documentation and also drew on an earlier review of the programme.

Smyth E, McCoy S and Kingston G (2015) *Learning from the evaluation of DEIS. Research Series Number 39*. Dublin: Economic and Social Research Institute <http://www.drugsandalcohol.ie/25567/>

This study drew on existing evaluations of the DEIS programme, along with international and Irish research on educational disadvantage, to provide an holistic overview of programme outcomes and to highlight the implications for future policy development. There were two components to their review. First, they reviewed existing international research on policy and practice relating to educational disadvantage in order to highlight the lessons that can be learned from interventions elsewhere. Second, they reviewed published work in relation to the DEIS programme, covering specific evaluations conducted by the Educational Research Centre and the Department of Education and Skills Inspectorate, as well as existing research that provides insights into the processes at play within DEIS schools.

6.3 References

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European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised EU agency based in Lisbon. The EMCDDA provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the European Union and Member States.

There are 30 National Focal Points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data-collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the Centre for analysis, from which it produces the annual *European drug report* and other outputs.

The Irish Focal Point to the EMCDDA is based in the Health Research Board. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators and supply indicators in the form of standard tables and structured questionnaires on response-related issues such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances.

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