IMO Position Paper on

Addiction and Dependency

June 2015

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IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Mission Statement

The role of the IMO is to **represent** doctors
in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,
efficient and effective Health Service.

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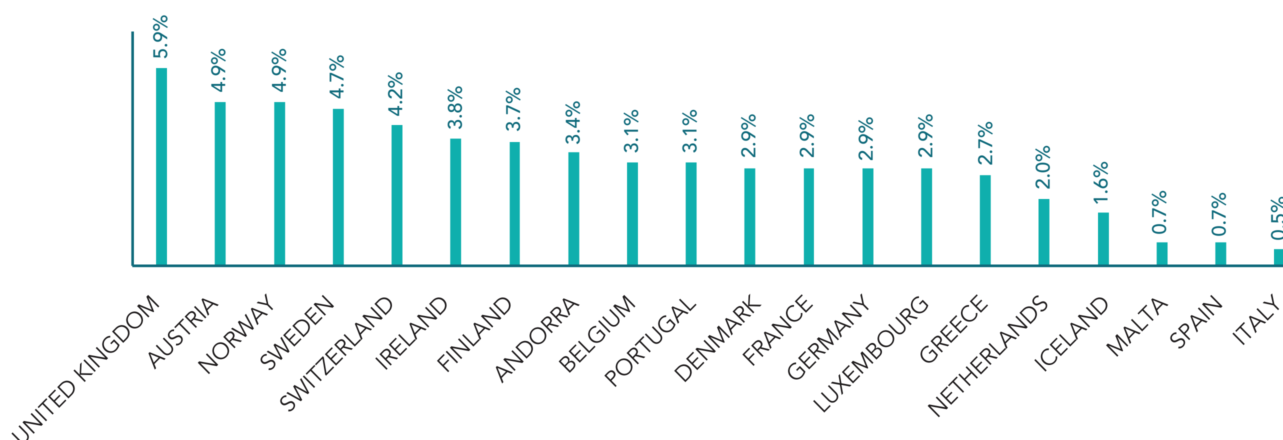
Addiction and dependency remains one the most challenging public health policy issues of recent times. Since the 1960s, the consumption of illegal drugs and alcohol has increased to a point where over one-quarter of all Irish adults now state that they have used an illegal psychoactive substance recreationally, and more than half of all Irish adults are classified by World Health Organisation (WHO) criteria as harmful drinkers.[1] In addition, gambling addiction has received greater attention in recent years, as the ubiquity of internet access provides problem gamblers with an ever-present means of exacerbating their disorder. With illegal substance and alcohol usage high in Ireland, comparable to other EU states, Irish public policy, health services, social services, policing, and legislation, must all combine in a manner that attacks the issue of harmful use and dependency on a variety of fronts. Without reform across these areas that places the needs of those engaging in harmful use first, from both preventative and curative perspectives, the burden such harmful use places on sufferers and their families, as well as public services and society at large, will continue. IMO doctors are advocating for sensible and workable measures that should be examined by legislators and policy-makers that will loosen the grip that substance abuse and addiction has placed on large tracts of our society.

Alcohol Dependence in Ireland

Per capita, Ireland's alcohol consumption remains one of the highest amongst the world's developed states. In 2012 Ireland's annual alcohol consumption was measured at 11.6 litres of pure alcohol per person, ranking fourth amongst the OECD member states.[2] This figure is all the more troubling when it is considered that approximately 21% of all Irish adults report abstaining from alcohol entirely, which is a significantly higher number than in many other west European countries, and indicates that the average consumption of alcohol per adult who drinks is a deal greater than the 11.6 litres average for all adults.[3] Ireland also has a high level of alcohol dependence, compared to other west European states. The WHO's assessment of the prevalence of alcohol dependence in Europe measures Ireland at 3.8% of the adult population.[4] This places Ireland at the upper end of the west European scale, alongside other high consumers of alcohol such as Finland, Norway, and Sweden.

Figure 1: Percentage of Population with Alcohol Dependence - Western Europe



Source: WHO, Global Status Report on Alcohol and Health 2014, Geneva, 2014, pp. 197-240.

1 National Advisory Committee on Drugs and Public Health Information and Research Branch, *Drug use in Ireland and Northern Ireland: First results from the 2010/11 Drug Prevalence Survey*, Dublin, 2011, p. 13; J. Long and D. Mongan, *Alcohol Consumption in Ireland 2013: Analysis of a National Alcohol Diary Survey*, Health Research Board, Dublin, 2014, p. 13.

2 Organisation for Economic Co-operation and Development (2014), *OECD Health Statistics 2014: How does Ireland compare?*, OECD Health Statistics (database), (available at http://www.oecd.org/health/healthdata [accessed on 19 February at 11.13am]).

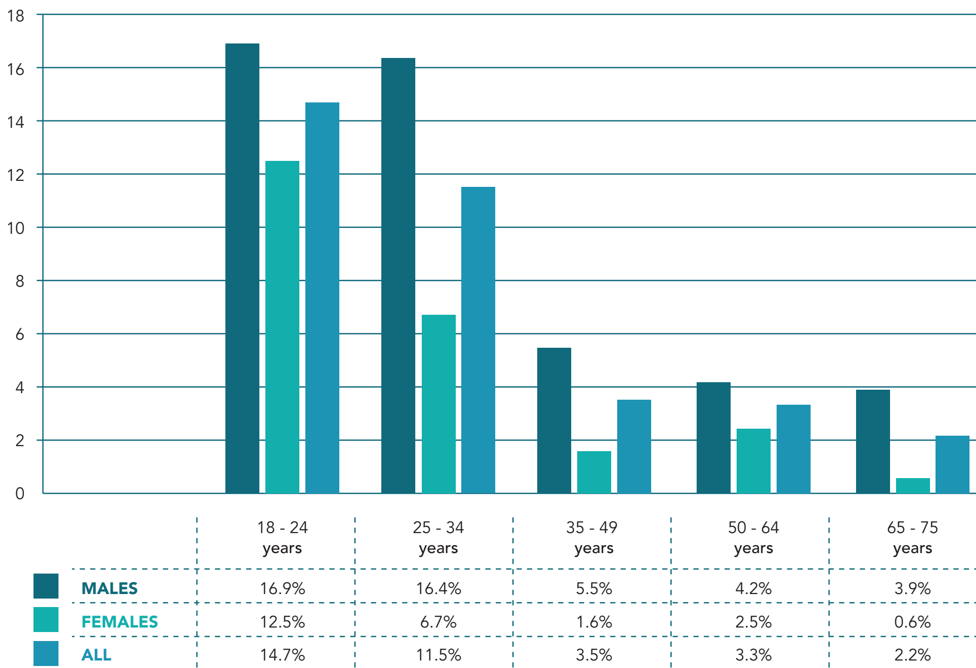
3 J. Long and D. Mongan, *Alcohol Consumption in Ireland 2013: Analysis of a National Alcohol Diary Survey*, Health Research Board, Dublin, 2014, p. 25; World Health Organisation, European Status Report on Alcohol and Health 2010, Copenhagen, 2010, p. 21

4 World Health Organisation, *Global Status Report on Alcohol and Health 2014*, Geneva, 2014, p. 216.

Recent research from the Health Research Board, using the American Psychiatric Association's DSM-IV criteria, suggests the number of Irish adults dependent on alcohol may be far higher than reported by the United Nations body. In a 2013 national survey, the Health Research Board measured the prevalence of alcohol dependence amongst adults in Ireland at 6.9%, a figure over 80% higher than the WHO's estimate.[5]

Figure 2 contains an overview of alcohol dependence within various demographics of Irish society. Of particular note is the level of dependency within the eighteen to twenty-four and twenty-five to thirty-four age brackets, which are substantially above both the national average and the averages of all other demographics. Given the established correlations between alcohol abuse, psychiatric illness, and suicidality amongst younger age groups, the scale of this issue must be viewed as a cause of immediate and grave concern to all those with an interest in maintaining public health in Ireland.

Figure 2: Alcohol Dependence amongst Irish Adults



	18 - 24 years	25 - 34 years	35 - 49 years	50 - 64 years	65 - 75 years
MALES	16.9%	16.4%	5.5%	4.2%	3.9%
FEMALES	12.5%	6.7%	1.6%	2.5%	0.6%
ALL	14.7%	11.5%	3.5%	3.3%	2.2%

Source: J. Long and D. Mongan, Alcohol Consumption in Ireland 2013: Analysis of a National Alcohol Diary Survey, Health Research Board, Dublin, 2013, p. 44.

While 6.9% of the adult population may be classified as clinically alcohol dependent, comparatively few drinkers are of the opinion that their drinking is particularly heavy. In fact, just 2.1% of Irish adults consider themselves to be heavy drinkers, with 39.6% and 58.3% describing themselves moderate and light drinkers respectively.[6] The disparity between the percentage of the population classified as alcohol dependent and that of the cohort that defines itself as heavy drinkers strongly suggests that the overwhelming majority of those living with alcohol dependence do not believe themselves to have a clinically significant problem with the substance.

5 J. Long and D. Mongan, *Alcohol Consumption in Ireland 2013: Analysis of a National Alcohol Diary Survey*, Health Research Board, Dublin, 2014, p. 13.

6 Ibid, p. 49.

Physical and Psychological Effects of Alcohol Dependence

Alcohol dependence is associated with a range of physical and psychological conditions. There is a strong correlation between the risk of liver cirrhosis and the daily volume of alcohol consumed, with approximately 20% of people dependent on alcohol developing the disease. Chronic alcohol consumption is a significant risk factor for a number of cancers including cancer of the oropharynx, larynx, and oesophagus, cancer of the liver, colorectum, and breast, as well as a causal factor in both haemorrhagic and ischemic stroke. Alcohol dependence is also associated with neuropsychiatric disorders, including depression, peripheral neuropathy, and cognitive impairment.[7]

Alcohol was responsible for 799 deaths, or the equivalent of at least sixty-seven deaths every month, in Ireland in 2008 in alcohol dependent people.[8] The overwhelming majority of these deaths occurred before the age of sixty-nine, with mortality highest in the fifty to sixty-four age bracket.[9]

Supply and Prevention

In February 2012, the Department of Health published the *Steering Group Report on a National Substance Misuse Strategy* to tackle the issue of alcohol misuse. The Report makes a number of recommendations under the pillars of Supply, Prevention, Treatment and Rehabilitation, and Research and is aligned with the National Drugs Strategy 2009-2016. Recommendations under the Supply pillar include the introduction of Minimum Unit Pricing, restrictions on advertising and promotion of alcohol, alcohol labelling, structural separation of alcohol from other products in retail outlets, and the introduction of a levy on alcohol manufacturers in order to contribute to the healthcare costs of alcohol-related harm, all of which are supported by the IMO (see *IMO Position Paper on Alcohol and Young People*, 2013).

In October 2013 the Government announced measures to deal with alcohol misuse to be provided for in a Public Health (Alcohol) Bill. The Bill has yet to be drafted, but an outline of the provisions in the Bill has been provided. While the IMO has welcomed the proposal to introduce Minimum Unit Pricing, the organisation is disappointed that the Bill will not include a ban on alcohol sponsorship and promotion of sports.

IMO Recommendation

- **Implement the National Alcohol Strategy without delay, to take immediate action to ban sponsorship and promotion of sports by the alcohol industry, and to introduce Minimum Unit Pricing for alcohol products.**

Drug Use and Dependency in Ireland

Drug use in Ireland has continued to increase by significant degrees over the past decade. Recently released statistics, compiled by the National Advisory Committee on Drugs and Alcohol (NACDA), show that the usage of almost all kinds of illicit drugs has increased during the last ten years. In 2003 lifetime use of any illegal drug stood at 18.5% of the population, but by 2011, the year of the most recent assessment, this had risen to 27.2%.[10] As is visible from Figure 3, both lifetime prevalence of drug use and usage within the last year and month, usage patterns which may denote regular use, have increased for almost all illegal drugs.

Usage figures in Ireland are generally high, relative to our EU counterparts, as displayed by Figure 4, which contrasts estimate figures for problem opioid use in Ireland, versus the average of other west European states.

7 D. Mongan, S. Reynolds, S. Fanagan, and J. Long, *Health-related consequences of problem alcohol use: Overview 6*, Health Research Board, Dublin, 2007, p. 46.

8 S. Lyons *et al.*, *Alcohol-related deaths and deaths among people who were alcohol dependent in Ireland, 2004 to 2008*, Health Research Board, Dublin, 2011, p. 11-18.

9 Ibid.

10 National Advisory Committee on Drugs and Public Health Information and Research Branch, *Drug use in Ireland and Northern Ireland: First results from the 2010/11 Drug Prevalence Survey*, Dublin, 2011, p. 13.

Figure 3: Drug Use Prevalence in Ireland

	Lifetime use (%)			Last year (%)			Last month (%)		
Drug	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Any illegal drug	18.5	24.0	27.2	5.6	7.2	7.0	3.0	2.9	3.2
Cannabis	17.3	21.9	25.3	5.1	6.3	6.0	2.6	2.6	2.8
Heroin	0.5	0.4	0.8	0.1	0.1	0.1	0.1	0.0	0.1
Methadone	0.3	0.4	0.5	0.2	0.2	0.2	0.1	0.1	0.2
Other opiates ^	3.0	6.2	38.8	0.5	2.2	27.9	0.2	0.9	14.2
Cocaine (including crack)	3.0	5.3	6.8	1.1	1.7	1.5	0.4	0.5	0.5
Crack	0.3	0.6	0.6	0.1	0.1	0.1	0.0	0.0	0.0
Cocaine powder	2.9	5.1	6.7	1.1	1.6	1.5	0.4	0.5	0.5
Amphetamines	2.9	3.5	4.5	0.4	0.4	0.4	0.2	0.1	0.1
Ecstasy	3.7	5.5	6.9	1.1	1.2	0.5	0.3	0.3	0.1
LSD	2.9	2.9	4.4	0.1	0.1	0.3	0.0	0.0	0.0
Magic mushrooms	3.8	5.9	6.5	0.4	0.6	0.5	0.0	0.0	0.0
Solvents	1.7	1.9	2.6	0.1	0.0	0.1	0.0	0.0	0.1
Poppers	2.6	3.3	3.9	0.4	0.5	0.2	0.1	0.1	0.1
Sedatives or tranquilisers	**	10.6	13.9	**	4.7	6.5	**	3.0	2.8
Anti-depressants	**	9.3	10.4	**	4.4	4.8	**	3.2	4.1
New psychoactive substances	***	***	***	***	***	3.5	***	***	***
Tobacco	60.0	57.9	56.7	38.0	36.3	32.5	33.2	32.6	28.3
Alcohol	90.1	90.2	90.3	83.3	84.0	85.3	73.9	73.2	70.6

*Any illegal drugs refers to amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

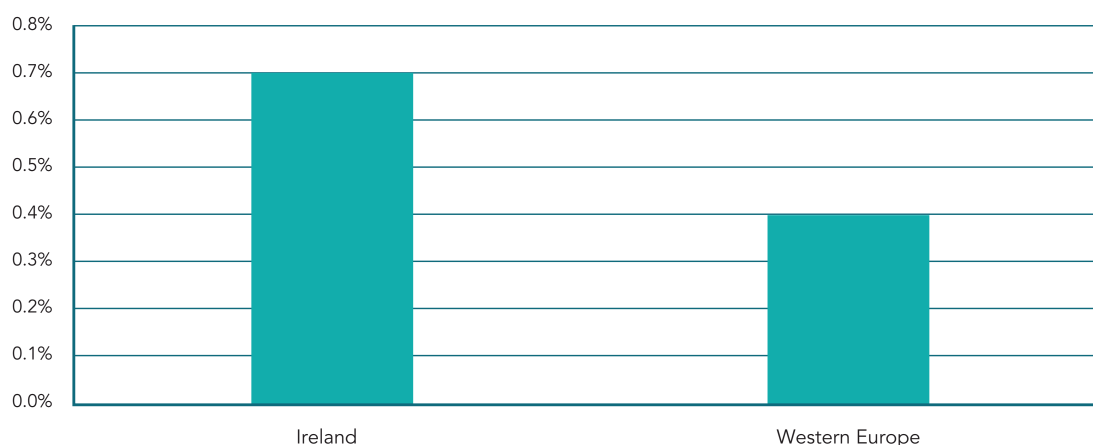
**In 2002/3 the survey asked about use of sedatives, tranquillisers or anti-depressants together. Since 2006/7 the survey has asked about sedatives/tranquillisers and anti-depressants separately.

***In 2010/11 the survey asked respondents about their use of New Psychoactive Substances for the first time. The survey asked about use in the last 12 months only.

^ Tests for statistical significance between the prevalence of 'Other opiates' are not reported. As a result of measurement changes in 2006/7 and 2010/11, the 'Other opiates' category is not comparable between the surveys. The measurement of 'Other opiates' in Ireland in 2002/3 included nine drugs: Opium, Temgesic®, Diconal®, Napps, MSTs®, Pethidine, DF118®, (Dihydrocodeine), Buprenorphine and Morphine. In 2006/7 the category 'Other opiates' was extended to be consistent with Northern Ireland and included: Codeine, Feminax, Kapake, Diffs, Dikes, Peach, Fentanyl (Durogesic®, Sublimaze®, Actiq®), Oxycodone (Oxycontin®, Oxynorm®), and Buprehnorphine (Subutex®). In 2010/11 the category 'Other opiates' also asked specifically about substances containing codeine such as Maxilief, Migraleve, Nurofen Plus, Codeine Phosp, Panadeine, Paracetamol/Caffeine/Codeine and Doxylamine, Paracodin, Paramol, Solpadeine, Solpadol, Syndol, Tylex, Uniflu Plus, Veganin Plus.

Source: National Advisory Committee on Drugs and Public Health Information and Research Branch, Drug use in Ireland and Northern Ireland: First results from the 2010/11 Drug Prevalence Survey, Dublin, 2011, p. 13.

Figure 4: Prevalence of Problem Opioid Use



Sources: European Monitoring Centre for Drugs and Drug Addiction, European Drug Report 2014: Trends and Developments, Luxembourg, 2014, p. 73; and J. Long and S. Lyons, 'Problem opiate use in Ireland', Drugnet Ireland, Issue 32, Winter 2009, pp. 11-14.

Physical and Psychological Effects of Drug Dependency

Unlike alcoholic beverages, where a single psychoactive substance, ethanol, is responsible for the psychiatric and physiological side effects of consumption, a wide array of substances fall under the broad banner of illict drugs, all of which produce a variety of different reactions by the body, and in particular the brain.

Regardless of the various chemical effects of the array of different drug classes during intoxication, persistent use of virtually all drugs can produce a usage disorder within an individual. This disorder can be characterised by:

- the use of the substance in larger amounts or over a longer period than was intended;
- a persistent desire or unsuccessful efforts to cut down or control use of the substance;
- spending a lot of time on activities necessary to obtain the substance, use the substance, or recover from its effects;
- craving, or a strong desire or urge to use the substance;
- recurrent use of the substance resulting in a failure to fulfil major role obligations at work, school, or home;
- continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use;
- important social, occupational, or recreational activities given up or reduced because of use of the substance;
- recurrent use of the substance in situations in which it is physically hazardous;
- tolerance of the substance, marked by the use of increased amounts of the substance to achieve intoxication or desired effect, or experiencing a diminished effect while continuing to use the same amount; and
- withdrawal, manifested by exhibiting the symptoms of physical withdrawal characteristic of that substance, or use of the substance to alleviate or avoid withdrawal symptoms.[11]

The number of symptoms of substance use disorder a sufferer exhibits will, in most cases, determine the severity of that dependency.

11 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, American Psychiatric Association, Arlington, 2013.

A large number of illegal substances see regular use in Ireland, all of which may pose serious risks to the user, either by presenting acutely or developing over time into chronic health problems. Broadly, the most popular of such chemicals can be divided into five categories, each presenting their own particular health risks. They include:

1 Sedatives and Tranquilisers

Benzodiazepines are probably the most popular class of drug within this category, with well-known names like Xanax and Valium being products within its class. These drugs can be legally prescribed by doctors and can be of benefit to patients when taken as directed over short periods of time. Long-term or unregulated use of these drugs can be harmful, however, as they can induce dependency, poison users when taken in large doses, and long-term use has been linked to neurological illnesses, like Alzheimer's disease.[12] Combining benzodiazepines with alcohol, or with painkillers or anti-histamines can lead to coma or respiratory failure.

2 Opiates

These are strong pain-killers and include drugs such as morphine, which is often used in hospital settings under the direction of a doctor. Other opiates, such as heroin, are illegal and frequently contain additives that are dangerous, particularly when injected. Heroin is extremely addictive and heroin users often experience a wide range of health problems including abscesses, blood clots, gangrene, and various intellectual and psychiatric disorders.[13] Heroin users are also at high risk of blood-borne viruses such as Hepatitis B and C and HIV from the use of contaminated needles.[14]

3 Stimulants

Stimulants produce chemical reactions in the brain that frequently make the user feel more alert, awake, or energetic and include substances like amphetamines and cocaine. Their use can produce immediate negative health consequences, such as cardiac problems, as well as long-term psychiatric illness, such as depression and anxiety disorders.[15] Many can also be injected, and therefore carry the risk of contracting blood-borne diseases in a similar manner to opioid users.

4 Hallucinogens

Hallucinogens, such as ecstasy and lysergic acid diethylamide (LSD), when ingested can produce powerful visions or hallucinations and addiction to this class of drugs can cause severe and lasting health problems. Several studies have reported that use of ecstasy (MDMA) ultimately leads to impaired memory and decreased performance on intelligence testing and that the level of consumption serves to increase these effects.[16] There are suggestions that some of this brain damage can remain after use of ecstasy has long been discontinued.[17]

5 Cannabis

Cannabis is the most commonly used illegal drug in Ireland.[18] It is generally either smoked or eaten and its use can therefore carry similar health risks as other forms of smoking. Cannabis is associated with memory problems

12 S. Billioti de Gage *et al.*, 'Benzodiazepine use and risk of Alzheimer's disease: case-control study', *British Medical Journal*, 2014;349:g5205.

13 M. Lyvers and M. Yakimoff, 'Neuropsychological correlates of opioid dependence and withdrawal', *Addictive Behaviours*, Vol. 28, Issue 3, pp. 605-611.

14 M. Gossop *et al.*, 'Multiple risks for HIV and hepatitis B infection among heroin users', *Drug and Alcohol Review*, Vol. 13, Issue 3, 1994, pp. 293-300.

15 L. L. Cregler, 'Adverse health consequences of cocaine abuse', *Journal of the National Medical Association*, Vol. 81, Issue 1, January 1989, pp. 27-38; B. J. Rounsaville, 'Psychiatric Diagnoses of Treatment-Seeking Cocaine Abusers', *Archives of General Psychiatry*, Vol. 48, Issue 1, January 1991, pp. 43-51.

16 F. X. Vollenweider *et al.*, 'Acute Psychological and Neurophysiological Effects of MDMA in Humans', *Journal of Psychoactive Drugs*, Vol. 34, Issue 2, 2002, pp. 171-184; G. J. H. Dsumont *et al.*, 'Acute neuropsychological effects of MDMA and ethanol (co-)administration in healthy volunteers', *Psychopharmacology*, Vol. 197, Issue 3, April 2008, pp. 465-474; J. H. Halpern *et al.*, 'Residual neuropsychological effects of illicit 3,4-methylenedioxymethamphetamine (MDMA) in individuals with minimal exposure to other drugs', *Drug and Alcohol Dependence*, Vol. 75, Issue 2, August 2004, pp. 135-147.

17 K. I. Bolla, U. D. McCann, and G. A. Ricaurte, 'Memory impairment in abstinent MDMA ("Ecstasy") users', *Neurology*, Vol. 51, Issue 6, December 1998, pp. 1532-1537.

18 National Advisory Committee on Drugs and Public Health Information and Research Branch, *Drug use in Ireland and Northern Ireland: First results from the 2010/11 Drug Prevalence Survey*, Dublin, 2011, p. 13.

and lack of concentration and motivation. In young people, long-term use can impact on brain function and behaviour and is associated with schizophrenia. The use of cannabis has been associated in a number of studies with the use of other illicit drugs, and it may provide a gateway, therefore, into habitual consumption of other substances[19]. At the same time cannabinoids from the marijuana plant may be useful in reducing pain and inflammation, muscle control, controlling epileptic seizures, and is used in the treatment of multiple sclerosis. There is a need to establish an expert committee to examine these issues.

Use of all of these drugs, to a greater or lesser degree, bears the possibility of developing substance use disorders or dependency, which carry social and psychological consequences independent of the physiological effects caused by the ingestion of each of these chemicals. The patterns and locations of use, dosages and physiological effects all differ significantly between these classes. As a result, in order to achieve success in preventing and combating drug use, all public policy in this area must be reflective of these variances.

Hospitalisation and Mortality amongst Drug Users in Ireland

Recently released statistics from the Health Research Board on drug-related deaths in Ireland show that in the eight year period from 2004 to 2011, a total of 4,606 deaths by drug poisoning and deaths amongst drug users were recorded, with the annual number of poisoning deaths recorded in 2011 rising to 365, compared to the 267 recorded in 2004.[20] The majority of these deaths involved a number of substances simultaneously, including alcohol, however alcohol alone was responsible for only 17%, or sixty-one, of deaths due to poisoning in 2011, while just under 25% were caused by a single non-alcohol drug.[21] The disastrous consequences of opioid use are evident from this report, as drugs of this class were shown to be involved in 57% of poisoning fatalities.[22] Ireland has the third-highest rate of adult drug-induced deaths in the EEA, with 70.5 cases per million presenting annually, behind only Estonia (190.8 cases per million), and Norway (75.9 cases per million).[23] Adult drug-induced deaths in Ireland occur at more than three times the EU average of 17.1 cases per million, and more than twice the west European average of 29.1 cases per million.[24] 78% of those who die from poisoning as a result of opioid use are not part of a methadone treatment programme, underscoring how vital treatment access is to users.[25]

In 2011 there were 580 overdose cases admitted to Irish hospitals that involved narcotics or hallucinogens including opioids, cocaine, and cannabis, with a further 960 resulting from benzodiazepine ingestion.[26] Furthermore, those with drug disorders represented 18% of all admissions to Irish psychiatric units and hospitals in 2013, a figure that amounts to over 3,300 cases.[27]

19 D. M. Fergusson, J. M. Boden, and L. J. Horwood, 'Cannabis use and other illicit drug use: testing the cannabis gateway hypothesis', *Addiction*, Vol. 101, Issue 4, pp. 556-569; H. O. Mellberg, A. M. Jones, and A. L. Bretteville-Jensen, 'Is cannabis a gateway to hard drugs?', *Empirical Economics*, Vol. 38, Issue 3, pp. 583-603.

20 Health Research Board and Public Health Information and Research Branch, *Drug-Related Deaths and Deaths among Drug Users in Ireland: 2011 figures from the National Drug-Related Deaths Index*, January 2014, p. 1.

21 Ibid, p. 7.

22 Ibid, p. 8.

23 European Monitoring Centre for Drugs and Drug Addiction, *European Drug Report 2014: Trends and Developments, Publications Office of the European Union*, Luxembourg, 2014, p. 78.

24 Ibid.

25 C. Ó Súilliobháin, *Access to Community Based Drug Treatment*, presentation delivered to the British Medical Association and Irish Medical Organisation All-Ireland Conference on Mental Health and Addiction, Dublin, 21 November 2014.

26 Health Research Board, *2013 National Report (2012 Data) to the EMCDDA by the Reitox National Focal Point: Ireland – New Developments,Trends, and In-Depth Information on Selected Issues*, Dublin, 2013, pp. 88-89.

27 Health Research Board, *HRB Statistics Series 25: Activities of Irish Psychiatric Units and Hospitals 2013 – Main Findings*, Dublin, 2014, p. 4.

Dual-Diagnosis: Comorbidity of Psychiatric and Substance Abuse Disorders in Ireland

A variety of studies across Europe have estimated that between a third and half of patients being treated for substance abuse have an independent co-occurring psychiatric illness.[28] These findings have been replicated in studies that have focused on cohorts of Irish patients.[29] Psychiatric illnesses found to co-occur with substance problems range from anxiety or depressive disorders to ADHD, paranoia, schizophrenia, and other mood or personality disorders.[30] It is possible that a variety of issues lead to comorbidity as described: drug use may cause users to experience the symptoms of a psychiatric illness; drug use may lead to the triggering of an underlying psychiatric illness; suffers of psychiatric illnesses may use drugs to alleviate the symptoms of such illnesses; and problem substance use and psychiatric illnesses may both be triggered by common factors such us environmental stressors or genetic predispositions.[31]

Research has shown that those suffering from comorbid substance abuse and psychiatric illness typically experience poorer treatment outcomes than those suffering from a single mental health ailment. Those suffering from a substance misuse disorder are more likely to relapse following treatment and in some cases may take longer to recover from a psychiatric episode.[32]

Supply and Prevention of Drug Use in Ireland

The current strategy for tackling drug abuse is contained in the *National Drugs Strategy (Interim) 2009-2016* which, as mentioned above, makes a number of recommendations under the pillars of Supply, Prevention, Treatment and Rehabilitation, and Research.

The first objective of the Strategy aims to reduce the volume of illicit drugs in Ireland with a targeted increase of 25% in the volume of drugs seized. However despite the increase in seizures between 2004 and 2007 Figures 5 and 6 show the extent to which drug seizures have fallen since their height in 2007. This reduction in seizures, coupled with the increase in drug use nationally reported across almost all substances, leads to the conclusion that the reduction in seizure numbers are not as a result of a fall in demand. The restriction of availability, much like in the case of alcohol, is an important facet in tackling consumption, and therefore the IMO urges the Government to restore all resources to State agencies charged with seizing drugs and intercepting drugs shipments in an effort to reduce the volume of drugs on Irish streets, thereby affecting their availability and price in a manner that will reduce consumption.

Stiff penalties are also required to deter the importation and sale of illegal drugs into Ireland. The IMO recommends that mandatory life sentences should be imposed on those found guilty of major drug crimes.

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28 S. J. Schulte *et al.*, 'Treatment approaches for dual diagnosis clients in England', *Drug and Alcohol Review*, Vol. 27, Issue 6, November 2008, pp. 650-658; R. Wynn, A. Landheim, and E. Hoxmark, 'Which factors influence psychiatric diagnosing in substance abuse treatment?', *International Journal of Mental Health Systems*, Vol. 7, Issue 1, June 2013, doi: 10.1186/1752-4458-7-17; K. E. Watkins *et al.*, 'Prevalence and Characteristics of Clients with Co-Occurring Disorders in Outpatient Substance Abuse Treatment', *American Journal of Drug and Alcohol Abuse*, Vol. 30, Issue 4, November 2004, pp. 749-764.

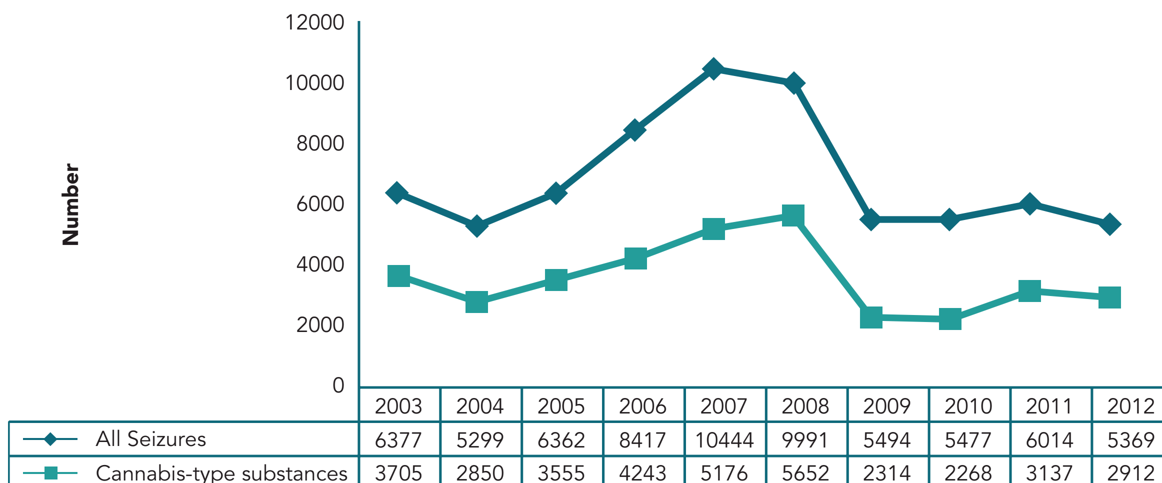
29 A. Dixit and A. Payne, 'Prevalence of substance misuse comorbidity in an Irish university training hospital', *Irish Journal of Psychological Medicine*, Vol. 28, Issue 4, pp. 201-204; P. D. James, B. P. Smyth, and T. Apantaku-Olajide, 'Substance use and psychiatric disorders in Irish adolescents: a cross-sectional study of patients attending substance abuse treatment service', *Mental Health and Substance Abuse*, Vol. 6, Issue 2, 2013, pp. 124-132.

30 D. S. Hasin *et al.*, ' Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Alcohol Abuse and Dependence in the United States', *Archives of General Psychiatry*, Vol. 64, Issue 7, July 2007, pp. 830-842.

31 European Monitoring Centre for Drugs and Drug Addiction, *Co-morbid substance use and mental disorders in Europe: a review of the data*, Lisbon, 2013, p. 3, (available at http://www.emcdda.europa.eu/publications/emcdda-papers/co-morbidity [accessed on 4 March 2015 at 10.23am]).

32 M. Tohen, C. M. Waternzux, and M. T. Tsuang, 'Outcome in mania: a 4-year prospective follow-up of 75 patients using survival analysis', *Archives of General Psychiatry*, Vol. 47, 1990, pp. 1106-1111; M. Tohen *et al.*, 'The McLean-Harvard First-Episode Mania Study: Prediction of Recovery and First Recurrence', *American Journal of Psychiatry*, Vol. 160, Issue 12, December 2003, pp. 2099-2107.

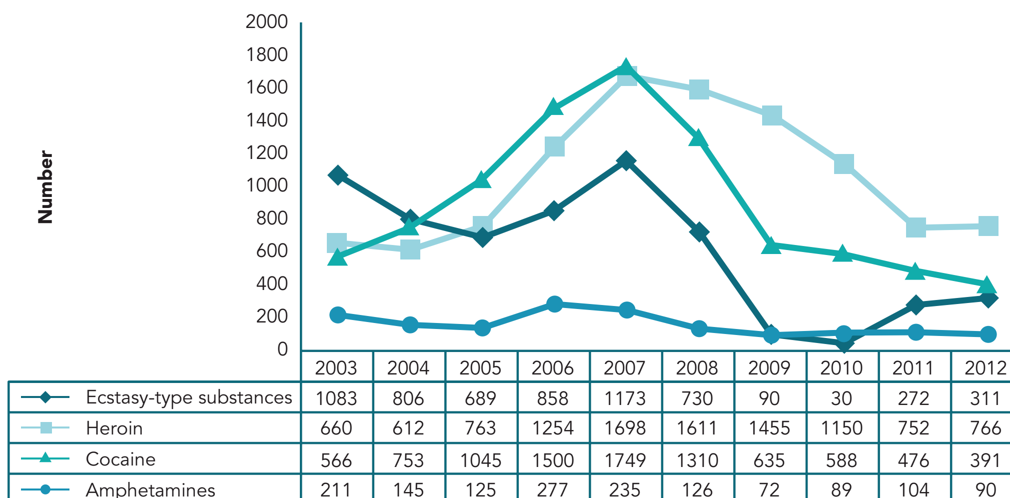
Figure 5: Trends in the Total Number of Drug Seizures and Cannabis Seizures, 2003-2012



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
All Seizures	6377	5299	6362	8417	10444	9991	5494	5477	6014	5369
Cannabis-type substances	3705	2850	3555	4243	5176	5652	2314	2268	3137	2912

Source: Health Research Board, 2013 National Report (2012 Data) to the EMCDDA by the Reitox National Focal Point: Ireland – New Developments, Trends, and In-Depth Information on Selected Issues, Dublin, 2013, p. 147-148.

Figure 6: Trends in the Number of Seizures of Selected Drugs, Excluding Cannabis, 2003-2012



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Ecstasy-type substances	1083	806	689	858	1173	730	90	30	272	311
Heroin	660	612	763	1254	1698	1611	1455	1150	752	766
Cocaine	566	753	1045	1500	1749	1310	635	588	476	391
Amphetamines	211	145	125	277	235	126	72	89	104	90

Source: Health Research Board, 2013 National Report (2012 Data) to the EMCDDA by the Reitox National Focal Point: Ireland – New Developments, Trends, and In-Depth Information on Selected Issues, Dublin, 2013, p. 147-148.

Given the clear and well accepted health risks associated with drug use, much psychological and sociological research has attempted to understand the reasons for persistent drug use in populations and many competing theories exist to explain the phenomenon. Common themes, however, are evident across the academic literature in this field, which can essentially be distilled to socio-economic class or standing, peer use, level or standard of parental or guardian supervision, and drug market forces, namely availability and cost. A recent study by the NACDA reaffirms that many of these aforementioned themes play primary causal roles in drug use in Ireland, with the absence of facilities for young people; high unemployment; boredom; poor parental supervision; and drug availability mentioned as part of the study.[33]

33 J. Connolly and M. Donovan, *Illicit Drugs Markets in Ireland,* National Advisory Committee on Drugs and Alcohol, Dublin, 2014, pp. 1-10.

In 2013, the Department of Children and Youth Affairs provided overall funding of €51.423m to support the provision of youth services, with an additional €1.55m in capital funding for a Youth Café Scheme in that year.[34] While the additional funding is welcome, further resources are required to support evidence-based training, and education and prevention programmes. Established organisations with high levels of respect in the community, such as sporting bodies, theatre and artistic groups, and social clubs or societies focused young people or young adults must be encouraged to promote drug education and prevention programmes in a manner where adequate support, both in terms of training and finance, is provided to local leaders of such groups or projects. This also must be completed in a manner that attempts to guarantee the availability of such services to young people and young adults nationally.

IMO Recommendations

- **Restore funding and resources to State agencies in order to halt and reverse the sharp reduction in drugs seizures of recent years.**
- **Impose mandatory life sentences for all those convicted of major drug trafficking crimes.**
- **Strengthen funding and resources to support community organisations focused on young people or young adults that promote drug education and prevention programmes.**

Gambling Addiction in Ireland

Though often overlooked, most likely due to its insidious and mental effects on health, rather than the severe and acute physiological reactions that can be produced by alcohol and drug abuse, problem gambling is undoubtedly a strong feature on the Irish addiction landscape. In recent times well-known Irish and Northern Irish athletes and sports figures such as Niall McNamee, Oisín McConville, and Keith Gillespie have spoken publicly about their struggles with gambling addiction. No academic studies have adequately investigated the extent of problem gambling in Ireland, however what research has been conducted indicates that at any one time 1% of the adult population may be experiencing problem gambling, while lifetime prevalence of this addiction may be as high as 5%.[35] Without a detailed awareness of the extent and causes of this problem, the potential for the development of effective remedial action is greatly reduced. The IMO therefore calls for urgent critical survey work to be conducted into problem gambling on this island, which will aid policy makers and health service providers in tackling this condition.

Although it is unclear, as a result of the absence of adequate research, what the precise gambling habits of the Irish populace are, it is evident that gambling is a growing sector in Ireland. Expenditure in gambling grew from €1.6bn in 2001 to €3.6bn in 2006, with share prices of companies associated with gambling services continuing to rise, demonstrating confidence in the industry.[36] As many as 60% of Irish adults gamble to some degree weekly, although for some the extent of this gambling may be playing the National Lottery.[37] There is little reliable information however on betting patterns outside of the National Lottery, or on the average weekly expenditure of Irish gamblers on the habit.

Supply and Prevention Measures

Robust regulations capable of protecting young people from the advertising efforts of gambling or betting service providers, or the means through which such operators attempt to win customers, do not yet exist. The IMO believes that regulatory controls to limit the exposure of young people to gambling should be instigated immediately, including those that limit the intensity or frequency of gambling service advertisements, especially those hosted on web pages and social networks that facilitate immediate access to online gambling through "one-click" hyperlinks.

34 Department of Health, *National Drugs Strategy 2009-2016: Progress Report to End 2013*, Dublin, 2014, p. 13.

35 Institute of Public Health in Ireland, *Developing a Population Approach to Gambling: Health Issues – Briefing Paper*, Dublin, December 2010, p.1 (available at http://www.publichealth.ie/files/file/Developing%20a%20population%20approach%20to%20gambling.pdf [accessed on 10 March 2015 at 4.22pm]); C. O'Gara, 'Assessing and treating problem gambling', *Irish Medical Times*, Dublin, 5 October 2010, (available at http://www.imt.ie/clinical/2010/10/assessing-and-treating-problem-gambling.html [accessed on 11 March at 9.41am]).

36 P. Wall, *Gambling in Ireland: Some public health considerations*, Paper presented at the Public Health Conference, University College Dublin, Dublin, 2007 p. 1; Institute of Public Health in Ireland, *Developing a Population Approach to Gambling: Health Issues – Briefing Paper*, Dublin, December 2010, p. 2, (available at [accessed on 10 March 2015 at 4.22pm]).

37 M. D. Griffiths, 'Problem gambling in Europe: what do we know?', *Casino and Gaming International*, Vol. 6, Issue 2, 2010, pp. 81-84.

Taking a tough regulatory line is essential. It has been well established that gambling service providers rely on problem gamblers for a considerable fraction of their income, with estimates from studies in Australia and Canada revealing this amounted to one-third and one-quarter of income in the respective cases.[38] There is therefore little incentive for the industry to self-regulate effectively or put in place strong measures that will drastically reduce the prevalence of problem gambling.

Effective educational programmes are also required to raise awareness of problem gambling. Social, Personal, and Health Education curricula at primary and secondary level deal with a broad variety of addiction and dependence topics, but focus heavily on alcohol and drug abuse. Given the prevalence of gambling in Ireland, and the increased access that most young people and adults have to gambling through smartphones or other portable internet-enabled devices, it is crucial that formal educational programmes are put in place in an effort to prevent engagement in problem gambling or behaviour that may lead to problem gambling.

IMO Recommendations

- **Fund research into the extent of problem gambling and its effects on individuals and their families in Ireland.**
- **Introduce regulatory control measures that limit the frequency of advertisements for gambling services.**
- **Develop educational programmes that raise awareness of the issue of problem gambling in the Social, Personal, and Health Education curricula.**

Substance Abuse and Addiction Services in Ireland

Detoxification and rehabilitation services for alcohol and drug dependency are provided by a mixture of public, voluntary not-for-profit, and private services, including general hospitals and psychiatric hospitals. Most treatment takes place in outpatient facilities, with more complex treatment taking place in residential settings. No centralised strategy exists for the treatment of substance abuse in Ireland, and significant gaps in services exist.

- Despite the substantial prevalence of alcohol dependence amongst adults in Ireland, relatively few are treated. Problem alcohol use was treated in 8,336 cases in 2012 in Ireland and the prevalence of problem alcohol treatment in the age fifteen to sixty-four group was 0.26%, with a median treatment age of forty.[39] The WHO's assessment of the prevalence of alcohol dependence in Europe measures Ireland at 3.8% of the adult population, while other estimates suggest that approximately 7% may be dependent.[40] This clearly displays that health services in Ireland have failed to penetrate the sizeable portion of the Irish population who are alcohol dependent, particularly within young adult age groups, to any great degree. This failure to treat alcohol dependence leads to continuing pressure on health services in other areas and increased premature mortality.

  There is a clear disparity in the uptake of treatment services for problem alcohol use nationally, with treatment incidence ranging from 60.3 per 100,000 of the age fifteen to sixty-four population in Clare, to 309.6 per 100,000 of the age fifteen to sixty-four population in Waterford, as displayed in Figure 7. Furthermore, the incidence of treatment does not appear to bear any correlation with alcohol consumption in the assessed regions, as previous observations have reported both Clare and Dublin as amongst the top five counties in Ireland in terms of alcohol consumption, yet have some of the lowest rates of treatment.[41] This is suggestive that problem alcohol treatment in Ireland is not responsive to the level of alcohol abuse or dependence in various regions of the country, but instead is dependent on criteria other than patient need.

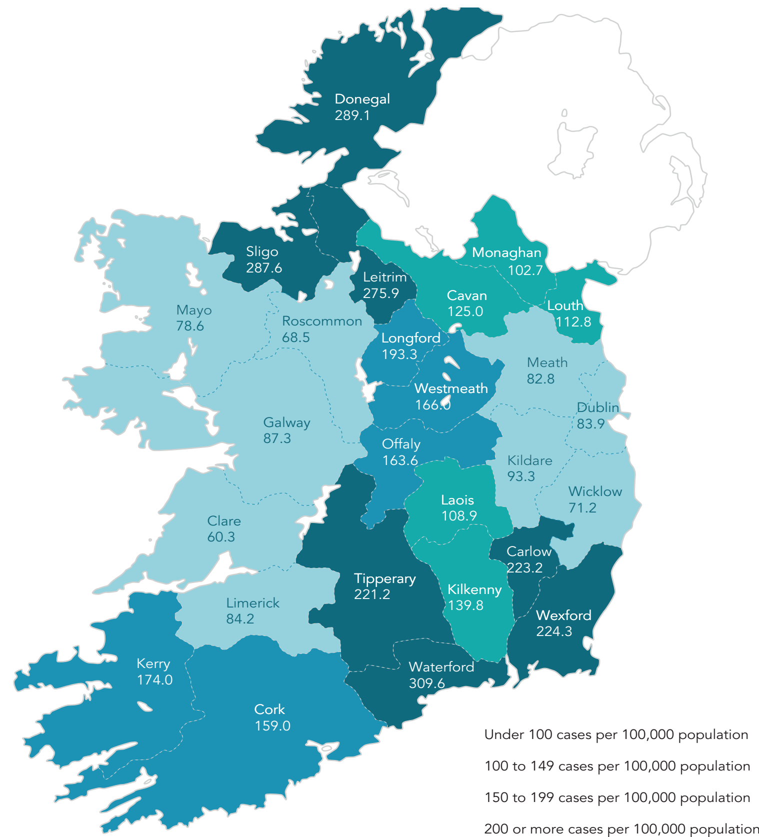
38 R. J. Williams, and R. T. Wood, 'The Proportion of Gaming Revenue Derived from Problem Gamblers: Examining the Issues in a Canadian Context', *Analyses of Social Issues and Public Policy*, Vol. 4, Issue 1, pp. 33-45; The Productivity Commission*, Australia's Gambling Industries, Report No. 10*, AusInfo, Canberra, 1999, p. 21.

39 Health Research Board, *Treated alcohol use in Ireland: figures for 2012 from the National Drug Treatment Reporting System*, National Health Information Systems, Dublin, 2014, p. 1, (available at [accessed on 22 January 2015 at 12.30pm]).

40 World Health Organisation, *Global Status Report on Alcohol and Health 2014*, Geneva, 2014, p. 216; National Advisory Committee on Drugs and Alcohol and Public Health Information and Research Branch, *Drug Use in Ireland and Northern Ireland: Alcohol Consumption and Alcohol-Related Harm in Ireland 2010/2011 Drug Prevalence Survey*, Dublin, 2012, p. 10.

41 L. Delaney, A. Kapteyn, and J. Smith, 'Why do some Irish drink so much? Family, historical and regional effects on students' alcohol consumption and subjective normative thresholds', *Review of Economics of the Household*, Vol. 11, Issue 1, March 2013, pp. 1-27.

Figure 7: Average Annual Incidence of Treated Problem Alcohol Use by County of Residence, per 100,000 of the 15-64 Year Old Population



Average Annual incidence of treated problem alcohol use,
by county of residence, per 100,000 of the 15-64-year-old population

Source: Health Research Board, Treated alcohol use in Ireland: figures for 2012 from the National Drug Treatment Reporting System, National Health Information Systems, Dublin, 2014, p. 10.

- From 2003 to 2008 problem benzodiazepine use treated by Irish health services rose by 63%, increasing from 1,054 cases to 1,719.[42] The number of cases where benzodiazepines were the main problem substance was small, amounting to just 167 cases in 2008, however the number of cases where benzodiazepines were reported as a secondary or additional problem substance was considerably larger, with 982 cases reported in 2003, rising to 1,562 cases by 2008. There are currently, however, no appropriate acute treatment facilities for those with alcohol and benzodiazepine addiction.[43]
- With some of the highest drug-related death rates and opioid dependence rates in the EU, reductions in the number of opioid-related problem drug cases entering treatment, seen between 2011 and 2012, is of particular concern. The 9% reduction in cases entering treatment year-on-year (4,351 in 2011 to 3,971 in 2012) shows that, despite the increasing prevalence of opioid use, fewer problem users are accessing treatment. Ireland has 8,923 clients in substitution treatment for opioid use from a total opioid user population of approximately 21,000 people.[44] This

42 D. Bellerose *et al.*, *Problem Benzodiazepine Use in Ireland: Treatment (2003 to 2008) and deaths (1998 to 2007)*, Health Research Board, Dublin, 2010, p. 1-3.

43 Ibid.

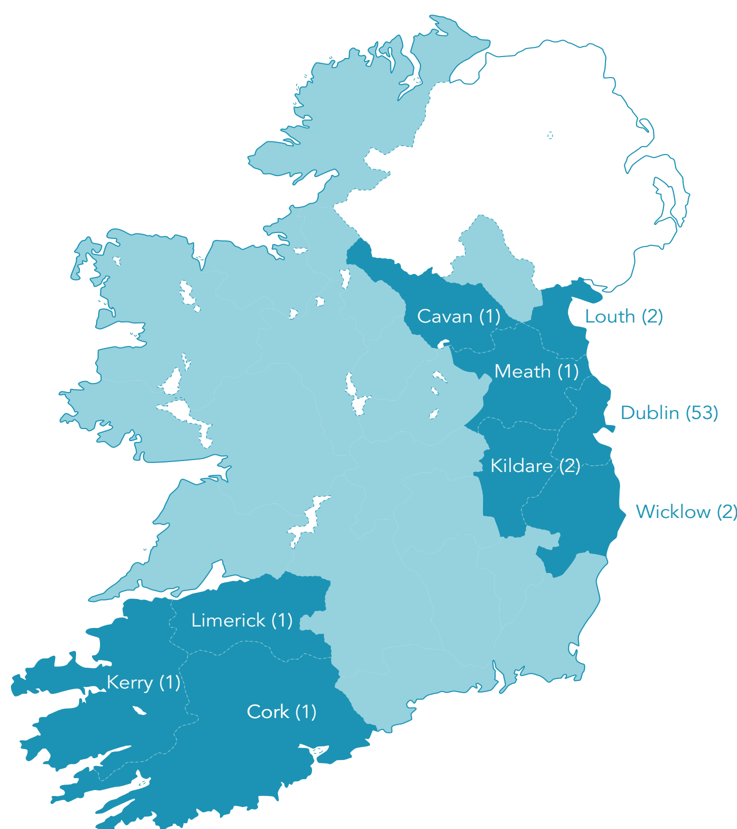
44 European Monitoring Centre for Drugs and Drug Addiction, *European Drug Report 2014: Trends and Developments, Publications Office of the European Union*, Luxembourg, 2014, p. 73; J. Long and S. Lyons, 'Problem opiate use in Ireland' in *Drugnet Ireland*, Issue 32, Winter 2009, pp. 11-14.

compares unfavourably to many other west European states including Luxembourg, Malta, Italy, Austria, the United Kingdom, and the Netherlands, all of which report that the majority of problem opioid users within their states are receiving substitution treatment.[45]

The Methadone Protocol Scheme was introduced in 1998 following a shift in policy direction regarding drug treatment from an in-patient abstinence philosophy to a community-based model of services delivered by GPs from a harm reduction perspective. At the IMO and BMA Northern Ireland Joint Conference on Mental Health and Addiction in November 2014, a number of issues were raised in relation to the Scheme.

While the majority of opioid users are based in Dublin, approximately 30% live outside the capital.[46] Despite this, the distribution of methadone treatment services remains concentrated in Dublin, with few Level 2 GPs practising outside the Dublin region and none west of the Shannon. In 2009 8,551 patients were receiving methadone treatment, however only 1,674 of these were patients of a Level 2 GP.[47] Figure 8 clearly shows this unequal distribution, which severely limits the treatment options of those living outside of the Dublin area.

Figure 8: Geographical Distribution of Level 2 GPs in Ireland



Source: C. Ó Súilliobháin, Access to Community Based Drug Treatment, presentation delivered to the British Medical Association Northern Ireland and Irish Medical Organisation All-Ireland Conference on Mental Health and Addiction, Dublin, 21 November 2014.

45 Ibid, p. 59.

46 A. Kelly, C. Teljeur, M. Carvalho, *Prevalence of Opiate Use in Ireland 2006: A 3-Source Capture Recapture Study*, National Advisory Committee on Drugs and Alcohol, Dublin, 2009, p. 7.

47 M. Farrell and J. Barry, *The Introduction of the Opioid Treatment Protocol*, Health Service Executive Social Inclusion Unit, Dublin, 2010, p. 7.

Other issues highlighted at the IMO and BMA Northern Ireland All-Ireland Conference on Mental Health and Addiction were the lack of governance structures for addiction services, the absence of evidence-based guidelines for care, and a focus on the medical model rather than a more holistic approach including psychotherapeutic interventions for the treatment of patients.

In 2009 the HSE commissioned Professor Michael Farrell to carry out a review of the Methadone Treatment Protocol (MTP). The report published in 2010 made a number of proposals including recommendations in relation to maximising treatment provision and the effectiveness of referral pathways as well as recommendations in relation to the enrolment and training of GPs in the MTP. The IMO supports the recommendations of the Farrell Report (2010) and calls on the HSE to allow for the expansion of numbers of patients on the Opioid Treatment Protocol and thus increase access to treatment for heroin dependence throughout the country.

- Certain harm reduction initiatives such as the Pharmacy Needle Exchange have been successful in reducing the spread of blood-borne diseases and directing patients towards treatment services.[48] Given Ireland's high rate of adult drug-induced deaths, it would be prudent for research to be conducted that will assess the potential benefits and risks of establishing medically-supervised safer injection facilities within State as a means of curtailing deaths due to overdose and directing further patients into treatment. Several other EU states, such as Portugal, Germany, and Spain have introduced such sites, which concentrate on harm reduction and prioritising the health interests of the drug user. International research has established the ability of such facilities to reduce drug-related harm to users, and so this option must be properly assessed as a potential viable public health measure to tackle drug-related harm.[49]
- *A Vision for Change* recommended the development of specialist services for patients with dual-diagnosis, comorbid substance abuse and mental illness, with clear pathways of referral in and out of services. Bar a dual diagnosis clinic at the National Drug Treatment Centre, few developments have been made in the establishment of services for patients with comorbid substance abuse and mental illness, or in the development of agreed protocols in the management of patients with co-existing disorders. The majority of patients continue to be treated by the mental health services or addiction services depending on their primary diagnosis. Research has indicated that addiction services in Ireland are reluctant to admit and treat patients with comorbid disorders due to a lack of mental health training of staff in those facilities.[50]
- In addition, there is no statutory provision of services to treat gambling addiction in Ireland. Financial loss and debt are often a consequence of problem gambling and as such private services are generally prohibitive to patients with a gambling addiction.

IMO Recommendations

The IMO is calling on the Government to urgently create a strategy for the development of treatment and rehabilitation services for alcohol and drug dependency to include the:

- **establishment of acute alcohol and illicit drugs detoxification centres for those who wish to choose detoxification as part of their recovery;**
- **development of appropriate acute treatment facilities for those with alcohol and benzodiazepine dependency;**
- **full implementation of the Farrell Report (2010) to allow for the expansion of numbers of patients on the Opioid Treatment Protocol and thus increase access to treatment for heroin dependence throughout the country;**
- **pursuit of research that will assess the potential benefits and risks of utilising supervised injection sites as a means of reducing drug-related harm and bringing patients into contact with drug treatment services;**

48 Health Service Executive Health Protection Surveillance Centre, *Health Protection Surveillance Centre Annual Report 2012*, Dublin, 2013, pp. 89-97; Department of An Taoiseach, *Programme for Government Annual Report 2015*, Dublin, 2015, p. 70; J. Long, J. Doyle, and D. O'Driscoll, 'Pharmacy needle exchange in Ireland', *Drugnet Ireland*, Issue 49, Spring 2014, pp. 19-20.

49 M. S. Milloy *et al.*, 'Estimated Drug Overdose Deaths Averted by North America's First Medically-Supervised Safer Injection Facility', *PLoS ONE*, 3(10), October 2008: e3351. doi:10.1371/journal.pone.0003351.

50 H. Byrne, *The role of mental health service (psychiatrists) and primary care services (GPs) in their treatment of dual diagnosis, a comparative study*, Thesis (Master's), Dublin City University, 2006, pp. 50-51.

- **development of specialist services in dual-diagnosis, comorbid substance dependency, and mental health illness with appropriate pathways of referral in and out of services and standardised protocols for care;**
- **appropriate training of all physicians in treatment of addiction and dual-diagnosis both as part of the core curriculum and continuing professional development; and**
- **provision of State funding for the treatment of gambling addiction.**

The Social Cost of Addiction

Addiction and Crime

The link between addiction and crime has been well established and extends beyond the simple illegality of manufacture, possession, or trade of most psychoactive substances in Ireland. This link is drawn primarily as a result of the economic incentives to commit crimes as a means of financing habitual drug use or dependency. A 2004 study, conducted by An Garda Síochána, concluded that 28% of all detected crime was perpetuated by drug users, while virtually all of the opioid users surveyed as part of this study admitted to funding their drug habits, at least in part, through criminal activities.[51]

Additionally, an internationally recognised connection exists between alcohol consumption and violent crimes. Statistics collected by An Garda Síochána support such findings, and an assessment of recorded public order incidents sampled over a five-month period showed that alcohol had been consumed by the offender in 97% of cases.[52]

One of the central features absent from Irish alcohol health services is an effective intervention programme, incorporating a referral procedure, for people who have come to the attention of various State authorities such as An Garda Síochána or officers of the Department of Social Protection. Systemised intervention schemes of this kind have been advocated repeatedly and a strong evidence base exists to suggest their efficacy.[53] Despite such recommendations, a comprehensive system has not been implemented whereby alcohol dependence risk-factors, such as alcohol abuse, identified by State agencies do not provoke an intervention by health service providers.

In order to reduce crime, factors that encourage or motivate criminal activities must be tackled. By effectively treating drug use, the impact of the criminal associations of addiction and dependency can be mitigated, thus rendering the policing of communities with an existing drugs problem more manageable.

It is also crucial that former drug users, including those who have been convicted of minor possession charges, are effectively supported in their reintegration into the workforce. Integration or reintegration into the workforce has been shown to be one of the most effective measures in preventing relapses into drug use, particularly amongst those who have served time in prison for drug possession or use.[54] Educational and vocational programmes that increase a treated problem drug user's labour market attractiveness must be seen as a vital component in a holistic treatment plan, as it is often only through the reintegration of the individual into society that reuse can be avoided. It must also be acknowledged that Ireland is the only country within the EU to not have in place a form of spent convictions legislation that will allow minor crimes to be removed from an individual's criminal record and that the implementation of such legislation would better enable many to re-enter the workforce following a conviction.

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51 M. Furey and C. Browne, *Opiate use and related criminal activity in Ireland 2000 & 2001: research report no. 4/03*, An Garda Síochána, Templemore, 2004.

52 University College Dublin Institute of Criminology, *Public order offences in Ireland: a report by the Institute of Criminology, Faculty of Law, University College Dublin for the National Crime Council*, Stationery Office, Dublin, 2003, p. 79.

53 Department of Health, *Steering Group Report on a National Substance Misuse Strategy*, Stationery Office, Dublin, 2012, p. 61; J. Barry and R. Armstrong, *Towards a Framework for Implementing Alcohol Based Alcohol Interventions*, Health Service Executive, Dublin, 2011, pp. 1-24; T. H. Bien, W. R. Miller, and J. S. Tonigan, 'Brief interventions for alcohol problems', *Addiction*, Vol. 88, Issue 3, 1993, pp. 315-336; A. I. Wilk, N. M. Jensen, and T. C. Havighurst, 'Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers', *Journal of General Internal Medicine*, Vol. 12, 1997, pp. 74-83.

54 Freudenberg, N. *et al.*, 'Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities' in the *American Journal of Public Health*, Vol. 95, Issue 10, October 2005, pp. 1725-1736.

Addiction and Homelessness

At the time of the last census, in April 2011, it was estimated that approximately 3,800 people in Ireland were homeless.[55] The homeless population has been observed to have a higher prevalence of substance abuse and dependency than the general population, particularly of illicit drugs. 36% of Irish homeless people are problematic drug users, with 22% of the homeless population being current users of heroin.[56] This very much contrasts to the equivalent figure in the general population, where 0.7% of adults are estimated to be heroin users.[57]

Alcohol and drug use is also a major causal factor leading to poverty and homelessness. Personal drug use (19% of homeless people) and alcohol use (13% of homeless people) were rated as the second and third most common causes of homelessness respectively in an analysis conducted by the National Advisory Committee on Drugs and Alcohol, after family conflict (24% of homeless people).[58] Homelessness is also an impediment to recovery with many of the most vulnerable homeless patients relapsing into addiction after detoxification.

Hidden Harm

The concept of 'Hidden Harm', that is to say the effect of addiction on persons other than the addict, such as close friends, family, or dependents, has received some academic attention in recent years. International research has shown that children, in particular, suffer acutely from a parent's hazardous relationship with alcohol, causing emotional distress, and being the genesis for physical and verbal abuse, as well as a degradation in expected parental care and support.[59] A large study into alcohol's harmful effects on others in Australia revealed that 12% of parents and carers reported that one or more of their children, under eighteen years of age, had been physically hurt, emotionally abused, or exposed to domestic violence because of the drinking of others, while a similar examination in the UK concluded that up to one in eleven children are affected by parental alcohol problems.[60]

Irish children are affected to the same degree as their international comparators, a fact confirmed by research conducted by the Irish Society for the Prevention of Cruelty to Children (ISPCC), which reported that 9% of children, aged between twelve and eighteen years of age, said that the alcohol use of their parents had affected them in a negative way.[61] Indeed, hazardous alcohol use in the presence of children is common in Ireland, with over half of all Irish adults (56%) who have children living in their households reporting regular hazardous drinking habits.[62] Children's exposure to parental drinking can have both immediate and persistent effects, both in terms of their attitude to alcohol, and their psychological health. Children who see their parents drunk are twice as likely to regularly get drunk themselves, while the effects of parental problem drinking have been noted to manifest as a broad range of psychological disorders in children such as shyness and social withdrawal, anti-social and aggressive conduct, and poor academic performance.[63] The consequences of such psychological disorders are obvious and may impact the development and prospects of children exposed to parental problem alcohol use.

55 Central Statistics Office, *Homeless Persons in Ireland: A special Census report*, Cork, 2011, p. 1, (available at [accessed on 15 January at 11.42am]).

56 M. Lawless, and C. Corr, *Drug Use Among the Homeless Population in Ireland: A Report for the National Advisory Committee on Drugs*, Stationery Office, Dublin, 2005, p. 97.

57 J. Long and S. Lyons, 'Problem opiate use in Ireland' in *Drugnet Ireland*, Issue 32, Winter 2009, pp. 11-14.

58 M. Lawless and C. Corr, *Drug Use Among the Homeless Population in Ireland: A Report for the National Advisory Committee on Drugs*, Stationery Office, Dublin, 2005, p. 54-57.

59 A. Wales and E. Gillan, *Untold Damage: children's accounts of living with harmful parental drinking*, Scottish Health Action on Alcohol Problems (SHAAP) and ChildLine in Scotland, Edinburgh, 2009, p. 9.

60 A. M. Laslett *et al.*, *The Range and Magnitude of Alcohol's Harm to Others*, Fitzroy, AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health, Victoria, 2010, p. 108; Prime Minister's Strategy Unit, *Alcohol Harm Reduction Strategy for England*, Cabinet Office Strategy Unit, London, 2004, p. 13.

61 Irish Society for the Prevention of Cruelty to Children, *If They're Getting Loaded, Why Can't I?*, Dublin, 2010, p. 9.

62 P. Bremner *et al.*, *Young People, Alcohol and Influences: A study of young people and their relationship with alcohol*, Joseph Rowantree Foundation, London, 2011, pp. 28-29.

63 S. Butler 'Addiction problems, addiction services, and social work in the Republic of Ireland', *Journal of Social Work Practice in the Addictions*, Volume 2, 2002, pp. 31-48.

Similar problems can be demonstrated in families where parental problem narcotic drug use is experienced. Parental problem drug use often impedes parenting and prevents the development of a suitably nurturing environment in which to raise children.[64] Furthermore, the risk of physical and sexual abuse of children more than doubles in households where a parent exhibits a substance abuse problem.[65]

Drugs Task Forces

The Local and Regional Drugs Task Forces, which have been in operation for almost twenty years, also have a crucial role to play in reducing drug consumption at regional and local level. The role of the Drugs Task Forces is to assess the nature and extent of drug problems in their area and develop local and regional strategies and action plans, and to co-ordinate local services to provide targeted responses at local level. Services include residential and community-based drug treatment and rehabilitation services, counselling, youth drug prevention projects, family support services and other measures aimed at reducing local substance abuse.

Now operating under the auspices of a newly formed National Co-ordinating Committee for Drug and Alcohol Task Forces, these bodies will have responsibility for alcohol use, as well as drugs. These changes arise from the Department of Health's *Report on the Review of the Drugs Task Forces and the National Structures under which they operate,* which was published in December 2012. The Department has not yet produced a clear and comprehensive report on the timeframe by which all of the fifteen recommendations contained in the report should be completed, including the amalgamation and expansion of a number of task forces nationwide, reducing their overall number from twenty-four to nineteen.[66]

Regrettably the ability of these task forces to achieve meaningful results in the combat of substance abuse in Ireland has been effectively neutered by continuous budget cuts. From 2013 to 2014 the funding from the Drugs Initiative, provided to Local and Regional Drugs Task Forces to spearhead community-based initiatives was reduced by 7%, from €29.95m to €27.95m.[67] There is no planned increase in these funds this year, which will now be split between available monies from the Department of Health (€7.83m) and the HSE (€21.6m).[68] This is in addition to a succession of cuts to the funding afforded to these bodies over the past seven years, with some budget cuts to task forces reported to be in excess of 20% over this period.[69]

Ultimately, if these renamed task forces are to play an active and pivotal role in reducing the supply of and demand for drugs at local and regional level throughout Ireland, they must be adequately resourced and given the ability to apply for funding for community-based projects through a system that is clear, simple, transparent, and comprehendible to all involved in the task forces' activities.

IMO Recommendations

- **Introduce spent convictions legislation that will allow minor crimes to be removed from an individual's criminal record, to better enable those convicted of minor possession offences to re-enter the workforce.**
- **Develop an effective substance abuse and dependence intervention programme, incorporating a referral procedure, for people who have come to the attention of various State authorities, such as An Garda Síochána or officers of the Department of Social Protection.**
- **Establish a cross departmental integrated approach to treatment and rehabilitation to ensure the education, housing, and social protection needs of patients and their families are met.**
- **Provide financial support to Local and Regional Drugs Task Forces and social services to address child and family related drug problems.**

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64 M. Bernard and N. McKenganey, 'The impact of parental problem drug use on children: what is the problem and what can be done to help?', *Addiction*, Volume 99, Issue 5, May 2004, pp. 552-559.

65 C. Walsh, H. L. MacMillan, and E. Jamieson, 'The relationship between parental substance abuse and child maltreatment: findings from the Ontario Health Supplement', *Child Abuse and Neglect*, Volume 27, Issue 12, December 2003, pp. 1409-1425.

66 Department of Health, *Report on the Review of Drugs Task Forces and the National Structures under which they Operate*, Dublin, 2012, pp. 1-12.

67 Department of Public Expenditure Reform, *Expenditure Report 2014*, Dublin, 2013, p. 168.

68 Department of Public Expenditure Reform, *Comprehensive Expenditure Report 2015-2017*, Dublin, 2014, p. 38.

69 Dáil Éireann, *Topical Issue Debate between Mr. Jonathan O'Brien, T.D. and Minister for State at the Department of Health, Mr. Alex White, T.D.*, Debates 2013, 22 October 2013.

Funding

Where reductions in available funding have given rise to impediments to effective treatment, alternative revenue streams should be sought. Proceeds acquired by the Criminal Assets Bureau relating to drug crime should be reinvested in drug treatment programs. In much the same way, levies should be placed on the alcohol and gambling industries in Ireland to ensure that contributions from these sectors of the economy fund the treatment and rehabilitation of those who have developed clinical dependencies on their products.

Mounting a successful campaign against drug use in Ireland requires, not only multi-faceted responses from our community infrastructure, education, health, housing, and criminal justice systems, but also adequate resources, both human and financial, to meet the challenge. So far, Ireland has failed to devote the necessary attention and resources to this problem to realise the possibility of reversing current usage trends.

IMO Recommendations

- **Introduce a levy on the alcohol and gambling industries to fund the treatment and rehabilitation of those who have developed clinical dependencies on their products.**
- **Route proceeds acquired by the Criminal Assets Bureau relating to drug crime to investment in drug treatment programs.**

Summary of Recommendations

Supply and Prevention

Alcohol

- **Implement the National Alcohol Strategy without delay to take immediate action to ban sponsorship and promotion of sports by the alcohol industry, and to introduce Minimum Unit Pricing for alcohol products.**

Substance Abuse

- **Restore funding and resources to State agencies in order to halt and reverse the sharp reduction in drugs seizures of recent years.**
- **Impose mandatory life sentences for all those convicted of major drug trafficking crimes.**
- **Strengthen funding and resources to support community organisations focused on young people or young adults that promote drug education and prevention programmes.**

Gambling

- **Fund research into the extent of problem gambling and its effects on individuals and their families in Ireland.**
- **Introduce regulatory control measures that limit the frequency of advertisements for gambling services.**
- **Develop educational programmes that raise awareness of the issue of problem gambling in the Social, Personal, and Health Education curricula.**

Substance Abuse and Addiction Services

The IMO is calling on the Government to urgently create a strategy for the development of treatment and rehabilitation services for alcohol and drug dependency to include the:

- **establishment of acute alcohol and illicit drugs detoxification centres for those who wish to choose detoxification as part of their recovery;**
- **development of appropriate acute treatment facilities for those with alcohol and benzodiazepine dependency;**
- **full implementation of the Farrell Report (2010) to allow for the expansion of numbers of patients on the Opioid Treatment Protocol and thus increase access to treatment for heroin dependence throughout the country;**
- **pursuit of research that will assess the potential benefits and risks of utilising supervised injection sites as a means of reducing drug-related harm and bringing patients into contact with drug treatment services;**
- **development of specialist services in dual-diagnosis, comorbid substance dependency and mental health illness, with appropriate pathways of referral in and out of services and standardised protocols for care;**
- **appropriate training of all physicians in treatment of addiction and dual-diagnosis both as part of the core curriculum and continuing professional development; and**
- **provision of State funding for the treatment of gambling addiction.**

Reducing the Social Cost of Addiction

- **Introduce spent convictions legislation that will allow minor crimes to be removed from an individual's criminal record, to better enable those convicted of minor possession offences to re-enter the workforce.**
- **Develop an effective substance abuse and dependence intervention programme, incorporating a referral procedure, for people who have come to the attention of various State authorities, such as An Garda Síochána or officers of the Department of Social Protection.**
- **Establish a cross departmental integrated approach to treatment and rehabilitation to ensure the education, housing, and social protection needs of patients and their families are met.**
- **Provide financial support to Local and Regional Drugs Task Forces and social services to address child and family related drug problems.**

Funding Prevention and Treatment

- **Ensure that contributions from the alcohol and gambling industries fund the treatment and rehabilitation of those who have developed clinical dependencies on their products.**
- **Route proceeds acquired by the Criminal Assets Bureau relating to drug crime to investment in drug treatment programs.**

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