DRIVE

Drug Related Intimidation & Violence Engagement

An interagency response in Ireland

Drug-related intimidation in Ireland: the first data report from the National DRIVE Project

HRB Health Research Board

Rialtas na hÉireann Government of Ireland

This document maybe cited as:
Janet Robinson, Anne Marie Carew, Michael O'Sullivan and Suzi Lyons (2026) *Drug-related intimidation in Ireland: the first data report from the National DRIVE Project.* Dublin: National DRIVE Oversight.

Rialtas na hÉireann
Government of Ireland

An Roinn Sláinte
Department of Health

An Roinn Dlí agus Cirt
Department of Justice

An tSeirbhís Phromhaidh
The Probation Service

An Garda Síochána
Seirbhís Náisiúnta Póilíneachta & Slándála na hÉireann
Ireland's National Police & Security Service

TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

NVDAS
NATIONAL VOLUNTARY DRUG & ALCOHOL SECTOR

Regional Drug and Alcohol Task Forces

HSE Social Inclusion

HRB
Health Research Board

LOCAL DRUGS & ALCOHOL TASK FORCES COORDINATORS NETWORK

2025 data published by the National DRIVE Oversight Committee

North Dublin Regional Drug and Alcohol Task Force,

32/33 Main Street, Malahide, Co Dublin, K36 EE72

ISSN 3088-702X

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AFMs	Affected family members
DIG	DRIVE interagency group
DRI	Drug-related intimidation
DRIRP	Drug-Related Intimidation Reporting Programme
DRIVE	Drug-Related Intimidation and Violence Engagement Project
HSE	Health Service Executive
HRB	Health Research Board
L/RDATF	Local and Regional Drug and Alcohol Task Forces
National DOC	National DRIVE Oversight Committee
NDTRS	National Drug Treatment Reporting System

EXECUTIVE SUMMARY

Background

Drug-related intimidation (DRI) is a pervasive and under-reported form of criminal activity that affects individuals, families and communities in Ireland. Research studies show awareness of DRI is high yet reporting remains low due to fear of reprisals, proximity to intimidators, stigma and limited awareness of supports. The DRIVE model was published in 2021 and provides a coordinated framework and data driven model for prevention, support for those impacted by DRI, community response, and system-level change.

Methodology

This report presents the first national overview of DRI among people engaged with addiction and/or family support services and is based on data collected through the National Drug Treatment Reporting System (NDTRS) in 2024-2025[a] in the Health Research Board (HRB). It summarises the DRIVE Project model, describes the DRI data collection within the NDTRS, and outlines key findings and recommendations to strengthen prevention, support and interagency responses.

Key findings

A total of 1,027 cases were reported to the NDTRS in 2024-2025. DRI was reported across all Health Service Executive (HSE) Health Regions and in every county. Dublin accounted for the largest share of cases (42.8%). Half of cases were aged 35 years or under (most cases were aged 20–44). The majority of cases were male (58.5%). Approximately three-quarters of cases (74.6%) were in stable accommodation; 12.3% were homeless. Most cases sought treatment for problem drug use (71.0%), most commonly cocaine (39.8%) and cannabis (11.1%). A further 19.2% of cases were affected family members (AFMs) impacted by a loved one's addiction.

[a] Although formal DRI recording commenced in 2025, some services recorded retrospective disclosures for 2024. Given the novel nature of this data, it was deemed appropriate to include the 2024 data, while acknowledging that they do not represent a complete dataset for this year.

Over one-third of all cases (36.5%) were currently experiencing DRI at the time of treatment; 63.5% of all cases had previously experienced DRI but not currently. Nearly two fifths of cases (38.5%) reported that this was their first experience of DRI. Cocaine was the most common problem drug linked to DRI (58.8%), and one-third (32.5%) reported the involvement of more than one drug.

Drug-related debt was common (67.1%) among cases reporting DRI. Drug-related debt varied from less than €100 to more than €20,000; the most frequent amount demanded was between €1,000 and €4,999 (23.8%). Where known, most intimidators were male. Types of intimidation most commonly reported were threats to the individual (64.2%), and threats to family members (25.1%). Other forms of DRI included violence to the individual (19.7%) and property damage (10.1%). In almost half of cases (46.4%), outcomes of the DRI were resolved informally (without the formal intervention of An Garda Síochána), while 20.2% of cases reported intimidation was ongoing during treatment.

1: BACKGROUND

Research demonstrates that drug-related intimidation (DRI) is widespread within communities yet remains substantially under-reported.[1,2,3] Research studies indicate high levels of awareness of DRI, for example, 83% of respondents to a survey in Dublin's North East Inner City recognised DRI as a local issue. However, reporting rates remain extremely low[1,2,3,4] due to fear of reprisals, proximity to intimidators, stigma and a lack of awareness about support pathways.

A consistent pattern of harms is evident, ranging from verbal threats and property damage to physical violence, coercion into drug distribution, and sexual exploitation. Those impacted by DRI include people who use drugs as well as their family members, partners, and their wider community, reflecting the broader social reach of intimidation linked to drug debt and criminal activity. DRI undermines safety, mental health and community cohesion, contributing to social isolation and the normalisation of violence. A robust understanding of the nature and prevalence of DRI is essential for designing effective interventions and policy responses.[1,5,6,7]

Although surveys provide important insights, many studies rely on a self-selected or otherwise non-representative research participant sample,[b] leading to gaps in the evidence base and hindering the design of effective interventions and policy responses.[2,3] These limitations highlight the need for more comprehensive, systematically collected data on DRI. The Drug-Related Intimidation and Violence Engagement (DRIVE) Project aims to address this gap through a data-driven model that integrates routine monitoring of DRI within existing national systems.

DRIVE Project

The DRIVE Project is an interagency initiative funded by the Department of Health to respond to DRI and associated violence in Ireland. It was a key action under the National Drug Strategy (2017-2025), which recognised the impact that drug-related criminality and anti-social behaviour has on communities, and committed to tackling drug-related crime and intimidation.[8] **The DRIVE Project will continue and expand its response to DRI, and is included as an action under pillar 2 in the draft National Drug Strategy (2026-2029).**[9]

[b] A non-representative sample is a subset of a population that does not accurately reflect the characteristics, diversity, or proportions of the larger group from which it is drawn; thus, research findings apply to the sample but may not be representative of the complete population.

Governance and implementation of the DRIVE Project is overseen by the National DRIVE Oversight Committee (National DOC), comprising of representatives from the statutory, community and voluntary sectors[7] (see Appendix 1 for the National DOC membership). The National DOC is supported by the DRIVE Project team, which coordinates day to day delivery and stakeholder engagement. Supports for individuals and families affected by DRI are situated within the interagency partnerships provided through the Local and Regional Drug and Alcohol Task Forces (L/RDATF). This is the key element of the project, bringing to bear a whole community approach, involving key statutory, voluntary and community-based supports, working together to support people with often complex and multi-faceted DRI-related issues in both formal/legal and informal, confidential support settings. A DRIVE interagency group (DIG) is established by each L/RDATF to implement and coordinate an interagency response at local and regional levels.

DRIVE Project model

The DRIVE Project model was developed through consultation with stakeholders with direct experience of supporting individuals affected by DRI and through a review of the research, strategic, policy and legislative context for DRI in Ireland. The model comprises six key pillars that provide a coordinated framework for prevention, support for those impacted by DRI, community response, and system-level change. The six pillars are:

1. **Capacity building and shared commitment:** Strengthen understanding of DRI and enhance the capacity of frontline workers, services, and communities through tailored training and shared responsibility.

2. **Data collection and analysis:** Improve the reporting of DRI data to develop a robust evidence base on the prevalence, patterns, and trends at local, regional, and national levels.

3. **Information sharing:** Strengthen connections between agencies and enable effective information sharing to support solution-focused approaches and supports at a local, regional and national level.

4. **Community-level supports:** Design and implement data-informed, evidence-based community level supports focused on prevention, desistance, and suppression of DRI, delivered in a non-judgemental, confidential, and safe manner.

5. **Law enforcement:** Support responsive, intelligence-led policing informed by local data, ranging from harm-reduction approaches to proactive and robust investigations.

6. **Legislative and systemic change:** Enable advocacy for policy, strategic, and legislative reforms aimed at improving justice system responses, increased convictions and reduce the incidence of DRI.

DRIVE Project objectives

The overarching aim of the DRIVE Project is to develop evidence-informed policies and practices through the data-driven model focused on data collection and information sharing.[c] Key objectives include:

- Supporting those impacted by DRI through safe, confidential, and non-judgemental pathways to support.
- Building capacity of communities and services to respond effectively to DRI with specialised training, resources, and details of local supports.
- Enhancing interagency collaboration and coordinated local responses.
- Improving the quality and availability of data to inform policy, practice, and legislative reform.
- Reducing stigma and barriers to accessing support.

The DRIVE Project offers a national approach that seeks to reduce incidents of DRI, reduce the harm caused and create safer and healthier communities.

[c] Further information about the DRIVE Project is available at https://driveproject.ie/

Key milestones and achievements of the DRIVE Project

The DRIVE Project was established in 2020 and is supported by funding allocated to the project by the Department of Health. Implementation of the DRIVE framework is managed and overseen by the National DOC with the support of the DRIVE Project team.

The following sets out the key milestones and achievements associated with the implementation of the DRIVE Project to-date:

Year	Key Milestones and Achievements
2020	• National DOC formed and Department of Health funding was secured to research effective models to respond to DRI.
2021	• Publication of the DRIVE Data Driven Intervention Model: 'A data-driven intervention model to respond effectively to drug-related intimidation and violence in communities in Ireland', which was launched by the Minister for Public Health, Wellbeing and the National Drug Strategy.
2022	• DRIVE Project roadshow – DRIVE Project team conducted information sessions on the DRIVE Project framework in each L/RDATF with key community, voluntary and statutory sectors.
2023	• DRIVE Project team commenced the roll out of the online DRIVE information sessions with relevant sectors, and the continued promotion of the DRIVE model through other avenues. • National DRIVE Conference 'Policy, Programmes & Perspectives' was held in November 2023 with key community, voluntary and statutory sectors. • Appointment of DRIVE Leads/Liaisons commenced in each L/RDATF. • DRIVE Liaison Network established for DRIVE Leads/Liaisons; monthly meetings coordinated by the National DRIVE Coordinator. • DRIVE information resources were developed by the National DRIVE Coordinator and disseminated to each L/RDATF for onward distribution to services.

Year	Key Milestones and Achievements
2024	• L/RDATF Coordinators commenced the establishment of a DIG in each area. This process was supported by the DRIVE Leads/ Liaison assigned to each area. • DRIVE Project team established the An Garda Síochána Nominated DRI Inspectors Network. These meetings continue to be held on a quarterly basis. • DRIVE training and resource materials were developed: - DRIVE Train the Trainer Programme - DRIVE Front line worker training - DRIVE Brief advisor training
2025	• On 1 January 2025, the National Drug Treatment Reporting System (NDTRS) officially started the DRI data collection. • DRIVE Project team commenced the roll out of the Train the Trainer Programmes across the country. Those who participate in this training then cascade the training to community, voluntary and statutory sectors within each L/RDATF area. • To support the roll out of a National DRIVE Awareness Campaign, a range of assets were developed to include short film, radio advert, social and digital assets, and posters. • In May 2025, with the support of the Department of Health, the DRIVE National Awareness Campaign was officially launched by Jennifer Murnane O'Connor, TD, Minister for Public Health, Wellbeing and the National Drug Strategy, alongside Jim O'Callaghan, TD, Minister for Justice.[10]

National Drug Treatment Reporting System

The National Drug Treatment Reporting System (NDTRS) is the national epidemiological database that records and reports on addiction treatment in Ireland. It is managed by the National Health Information Systems Unit in the Health Research Board (HRB) and is funded by the Department of Health. The NDTRS follows a common and systematic European methodology for collecting and reporting core data on the numbers and profiles of those entering specialised drug treatment each year (treatment demand). The European Treatment Demand Indicator protocol aims to provide objective, reliable and comparable information at a European level and is routinely used to identify trends and patterns in problem drug use and to assess the use and uptake of treatment facilities.[11]

NDTRS data are case-based, meaning an individual may appear more than once if treated at multiple centres or on multiple occasions within a year, as currently there is no unique health identifier operating within the addiction services. The NDTRS publishes aggregated anonymous data on addiction treatment annually.

The National Drug Strategy (2017-2025) required all publicly funded addiction services to complete the NDTRS for all people who use services (Action 5.1.47).[8] NDTRS covers a range of treatment settings including outpatient, residential (inpatient), low threshold, general practitioners, and prisons.[12]

The NDTRS dataset captures demographic characteristics, referral/assessment details, treatment status, drug use, risk behaviour, activity details, and exit outcomes. As recommended in the DRIVE model, the NDTRS was extended to include standardised DRI data collection.[7] Potential DRI questions were first piloted by a selection of addiction services to ensure that they were understandable, consistent, feasible and comprehensive. The expansion was funded by the Department of Health and operationalised in early 2025. This report presents data for cases who accessed addiction and/or family support services who disclosed DRI. These findings will increase understanding of DRI prevalence and trends, and inform responses to reduce the impact on individuals, families and communities.

2: METHODOLOGY

DRI data collection

The DRIVE Data, Research and Evaluation Coordinator and the NDTRS team have responsibility for managing the DRI data. DRI data is recorded by staff in the addiction treatment services from those seeking treatment for their addiction problems (drugs, alcohol or other addictions e.g. gambling). DRI data is also recorded in family support services from affected family members (AFMs), who are seeking support for this issue in their own right.

Recording of DRI data is voluntary and currently requires informed written consent from service users. Service users may choose not to disclose DRI at initial engagement and may disclose later in treatment; therefore, annual figures may change as records are updated. Due to the sensitivity of the data, services are encouraged to revisit DRI questions once relationships are established. The NDTRS team and the DRIVE Data, Research and Evaluation Coordinator provides training and reporting protocols to support service providers with data collection. Due to the sensitivity of the topic, when a person chooses not to answer any questions on DRI or some specific questions on DRI, this is recorded as 'did not wish to answer'.

DRI data collected include information on the frequency, duration and underlying reason for the intimidation. Details on the main drug that the DRI relates to are recorded, along with any additional drugs involved. The gender and age range of the initimidator(s) are recorded on the NDTRS. The nature of intimidation, the amount of any associated drug debt, and whether and how that debt was paid are also documented. In addition, the supports offered and those taken up by the individual are also recorded, together with the eventual outcome of the DRI incident. The DRI module includes the following questions:

1. Have you ever or are you currently experiencing DRI?
2. Is this the first time you have experienced DRI?
3. How long have you been experiencing DRI?
4. What is/was the reason for DRI?
5. What is/was the main drug that the DRI related to?
6. Are there/were there other drugs involved in addition to the main drug?
7. What age profile was the person(s) who is/was intimidating you?

8. Gender of the person(s) who is/was intimidating you?
9. What form does/did the intimidation take?
10. If there is/was a drug debt, how much was the debt?
11. Did you pay the debt?
12. How are you paying/how did you pay?
13. What supports/interventions have been offered, and which have been taken up?
14. What was the outcome of the intimidation?

The DRI questions were operationalised in December 2024 in preparation for the commencement of data collection on 1 January 2025. Although formal DRI recording commenced in 2025, some services recorded retrospective disclosures for 2024. Given the novel nature of this data, it was deemed appropriate to include the 2024 data, while acknowledging that they do not represent a complete dataset for this year.

Given confidentiality and sensitivity considerations, small numbers (less than 10) are not reported. Only limited, aggregated information on intimidators is collected; this prevents identification of any individuals or locations. These measures ensure the integrity of DRI reporting and safeguard the welfare of individuals who disclose their experiences. The data and information in this report refers to the 26 counties of the Republic of Ireland.

3: RESULTS

This report presents data for cases who accessed addiction and/or family support services in 2024 and 2025 and disclosed DRI. Although formal DRI recording commenced in 2025, some services recorded retrospective disclosures for 2024. The characteristics and patterns observed in 2024 are broadly similar to those recorded in 2025.

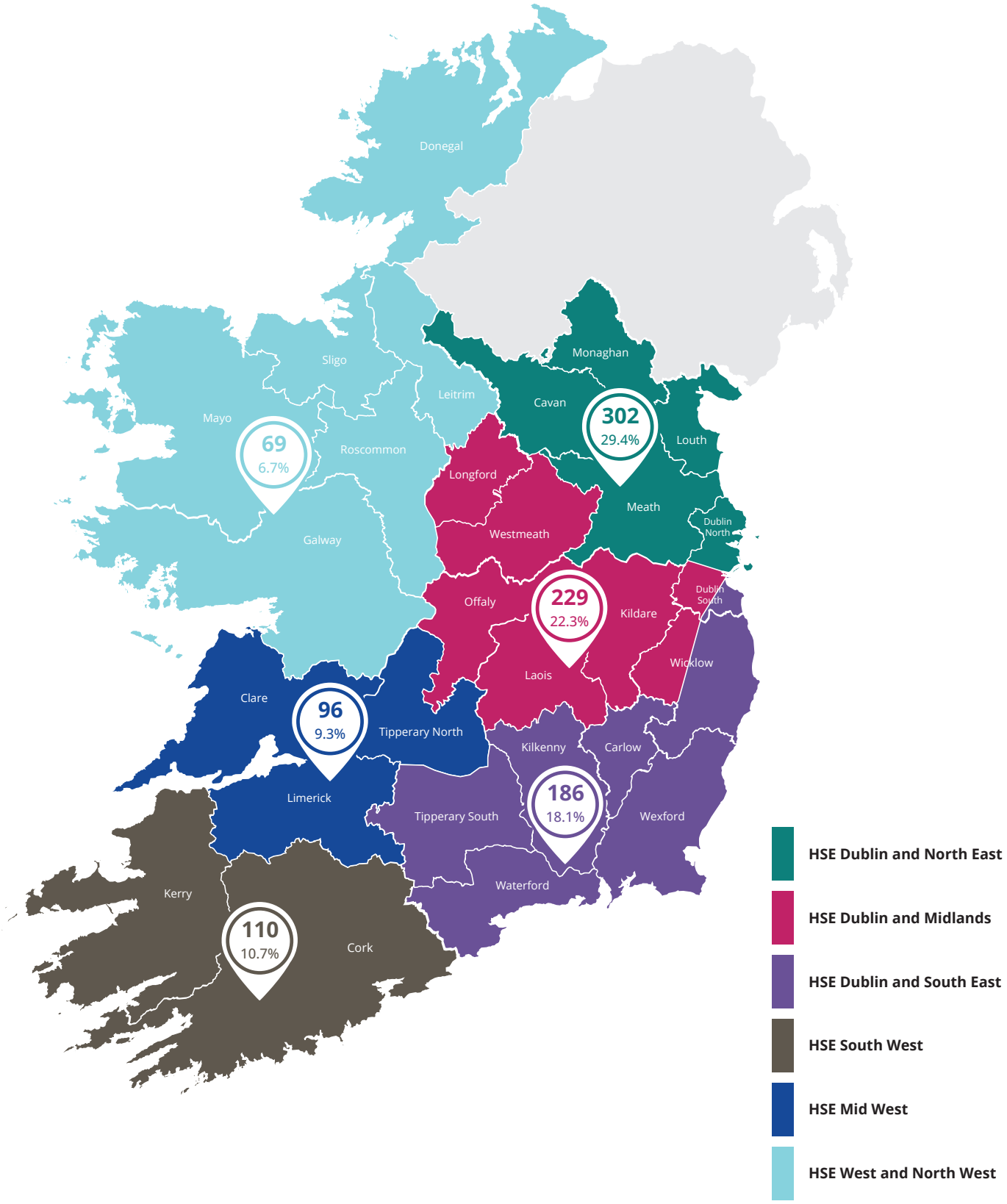
Number of cases experiencing DRI

A total of 1,027 cases were recorded, with 154 (15%) reported in 2024 and 873 (85%) in 2025. Given the novel nature of this data, it was deemed appropriate to include the 2024 data, while acknowledging that they do not represent a complete dataset for this year.

Geographical distribution of DRI cases

DRI was reported in every Health Service Executive (HSE) Health Region over the period. The highest proportions were in HSE Dublin and North East (29.4%) and HSE Dublin and Midlands (22.3%) (Figure 3.1).

Figure 3.1: Number of cases reporting DRI by Health Region of residence, NDTRS 2024-2025



Across counties, Dublin accounted for 42.8% of cases, followed by Cork (9.0%) and Tipperary (8.9%) (Table 3.1). Low numbers reported from some counties may reflect under-reporting of DRI, limited service provision where DRI can be reported to, or lack of participation in the NDTRS. The low numbers may also reflect the reluctance to disclose a DRI on the part of the individual due to fear or stigma, or a combination of these factors rather than the lower prevalence of DRI.

Table 3.1: Number of cases reporting DRI by county of residence, NDTRS 2024-2025

County	n	%
Carlow	~	~
Cavan	11	1.1
Clare	19	1.9
Cork	92	9.0
Donegal	13	1.3
Dublin	440	42.8
Galway	23	2.2
Kerry	18	1.8
Kildare	32	3.1
Kilkenny	~	~
Laois	18	1.8
Leitrim	~	~
Limerick	49	4.8
Longford	~	~
Louth	24	2.3
Mayo	~	~
Meath	24	2.3
Monaghan	~	~
Offaly	15	1.5
Roscommon	11	1.1
Sligo	12	1.2

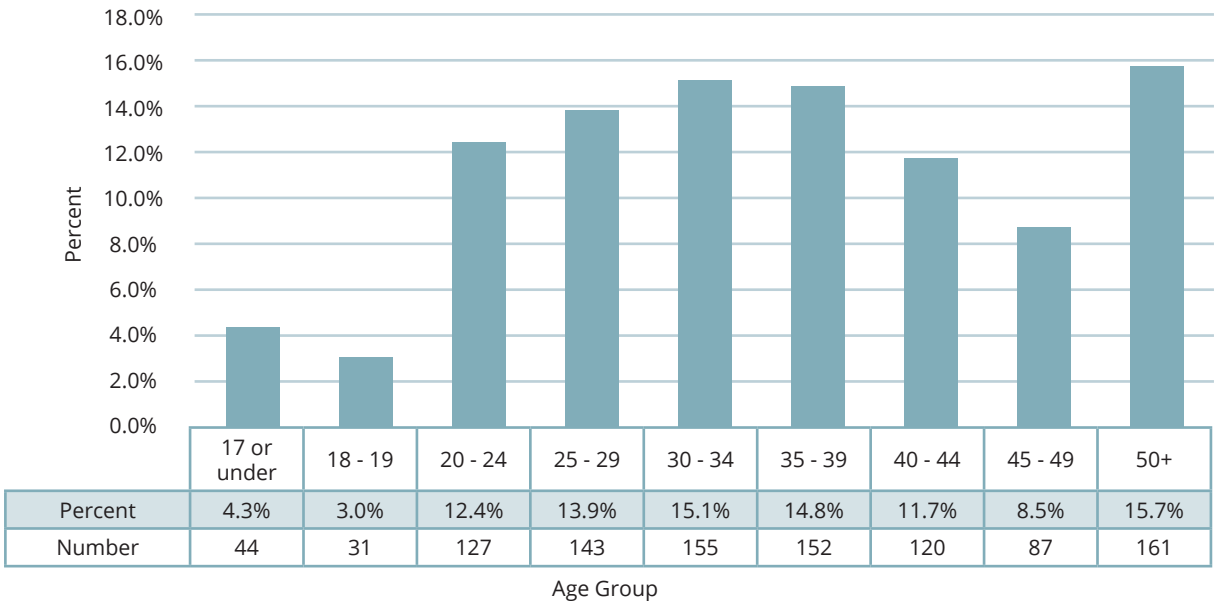
County	n	%
Tipperary	91	8.9
Waterford	33	3.2
Westmeath	13	1.3
Wexford	19	1.9
Wicklow	32	3.1
Other/Unknown	~	~
Total	**1027**	**100.0**

~ 10 cases or fewer

The geographical location of residence of DRI cases by each L/RDATF area is reported in Appendix 2.

Demographic profile of those reporting DRI

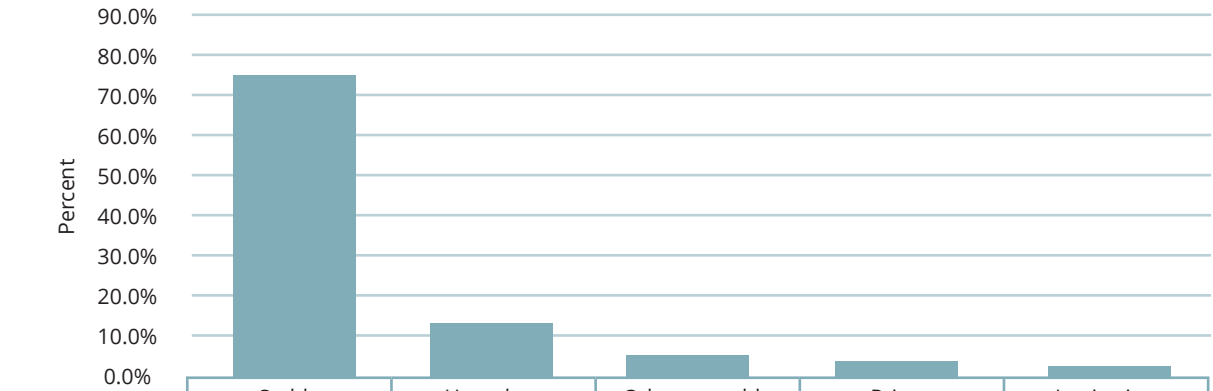
All age groups reported DRI, the median age was 35 years, with most cases (67.9%) aged 20-44 years (Figure 3.2).



	17 or under	18 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50+
Percent	4.3%	3.0%	12.4%	13.9%	15.1%	14.8%	11.7%	8.5%	15.7%
Number	44	31	127	143	155	152	120	87	161

Figure 3.2: Age group of cases reporting DRI, NDTRS 2024-2025

Males accounted for 58.5% (601) of all DRI-related cases, while females accounted for 41.4% (425). Where ethnicity was recorded, 91.8% (943) identified as White Irish; other categories included Irish Traveller (28, 2.7%), Black or Black Irish (17, 1.7%), and Roma (less than 10) communities.[d] Accommodation data showed that approximately three-quarters of cases (74.6%) were living in stable accommodation, while 12.3% were homeless (Figure 3.3).

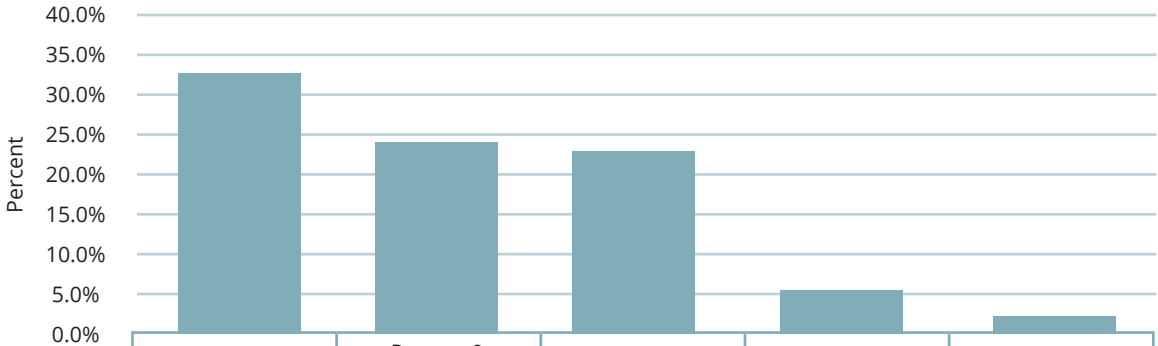


	Stable	Homeless	Other unstable	Prison	Institution
Percent	74.6%	12.3%	5.7%	3.7%	2.8%
Number	766	126	59	38	29

Accommodation status

Figure 3.3: Current accommodation status of cases reporting DRI, NDTRS 2024-2025

The majority of cases (62.7%) reporting DRI were living with family members including children, which may indicate potential hidden harm within households (Figure 3.4).



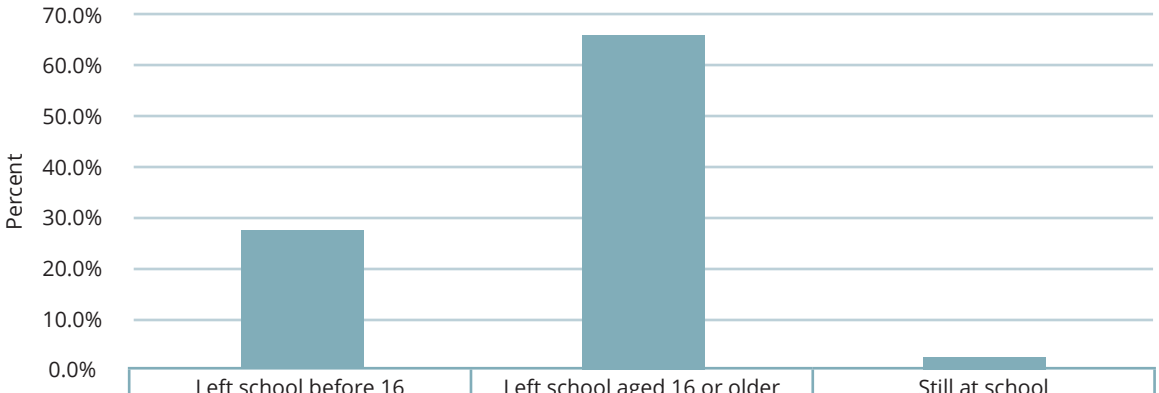
	Parents / Family	Partner & child(ren) or alone with child(ren)	Alone	Partner (alone)	Friends
Percent	33.2%	24.4%	23.9%	5.1%	2.0%
Number	341	251	245	52	21

Living with whom

Figure 3.4: Living with whom status of cases reporting DRI, NDTRS 2024-2025

[d] These ethnic minority categories as defined by the Central Statistics Office https://www.cso.ie/en/methods/classifications/csodatastandardsandclassifications/csodatastandards/csodatastandardforethnicity/

While the majority of cases reporting DRI left school aged 16 or older (64.4%), almost three in 10 (28.0%) were early school leavers i.e. left school before 16 (Figure 3.5).

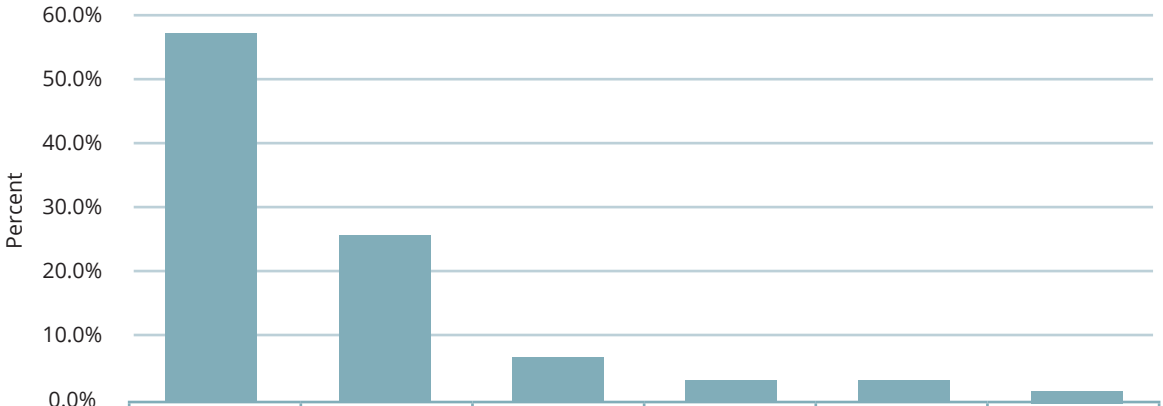


	Left school before 16	Left school aged 16 or older	Still at school
Percent	28.0%	64.4%	1.3%
Number	288	661	13

Early school leaving

Figure 3.5: Age left education of cases reporting DRI, NDTRS 2024-2025

The majority of cases reporting DRI were unemployed (57.0%), while 26.6% were in paid employment (Figure 3.6).



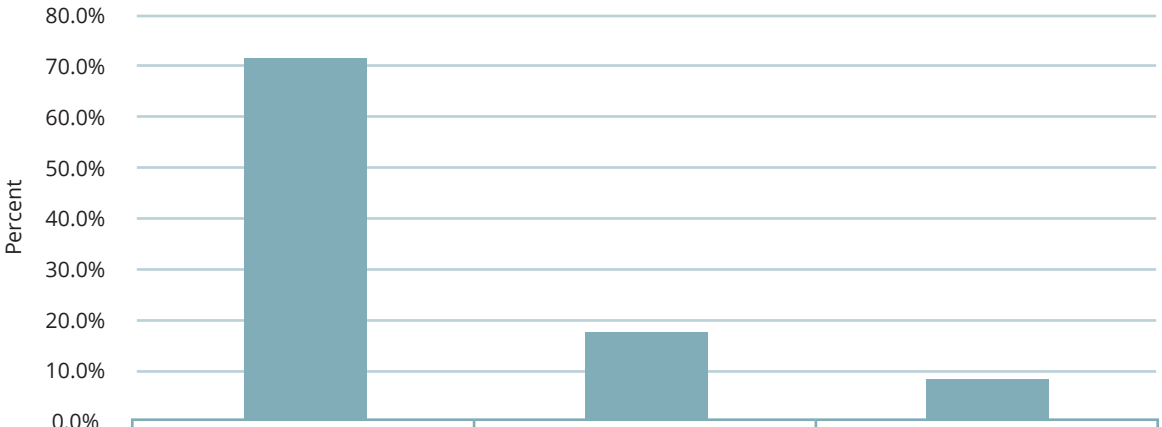
	Unemployed	In paid employment (incl. part-time)	Retired / unable to work (disability)	Training course	Student	Housewife / Husband
Percent	57.0%	26.6%	7.0%	2.7%	2.7%	1.5%
Number	585	273	72	28	28	15

Employment status

Figure 3.6: Current employment status of cases reporting DRI, NDTRS 2024-2025

Treatment context and referral reason

The main reason for referral and treatment was problem drug use (71.0%) (Figure 3.7). However, one fifth of cases (19.2%) were AFMs. Among those who sought treatment for their own problem drug use, cocaine was the most common problem drug reported (409, 39.8%), with powder cocaine (307, 29.9%) more common than crack cocaine (102, 9.9%). Cannabis was the second most common problem drug (114, 11.1%) and opioids (mainly heroin) (106, 10.3%) were the third most common problem drug.

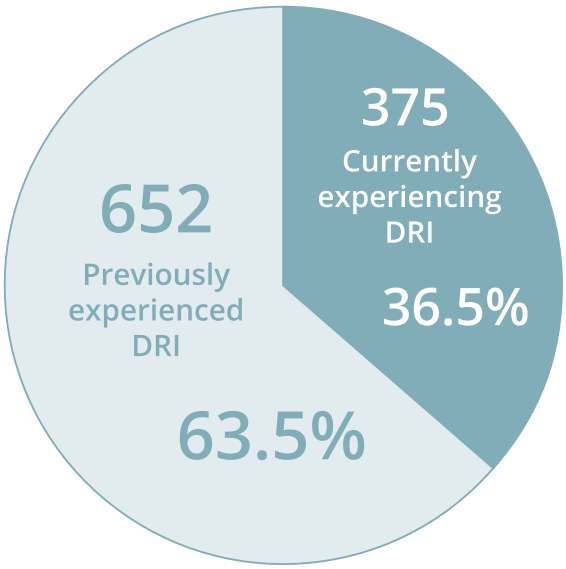


	Drug (as a main problem)	Affected family member	Alcohol (as a main problem)
Percent	71.0%	19.2%	9.6%
Number	729	197	99

Figure 3.7: Main reason for referral of cases reporting DRI, NDTRS 2024-2025

Prevalence and first-time experiences of DRI

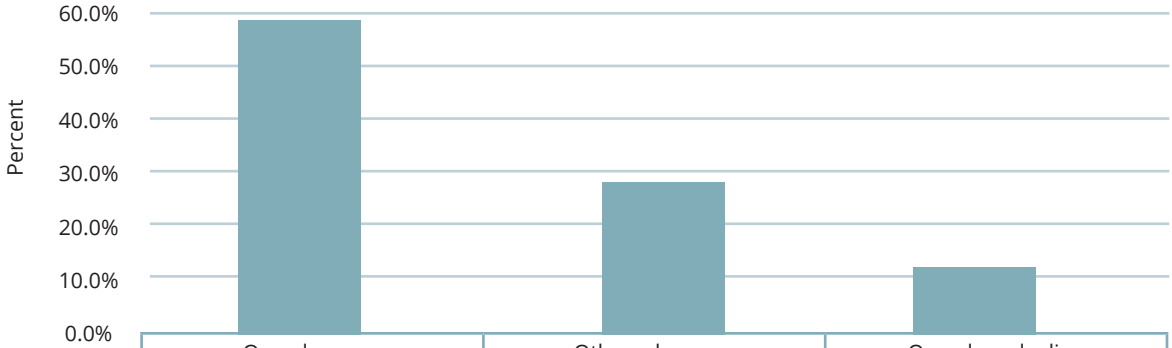
Over one-third of all cases (36.5%) were currently experiencing DRI at the time of treatment; 63.5% of all cases had previously experienced DRI but not currently.



Nearly two fifths of cases (38.5%) reported that this was their first experience of DRI.

Reasons for DRI

The majority of cases reported DRI related to their own drug use (59.2%) while for 28.0% of cases it was related to another person's drug use. It is notable that for 11.5% of cases the DRI was related to the individual's own drug dealing (Figure 3.8). A small proportion (33, 3.5%) did not wish to answer.



	Own drug use	Others drug use	Own drug dealing
Percent	59.2%	28.0%	11.5%
Number	556	263	108

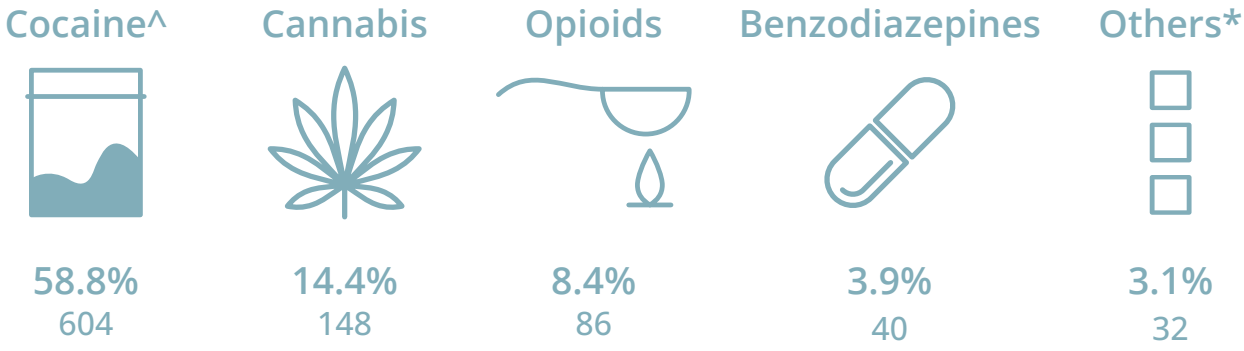
Reason for DRI

Figure 3.8: Reasons identified for cases reporting DRI, NDTRS 2024-2025

Drugs linked to DRI

This section reports on the drugs linked to DRI. These drugs may differ from the referral reasons for cases (reported in the 'Treatment context and referral reason' section). Cocaine (58.8%) was the most common drug linked to the DRI, with powder cocaine (484, 47.1%) more common than crack cocaine (99, 9.6%). Cannabis was the second most common drug (14.4%) linked to DRI.

Main drugs linked to DRI



^ Cocaine includes powder, crack and unspecified cocaine
* Others include amphetamines, sedatives/anxiolytic (not benzodiazepines), and ketamine

Analysis by gender reports similar patterns across drug types with cocaine and cannabis being the main drugs linked to DRI (Table 3.2).

Table 3.2: Main drugs linked to DRI by gender, NDTRS 2024-2025

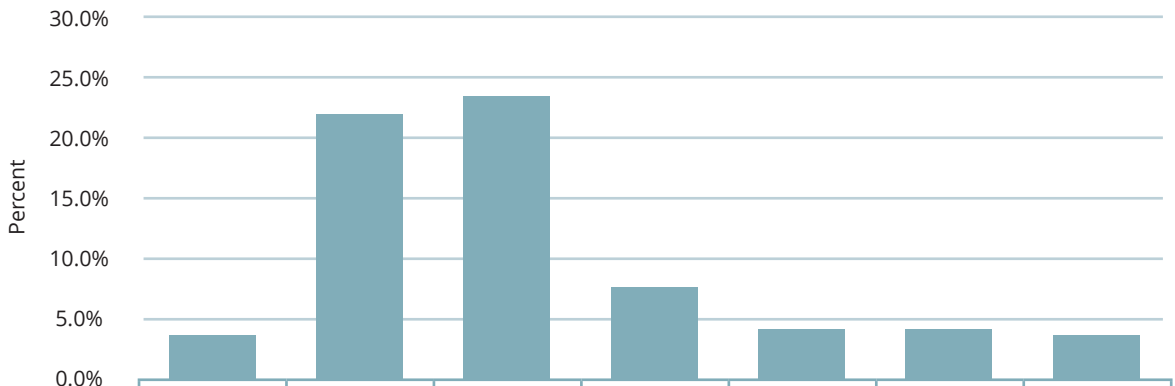
Drug type	Male		Female	
	n	%	n	%
Cocaine	352	58.6	251	59.1
Cannabis	96	16.0	52	12.2
Opioids	48	8.0	38	8.9

Polydrug involvement

Almost one-third of cases (334, 32.5%) reported involvement of additional drugs alongside the main drug linked to DRI.

Debt associated with DRI

Drug-related debt was common (689, 67.1%) among cases reporting DRI. Drug-related debt varied from less than €100 to more than €20,000 (Figure 3.9). The most frequent amount demanded was between €1,000 and €4,999 (23.8%), followed by debts of between €100 and €999 (22.0%). The amount of debt demanded was unknown for 19.2% (197) while 5.6% (57) of cases did not wish to answer.



	Less than €100	€100 - €999	€1,000 - €4,999	€5,000 - €9,999	€10,000 - €14,999	€15,000 - €19,999	More than €20,000
Percent	3.8%	22.0%	23.8%	7.4%	4.4%	1.9%	3.8%
Number	39	226	244	76	45	20	39

Debt associated with DRI

Figure 3.9: Debt associated with cases reporting DRI, NDTRS 2024-2025

DRI debt payment method

A variety of DRI debt payment methods were reported. Borrowing from friends and/or family (39.8%) and paying debts in instalments (30.4%) were the most common (Table 3.3). Less frequently reported were other methods (7.3%) which included borrowing from a loan shark or coercive behaviours such as dealing or holding drugs or sex work.

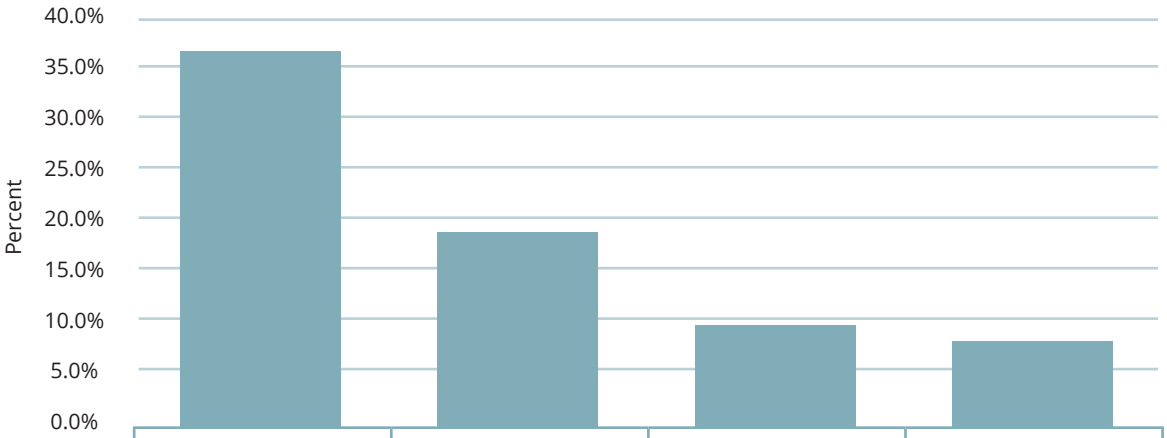
Table 3.3: DRI debt payment method for cases reporting DRI, NDTRS 2024-2025

DRI debt payment method	n	%
Borrowed from friends and/or family	212	39.8
Paid in instalments	162	30.4
Savings	117	22.0
Loan or credit card	40	7.5
Other debt payment method*	39	7.3
Sold belongings	19	3.6

* Other DRI debt payment method includes theft to cover the debt, borrowing from a loan shark, and coercive behaviours (e.g. dealing or holding drugs, sex work)
Total exceeds 100% as some cases reported more than one debt payment method

Debt repayment status

Of those with recorded debt information, 36.3% cases reported that they had fully paid their debt, while 18.3% were currently paying (Figure 3.10). A substantial proportion (269, 26.2%) did not report repayment information with 1.7% (17) of cases not wishing to answer this question.



	Debt fully paid	Currently paying debt	Debt not paid	No debt to repay
Percent	36.3%	18.3%	9.3%	8.2%
Number	373	188	96	84

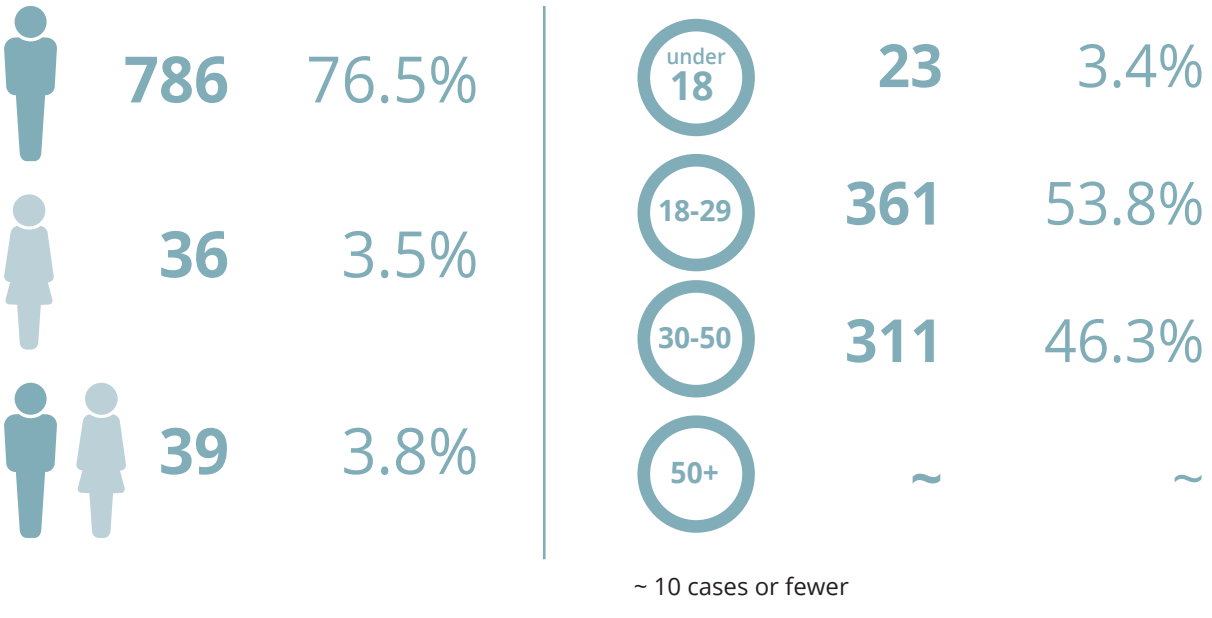
Debt payment status

Figure 3.10: Debt payment status of cases reporting DRI, NDTRS 2024-2025

Profile of intimidators

Where information was disclosed, intimidators were predominantly male (76.5%). Where age of the intimidator was recorded, most were aged 18–29 years (53.8%), while 3.4% were aged under 18. Information was not available in 12.4% (127) of cases.

Profile of intimidators



~ 10 cases or fewer

Nature of intimidation

A wide range of threats and intimidation types were reported. Threats to the individual (64.2%) and threats to family (25.1%) were the most common (Table 3.4). Though less common, some intimidation involved requests to engage in criminal activities (2.2%), blackmail (1.8%), or other extreme forms of coercive or criminal activity such as sexual exploitation, holding drugs, money, weapons or drug paraphernalia, kidnapping, or hostile takeover of homes ('cuckooing').

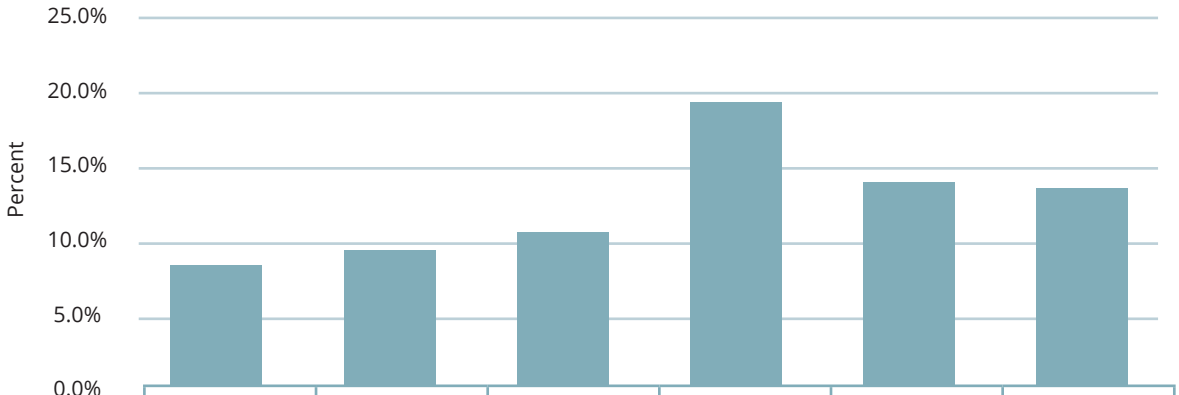
Table 3.4: Nature of intimidation for cases reporting DRI, NDTRS 2024-2025

Type of intimidation	n	%
Threats to the individual	558	64.2
Threats to family	218	25.1
Violence to the individual	171	19.7
Threats over phone	166	19.1
Threats to property	136	15.7
Property damage	88	10.1
Requests to hold drugs	47	5.4
Interest added to the debt	43	4.9
Violence to family	40	4.6
More than one source of intimidation	38	4.4
Requests to engage in criminal activities	19	2.2
Blackmail	16	1.8
Other forms of intimidation*	37	4.2

* Other forms of intimidation include sexual exploitation, individuals or family holding money, weapons or drug paraphernalia, kidnapping, and hostile takeover of homes/cuckooing
Total exceeds 100% as some cases reported more than one type of intimidation

Duration of DRI

The duration of intimidation varied (Figure 3.11). Nearly three in 10 cases experienced DRI for more than one year (29.0%). A duration of more than six months but less than a year was the next most frequent (19.0%). The duration of DRI was unknown for 18.3% (188) and 4.8% (49) of cases did not wish to answer.



	0 - 1 month	2 - 3 months	4 - 5 months	More than 6 months but less than a year	1 - 2 years	3 years +
Percent	8.6%	9.8%	10.5%	19.0%	14.6%	14.4%
Number	88	101	108	195	150	148

Duration of DRI

Figure 3.11: Duration of intimidation associated with cases reporting DRI, NDTRS 2024-2025

DRI supports offered

The provision of DRI-related support within addiction and/or family support services varied (Table 3.5). In over one-third of cases (36.4%), no DRI-related support was offered even though almost two in 10 (71, 19.1%) cases reported that they were currently experiencing DRI. The Drug-Related Intimidation Reporting Programme (DRIRP) operated by An Garda Síochána was offered to 58 cases (5.7%) and accepted by 18 cases (1.8%) only.

Table 3.5: DRI supports offered to cases reporting DRI, NDTRS 2024-2025

DRI supports offered	n	%
No support offered	372	36.4
Information offered and refused	265	26.0
Information offered and accepted	154	15.1
Brief advice offered and accepted	120	11.8
Brief advice offered and refused	85	8.3
DRIRP offered and refused	40	3.9
DRIRP offered and accepted	18	1.8
Counselling offered and accepted	~	~
Counselling offered and refused	~	~
5 Step Method offered and accepted*	~	~
5 Step Method offered and refused	~	~
Group support offered and accepted	~	~
Group support offered and refused	~	~

~ 10 cases or fewer
* The 5-Step Method is an evidence-based, psychosocial intervention designed to support family members affected by a loved one's drug use https://www.cftraining.ie/
A case may be represented on more than one row as more than one support can be offered

Outcome of the DRI

The outcomes of the DRI varied (Table 3.6). In 46.4% of cases, the situation was resolved informally (without the formal intervention of An Garda Síochána), while 20.2% reported that intimidation was ongoing during their contact with services. Almost one in 10 (9.8%) reported the intimidation to An Garda Síochána.

Table 3.6: Outcomes of the DRI for cases reporting DRI, NDTRS 2024-2025

DRI outcomes	n	%
Resolved informally*	378	46.4
Ongoing during treatment	165	20.2
Reported to An Garda Síochána	80	9.8
Resolved formally	68	8.3
Moved out of area	51	6.3
Ongoing at treatment end	47	5.8
Moved out of home	34	4.2
Attended drug treatment	34	4.2
DRI incidents reduced	17	2.1
Family member left home	15	1.8
Homelessness within family	~	~
DRI safety measures employed	~	~
DRI incidents increased	~	~

* DRI has been resolved without the formal intervention of An Garda Síochána
~ 10 cases or fewer
Total exceeds 100% as some cases reported more than one outcome of the DRI

4: DISCUSSION

These findings provide the first national overview of DRI among people engaged with addiction and/or family support services in Ireland. A total of 1,027 DRI-related cases were reported to the NDTRS across all counties in 2024-2025, indicating that DRI is widespread and affects diverse communities nationwide. DRI disclosure may occur at any point in treatment, leading to updates over time.

More than one-third of cases were currently experiencing DRI at the time of reporting and almost two-thirds reported previous experiences. DRI affected all age groups, including those under 18. Most cases were male, and the majority reporting DRI were people who use drugs, though family members were also affected. Early school leavers and the unemployed represented a notable proportion of cases. Where recorded, intimidators were predominantly male and under 30 years of age, including some under 18. Drug-related debt varied widely in scale. The most frequent amount demanded was between €1,000 and €4,999, with substantial proportions of cases reporting debts of €5,000 or more. The most common types of intimidation included threats to the individual or family, while less frequent were reports of sexual exploitation, and forced involvement in criminal activities. Despite many reporting current DRI, a significant amount reported no DRI-related supports were offered.

DRI as a recurring and evolving issue

More than one-third of people were currently experiencing DRI, and almost two-thirds reported previous experiences. These proportions indicate that DRI is a persistent issue among people engaging with addiction and/or family support services. Importantly, because 2025 marks the first year of systematic DRI recording, some individuals may disclose DRI later in treatment. The sensitivity of the topic and safety concerns mean that ‘did not wish to answer’ is an important and valid response category, especially given safety concerns and fear of retaliation. Over time, the proportion of ‘not known’ responses are expected to decrease as recording of NDTRS DRI data increases along with the increase in the rollout of capacity building by the DRIVE Project, in conjunction with public awareness campaigns which encourage people to seek confidential support.

The geographical spread of cases across all HSE Health Regions and every county reinforces that DRI is a nationwide issue affecting communities regardless of region, local drug market characteristics or service configuration. Dublin accounted for the largest proportion of disclosed and reported cases, followed by Cork, Tipperary and Limerick.

Factors influencing disclosure

The disclosure of DRI by an individual can be impacted by a variety of factors. Low numbers recorded in some counties may reflect availability of addiction and/or family support services. The low numbers may reflect varying levels of engagement: 1) the individual may be reluctant to engage with the available services; 2) the available services may not yet engage with the NDTRS; 3) it may also reflect the reluctance to disclose DRI on the part of the individual due to fear or stigma; or a combination of these factors. The reluctance to engage with services or disclose a DRI, underscores the need for consistent ongoing national awareness, training and service capacity, to build trust and encourage disclosure.

Profile of cases reporting DRI

The profile of cases reporting DRI shows that DRI affects all age groups and gender, people who use drugs and their family members. DRI was reported by under 18s and all adult age groups, with the greatest concentration between 20 and 44 years (67.9%). Males accounted for about three-fifths of DRI cases. While the majority of cases reporting DRI were people who used drugs (71.0%), almost one in five cases were AFMs (19.2%), clearly showing that DRI extends beyond people directly using drugs. Over time, the number of AFMs reporting DRI is expected to increase as service provider recording of NDTRS DRI data increases, along with the increase in the rollout of capacity building by the DRIVE Project, in conjunction with public awareness campaigns which encourage people to seek confidential support.

In addition, a significant proportion of cases (62.7%) reporting DRI were living with family members, including parents, partners and children, suggesting that further hidden harm may exist among this cohort. It is highly likely that many

AFMs are not engaging with available family support services. This further highlights the need for strengthened public awareness campaigns and enhanced capacity amongst service providers to identify and support this often hidden population, including under 18s and adult services.

The demographic patterns observed are similar with previous research, which has highlighted the vulnerability of young adults,[1,2,7] particularly men,[1] to intimidation linked to drug markets. The broad reach of DRI has also been identified, with under 18s[1,5,7] and older adults over 50,[2] as well as a considerable proportion of women[1,2,4,5,7] affected by DRI. Additionally, there is further evidence of the risk of secondary harm within households. The most common method for DRI debt payment was borrowing from family or friends, reinforcing evidence that DRI can destabilise wider family systems and place significant financial strain on households. Moreover, the nature of the intimidation includes coercive forms of repayment that extend beyond the individual to affect family members as well. These findings support framing DRI not only as an individual safety issue but as a wider family and community harm, requiring coordinated responses across addiction services, family support networks, community safety partnerships, and An Garda Síochána.

The socioeconomic profile of cases highlights key structural vulnerabilities. Over half of cases experiencing DRI were unemployed, and more than one-quarter had left school before the age of 16. These indicators align with well-established social determinants of drug-related harm, such as educational disengagement, limited economic opportunities and precarious living circumstances.[8,13] While early school leaving is not unique to individuals experiencing DRI, its prevalence within this cohort signals the need for intensified prevention and inclusion strategies targeting young people at risk of exploitation within local drug markets. Additionally, the unemployed are identified as a potential higher risk group that require more targeted DRI support.

The data also provide new national level clarity on the drugs linked to DRI. Cocaine, either powder or crack, was the most frequently implicated drug, consistent with trends of increasing cocaine use and expansion of cocaine markets.[14] The prevalence of polydrug involvement further indicates complex consumption patterns that may increase reliance on suppliers, elevate financial risk and create additional leverage for intimidation.

Nature of intimidation

The nature of intimidation reported, commonly threats to the individual or family, violence, property damage and coercive demands such as holding drugs, highlights the severity and coercive control underpinning DRI. While less frequent, reports of sexual exploitation, blackmail, and forced involvement in criminal activities such as holding weapons are of particular concern and align with international evidence on the exploitation of vulnerable individuals within criminal networks.[1,2,4,5,7,15] These findings emphasise the importance of trauma-informed and safety-focused responses within services.

The reported duration of DRI indicates many experience DRI for lengthy periods of time, highlighting the persistent and enduring nature of DRI and identifying its capacity to exert a prolonged impact over an extended period.

Profile of intimidators

Where recorded, intimidators were predominantly male and under 30 years of age. A small proportion were aged under 18, identifying that youth exploitation, coercion, and early criminal involvement are active components of the manifestation of DRI in Ireland. These findings are consistent with existing research, which indicates the majority of intimidators are young adult males.[1,4,7] The utilisation of under 18s as intimidators[1,4,5] and an increase in DRI among under 18s has also been reported.[7] A significant proportion of data was not available, and a further number of service users declined to answer, reflecting the safety concerns associated with disclosing details about intimidators.

Service responses and outcomes

Support uptake patterns suggest variability in service confidence, readiness and capacity to respond to disclosures. Over one-third of cases recorded no DRI-related support was offered, despite a substantial proportion reporting current intimidation. This may reflect the newness of the DRI data collection, uncertainty among service providers about appropriate next steps, or concerns about the safety implications of intervention. The numbers offered An Garda

Síochána's DRIRP were low, and the numbers taking up this programme were also low, potentially reflecting fears of retaliation, low confidence in formal reporting and/or a preference for community-based solutions. Since mid 2025, the DRIVE training and capacity building has been rolled out by L/RDATFs and will continue to be delivered nationwide. Therefore, as familiarity with the NDTRS DRI data collection increases and training becomes more embedded, improvements in both support provision, the training capacity building, and data completeness would be expected.

The outcomes reported show that almost half of cases resolved the situation informally, often without engagement with formal systems. While many informal resolutions may achieve safety in the short term, they may also mask ongoing coercion or create cycles of repeated intimidation. The proportion of cases reporting ongoing intimidation during treatment further reinforces the dynamic nature of DRI and the need for ongoing monitoring and timely intervention.

Limitations

NDTRS data are case-based and may include multiple treatment episodes for the same individual within a calendar year. DRI disclosure may occur at any point in treatment, leading to updates over time. Small numbers are suppressed to preserve confidentiality, and limited data are collected on intimidators to prevent identification of individuals or locations.

Conclusion

Overall, these emergent national data provide strong evidence of the harm of DRI across all socio-economic groups and all levels of society, showing that DRI is multifaceted, intersects with drug markets, social disadvantage and family systems, and requires joined up responses across health, community and justice sectors. The patterns observed underscore the value of the DRIVE model and the NDTRS DRI module as foundational components of a national monitoring and intervention framework. Continued development of service capacity, improved information sharing and enhanced integration with community safety and policing initiatives will be essential to address the complexity of DRI and to protect those affected.

5: RECOMMENDATIONS

These recommendations are derived from research evidence[1,2,5,6,7,8,16,17] and the NDTRS data presented in this report. They reflect opportunities to strengthen practice, improve data quality, and enhance safety for individuals and families experiencing DRI.

- ***Strengthen supports for individuals and families experiencing DRI***

  - Continue to expand nationwide access to evidence-based drug and alcohol supports, enhancing capacity and ensuring all services have standardised guidance, safety protocols and referral pathways.[1,2,7]

  - Continue to strengthen awareness of and referral pathways to drug and alcohol community and statutory supports, including the DRIRP, among individuals, families, communities and service providers.[1,2,7]

- ***Enhance prevention and community-level interventions***

  - Given that the data shows that all sectors of the Irish population are affected by DRI, continue to provide DRI population level supports (brief advice and information, counselling etc.).

  - Additionally, utilise evidence of risk factors associated with DRI to address structural determinants of vulnerability—unemployment, early school leaving and socio-economic disadvantage, through integrated community programmes.[2,7,8,17]

  - Support the continued implementation and development of the DIGs established by L/RDATF Coordinators with the support of DRIVE Leads/ Liaisons.

  - Continue the rollout of interagency collaborations and the DRIVE training programme in each L/RDATF area via the DIGs.

  - Continue to promote the DRIVE Project nationally through public awareness campaigns to increase visibility, understanding, and accessibility of supports for individuals affected by DRI.

- Recognise the link between DRI and addiction, mental health and trauma (such as adverse childhood experiences, exposure to violence) which requires training for professionals to provide an evidence-based multidisciplinary response focused on prevention.[1,5,16]

- Continue to work with organisations working with young people to respond to the risks associated with DRI, such as child exploitation/criminal grooming.

- Recommend the development of targeted prevention initiatives focused on groups most at risk of becoming perpetrators of DRI and those who are already involved as perpetrators (particularly males, under 30).[1,2,5,7,16,17]

- ***Strengthen interagency collaboration and policy development***

  - Enhance structured information-sharing mechanisms between services, community organisations, An Garda Síochána and relevant policy stakeholders to support coordinated, evidence-informed responses.

  - Use emerging DRI data to inform policy and legislative reforms aimed at strengthening protections, improving justice responses and reducing the incidence and impact of DRI.

  - Prioritise the reduction of 'not known' responses and recognise 'did not wish to answer' as a valid, safety-related response. Services should be supported and trained to revisit DRI questions appropriately as trust with service users develops.

- ***NDTRS as a model for DRI monitoring***

  - Expand the official remit of the NDTRS to include all family support services who provide assistance to families affected by a loved one's drug and alcohol use. This will contribute to the completeness of DRI data, building a robust understanding of the nature and patterns of intimidation, thereby enabling the design of more effective interventions and policy responses.[1,5,6,7]

  - Continue to rollout NDTRS DRI training and support for data collection to all participating services nationwide to improve data coverage and quality.

- Support continued development and implementation of the DRIVE model as a national framework expanding the data collection to other organisations and agencies who may support individuals and families impacted by DRI, to further inform, guide and strengthen the monitoring and response to DRI.

- Position the NDTRS as a transferable model for developing DRI monitoring frameworks internationally, offering a structured, standardised and evidence-based approach adaptable to diverse policy and service environments.

ACKNOWLEDGEMENTS

The DRIVE Project and the NDTRS team would like to acknowledge the ongoing support of the staff in the addiction treatment services, and family support services throughout the country, without whom it would not be possible to maintain the NDTRS and capture this important data in relation to DRI. Their participation and cooperation are very much appreciated and valued.

It is also important to acknowledge the ongoing commitment of the National DOC (current and previous members) and the DRIVE research subgroup for their sustained dedication to the national implementation and development of the DRIVE model. Their expertise, collaboration and consistent engagement have been instrumental in advancing the DRIVE data-informed model. Specifically, to acknowledge the contribution of Georgia Brown, the first DRIVE Data, Research and Evaluation Coordinator.

The DRIVE Project would also like to express appreciation to the Department of Health for its support in the establishment of the DRIVE Project and for its continued funding and strategic backing. This investment has been essential to enabling the development, implementation and ongoing operation of the project.

REFERENCES

1. Public Health Agency (2025) *Drug-related intimidation in Northern Ireland: nature, support needs and how to respond. A summary report.* Belfast: Executive Programme on Paramilitarism and Organised Crime. Available at https://www.drugsandalcohol.ie/44940/

2. McCreery SJ, Keane M, Bowden M (2021) *Debts, threats, distress and hope: towards understanding drug-related intimidation in Dublin's North East Inner City.* Dublin: Ana Liffey Drug Project. Available at https://www.drugsandalcohol.ie/33682/

3. Brennan R (2022) S*inging from the same hymn sheet: an evidence base for the development of an interagency drug-related intimidation specific training programme in the SICDATF area.* Dublin: South Inner City Local Drugs and Alcohol Task Force. Available at https://www.drugsandalcohol.ie/38915/

4. Connolly J, Buckley L (2016) *Demanding money with menace: drug-related intimidation and community violence in Ireland.* Dublin: Citywide Drugs Crisis Campaign. Available at https://www.drugsandalcohol.ie/25201/

5. Murphy L, Farragher L, Keane M, Galvin B, Long J (2017) *Drug-related intimidation. The Irish situation and international responses: an evidence review. HRB Drug and Alcohol Evidence Review 4.* Dublin: Health Research Board. Available at https://www.drugsandalcohol.ie/27333/

6. European Monitoring Centre for Drugs and Drug Addiction and Europol (2024) *EU Drug Markets Analysis: key insights for policy and practice.* Luxembourg: Publications Office of the European Union. Available at https://www.drugsandalcohol.ie/40605/

7. DRIVE Oversight Committee (2021) *A data-driven intervention model to respond effectively to drug-related intimidation and violence in communities in Ireland.* Dublin: Department of Health. Available at https://www.drugsandalcohol.ie/35239/

8. Department of Health (2017) *Reducing harm, supporting recovery. A health-led response to drug and alcohol use in Ireland 2017-2025.* Dublin: Department of Health. Available at https://www.drugsandalcohol.ie/27603/

9. Department of Health (2026) Draft. *National Drugs Strategy 2026-2029. An integrated, equitable and evidence-based response to drug and harmful alcohol use.* Dublin: Department of Health. Available at https://www.drugsandalcohol.ie/45067/

10. Lyons S (2025) Launch of the national awareness campaign for the *DRIVE Project.* Drugnet Ireland, Issue 92, Autumn 2025, pp.28-29. Available at https://www.drugsandalcohol.ie/44409/

11. European Union Drugs Agency (EUDA) (2012) *Treatment demand indicator (TDI) standard protocol 3.0: guidelines for reporting data on people entering drug treatment in European countries.* EUDA. Available at https://www.drugsandalcohol.ie/18436/

12. More detailed information on the NDTRS methodology can be found in previously published HRB Trends Series papers at: www.hrb.ie/fileadmin/publications_files/HRB_Trend_Series_12_Trends_in_treated_problem_drug_use_in_Ireland_2005_to_2010_02.pdf

13. Collins P, Carew A, Craig S, Galvin B, Lyons S (2023) *Analysis of the relationship between addiction treatment data and geographic deprivation in Ireland.* A supplement to the Winter 2023 issue of Drugnet Ireland, Health Research Board. Available at https://www.drugsandalcohol.ie/38474/

14. Mongan D, Millar SR, Carew AM, Kelleher C, Daly A, Lyons S, Galvin B, Smyth BP (2025) *Trends in cocaine use and cocaine-related harms in Ireland: a retrospective, multi-source database study.* BMC Public Health. 2025 Jul 2;25(1):2285. Available at https://www.drugsandalcohol.ie/43633/

15. Connolly J (2017) *Illicit drug markets, systemic violence and victimisation.* Northern Ireland Legal Quarterly, 68, (4), pp. 415–32. Available at https://www.drugsandalcohol.ie/45323/

16. Comiskey CM, Marder ID, Corbally M (2026) *Understanding and preventing drug-related interpersonal violence in Ireland through a public health approach.* International Journal of Drug Policy, 149, 105156. Available at https://www.drugsandalcohol.ie/45036/

17. Bowden M (2019) *The drug economy and youth interventions: an exploratory research project on working with young people involved in the illegal drugs trade.* Dublin: Citywide. Available at https://www.drugsandalcohol.ie/30487/

Additional resources

For further research related to drug-related intimidation visit the HRB National Drugs Library at https://www.drugsandalcohol.ie/

APPENDIX 1

National DRIVE Oversight Committee Membership

The following are the representatives of the National DRIVE Oversight Committee:

Name	Role/Representative group
Antoinette Kinsella	Chairperson of National DRIVE Oversight Committee/Regional Drug and Alcohol Task Force Coordinators Network
Chris O'Sullivan	North Dublin Regional Drug and Alcohol Task Force Coordinator
Detective Superintendent Sé McCormack	An Garda Síochána, Garda National Drugs and Organised Crime Bureau
Mary Jane Trimble	Department of Health
Robert Hansberry	Department of Justice
Dr Suzi Lyons	Health Research Board
Fran Byrne	HSE National Addiction Advisory Group
Deirdre Matthews	Probation Service
Stephen Cashman	National Voluntary Drug and Alcohol Sector
Hugh Greaves	Local Drug and Alcohol Task Force Coordinators Network
Eibhlin Smith	Tusla Child and Family Agency
Supported by the DRIVE Project team: Siobhán Maher National DRIVE Coordinator Kevin Byrne DRIVE Project Officer Janet Robinson DRIVE Data, Research and Evaluation Officer	

APPENDIX 2

Geographical location of residence of DRI cases by Local and Regional Drug and Alcohol Task Forces, NDTRS 2024-2025

Analysis of residence of DRI cases by L/RDATF areas indicates the highest number in the South Eastern RDATF area (12.2%), followed by the Mid-West Regional Drug and Alcohol Forum (9.3%), and the North Inner City LDATF (8.5%) (Table A2.1).

Table A2.1: Number of cases reporting DRI by Local and Regional Drug and Alcohol Task Force area of residence, NDTRS 2024-2025

Drug and Alcohol Task Force area	n	%
Ballyfermot LDATF	12	1.2
Ballymun LDATF	32	3.1
Blanchardstown LDATF	23	2.2
Bray LDATF	13	1.3
Canal Communities LDATF	~	~
Clondalkin LDATF	18	1.8
Cork LDATF	39	3.8
Dublin North East LDATF	47	4.6
Dublin South Inner City LDATF	28	2.7
Dublin 12 LDATF	~	~
Dun Laoghaire/Rathdown LDATF	23	2.2
East Coast RDATF	20	1.9
Finglas/Cabra LDATF	15	1.5

Drug and Alcohol Task Force area	n	%
Midlands RDATF	56	5.5
Mid-West Regional Drug and Alcohol Forum *	96	9.3
North Dublin RDATF	34	3.3
North Eastern RDATF	64	6.2
North Inner City LDATF	87	8.5
North Western RDATF	26	2.5
South Eastern RDATF	125	12.2
Southern RDATF	71	6.9
South Western Substance Use Regional Forum (SURF) ^	59	5.7
Tallaght LDATF	47	4.6
Western RDATF	43	4.2
Other/Unknown	35	3.4
Total	**1027**	**100.0**

~ 10 cases or fewer
* Previously Mid Western RDATF
^ Previously South Western RDATF

APPENDIX 3

Support services

DRIVE Project

For free and confidential supports for people experiencing drug-related intimidation, please contact the National DRIVE Coordinator, Siobhán Maher, at the DRIVE Project office. Contact details for Local and Regional Drug and Alcohol Task Forces can be found on the DRIVE website. You can also find an up-to-date list of your local An Garda Síochána Nominated DRI Inspectors on the website.

- Tel: 086 1281782
- Email: drive@ndublinrdtf.ie
- Website: www.driveproject.ie

Drug-Related Intimidation Reporting Programme (DRIRP)

An Garda Síochána's DRIRP provides support to individuals and families experiencing drug-related intimidation. Each Garda Division has a designated Drug-Related Intimidation Inspector who can meet people confidentially to offer safety information, discuss available options, and explain the process for making a formal complaint.

- Tel: contact your local Garda Station and request to speak with the Drug-Related Intimidation Inspector
- Website: https://www.garda.ie/en/crime/drugs/the-drugs-related-intimidation-reporting-programme.html

MABS

MABS is the Irish money advice service that provides impartial advice to help people to manage their money and deal with debt. Support is free and provided online, by phone and face to face.

- Tel: 0818 07 2000 (Helpline Monday to Friday from 9am to 8pm)
- Email: helpline@mabs.ie
- Website: www.mabs.ie

Citizens Information

Citizens Information is a free, confidential service providing comprehensive information, advice, and advocacy on public services, rights, and entitlements. It covers areas like social welfare, employment, housing, tax, and health. Citizens Information Centres are located in every Irish county.

- Tel: 0818 07 4000 (Phone Service Monday to Friday from 9am to 8pm)
- Website: https://www.citizensinformation.ie

Drugs and Alcohol Helpline

The HSE Drugs and Alcohol Helpline provides confidential support, information, guidance and referral to anyone with a question or concern related to drug and alcohol use. The service is non-judgemental and offers space to talk about your situation, to explore some options and to consider your needs.

- Tel: 1800 459 459 (Open Monday to Friday from 9.30am to 5.30 pm)
- Email: helpline@hse.ie

Drugs.ie

Drugs.ie is Ireland's national drug and alcohol information and support website. It is a comprehensive and confidential "one-stop-shop" for individuals, families, and professionals seeking information or services related to drug use.

- Website: https://drugs.ie/

Find an addiction service

Search for drug and alcohol treatment services in your area using an interactive map. Services cover a range of user needs and requirements, from adults to adolescents. You can select specific services using an interactive form to show the services you are interested in, use the map filters or simply zoom in to view an area.

- Website: https://www.drugsandalcohol.ie/services_map

Samaritans

Samaritans provide a free, 24-hour, confidential emotional support service for anyone who is struggling to cope, experiencing distress, or feeling suicidal. Staffed by trained volunteers, the service offers non-judgmental listening and support by phone, email, and in-person, with a core aim of reducing suicide and alleviating feelings of loneliness and isolation.

- Tel: 116 123 (24-hour helpline)
- Email: jo@samaritans.ie
- Website: https://www.samaritans.org/samaritans-ireland/

Rape Crisis Centres Ireland

There are 17 independent Rape Crisis Centres in Ireland providing free, specialist support to survivors of sexual violence. Services are provided free of charge.

- Tel: 1800 778 888 (24-hour helpline)
- Email: info@rcni.ie
- Website: https://www.rapecrisisireland.ie/find-help/rape-crisis-centres/

Rialtas na hÉireann
Government of Ireland

An Roinn Sláinte
Department of Health

An Roinn Dlí agus Cirt
Department of Justice

An tSeirbhís Phromhaidh
The Probation Service

An Garda Síochána
Seirbhís Náisiúnta Póilíneachta & Slándála na hÉireann
Ireland's National Police & Security Service

TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

NVDAS
NATIONAL VOLUNTARY DRUG & ALCOHOL SECTOR

Regional Drug and Alcohol Task Forces

HSE
HSE Social Inclusion

HRB
Health Research Board

LOCAL DRUGS & ALCOHOL TASK FORCES COORDINATORS NETWORK

2025 data published by the National DRIVE Oversight Committee

North Dublin Regional Drug and Alcohol Task Force,

32/33 Main Street, Malahide, Co Dublin, K36 EE72

ISSN 3088-702X