CPsychI
COLLEGE OF
PSYCHIATRISTS
OF IRELAND

Following the CPsychI submission to the Citizens Assembly on Drugs (CAD) 2023, the landscape on illicit drugs consumption and related harms continues to change. This revised College paper reflects the emerging drug related harms and updated data since 2023.

Submission to the National Drugs Strategy 2025 – 2033

Faculty of Addiction Psychiatry October 2025

Content

Section 1

Preparing for a new National Drugs Strategy 2025-2032

Role of psychiatrists in the wider drug policy conversation.

The College of Psychiatrists of Ireland (CPsychI) made a comprehensive submission to the Citizens Assembly on Drugs (CAD). We note the proposal that those submissions will now contribute to the public consultation in preparation for a new National Drugs Strategy. As some aspects of the drug problem have changed in the past two years and updated data on drug related harms has emerged, we decided to update this document to address this altered landscape. While continuing to support the previously made recommendations in the 2023 CAD submission, we add some additional recommendations here and also update some of the previously made recommendations.

CPsychI is concerned about drug use as this activity can result in a range of adverse outcomes for the person but also has potential to cause harm to those around the person using drugs, especially to family. The potential harms to self can include development of a substance use disorder, drug induced mental health problems, accidental overdose, medical problems and adverse events while intoxicated. Psychiatrists play a central and often leadership role in addressing many of these issues in a multitude of healthcare settings. These include specialist outpatient addiction treatment services, inpatient addiction treatment units, general mental health services, dual diagnosis services and in liaison psychiatry support to general medical hospitals.

On the issue of harm to others, we see the collateral damage caused by drug use across the entire age span. We work with children whose development has been adversely impacted by in utero exposure to alcohol and drugs. We deal with emotional and attachment issues which can arise for children and adolescents growing up in homes affected by parental substance use problems. We work with parents who have become anxious or depressed in the context of a son or daughter's substance use disorder. We also work with people who have PTSD after being the victim of an assault or robbery perpetrated by a person who is either intoxicated or has a substance use disorder.

Consequently, we see substance use as a health risk behaviour. As with other health risk behaviours, many who engage in drug use will neither experience harm nor cause any direct harm to others. In spite of this, a public health orientated policy makes efforts to curtail all health risk behaviours across the population(1).

There is a current vogue in drug policy discourse to address human rights. Ultimately, human rights transcend every Government policy on every societal challenge. The drug policy focused outputs to date from international groups have been striking in the extent to which they have actively overlooked the only human rights convention to specifically mention drug use. This occurs in Article 33 of the Convention of the Rights of the Child(2). This states emphatically that States must take all appropriate measures "*to protect children from the illicit use of narcotic drugs"*. Therefore, a human rights centred approach to drug policy should give absolute priority to primary and secondary prevention of drug use by children themselves and also give great emphasis to efforts to protect children from harms arising from drug use by the adults in their lives.

Changing structures governing drug policy over the past 30 years.

Alterations have been made to the structures which advise upon and lead on drugs strategy in Ireland over the past 30 years. Drug policy became an issue of very significant health, social and political importance in the mid-1990s(3). This occurred against the backdrop of a major heroin epidemic, which was focused in Dublin and largely affected youth living in the most deprived communities. The mortality, morbidity and social problems related to this epidemic generated substantial pressure on the political system to act. The core treatment response was expansion of services to provide medication based treatment such as methadone. The Methadone protocol was developed(3, 4). Local drug task forces (LDTFs) were established in 1997 in the communities most affected by the heroin epidemic (5). Policy was ultimately led by the Cabinet Committee on Social Inclusion. As stated by Moran et al at that time (5): *"This Committee receives input from the Inter-Departmental Group on National Drugs Strategy and the National Drugs Strategy Team. The relevant Government Departments and agencies are represented in these groups. In addition, two representatives, one from each of the community and voluntary sectors, are represented on the National Drugs Strategy Team which plays a central role in overseeing the implementation of the Government's Drug Strategy and at the operational level the work of the Local Drugs Task Force (LDTF), inter alia.... The Drugs Co-ordinating Committees of the Regional Health Boards operate at the regional level."*

The first National Drugs Strategy (NDS) commenced in 2000. While the above structures were fundamentally politically and civil servant led, there was recognition of the need for expert and science led guidance on policy. The National Advisory Committee on Drugs (NACD, 2001) was established "*in recognition of the importance of having authoritative information and research findings available as a guide to policy*"(6). The NACD reported directly to the Cabinet Committee on Social Inclusion. The NACD was mandated to engage in "*analysis and interpretation of research findings and information available to it*" focusing on "*the prevalence, prevention, treatment and consequences of problem drug use in Ireland*"(5).

In response to the growth of the heroin problem outside of Dublin after 2000, regional drug task forces (RDTF) were established in 2003 to ensure coverage of the entire country.

Over subsequent years, the overall importance of "the drug problem" declined in the minds of the general public and politicians. Efforts were made to include alcohol during the second NDS (2009-2016)(7). These efforts were half-hearted and amounted to little more that changes in titles, as minimal additional resources were provided to front line services to address alcohol problems across society. The financial crisis in Ireland and subsequent policy of austerity resulted in dramatic reductions in funding to LDTFs and RDTFs.

Towards the end of this second NDS, the Department of Health decided to deprioritise the NACD. Meetings of the NACD became infrequent and then stopped completely.

The government departments that have had the leadership role in delivery of the NDS have changed over the years. Originally in 2001, the NDS rested within the Department of Sports, Tourism & Recreation. It then moved to the Department of Community, Rural and Gaeltacht Affairs. Then in 2011, responsibility for the NDS was transferred to the Department of Health, where it remains.

In preparing for the third NDS (2017-2025), the Minister with responsibility for Drugs obtained input from a small group of international experts(8). They advised changes in the organisational structures, moving from the model depicted in figures 1.1 & to that shown in 1.2 below.

Figure 1.1 Organisational structure of the National Drugs Strategy 2009–2016

* Copy of Figure 10 from *Reducing harm, Supporting Recovery (8)*,

The international expert group proposed a new National Oversight Committee (NOC). This was established with terms of reference outlined in Box 1.1. The initial proposed membership of the NOC was largely civil servants from a range of government departments. The NOC also had membership from community and voluntary services. These largely represented services based in Dublin that had a historical focus on 'the heroin problem'.

Box 1.1 Terms of Reference* for the National Oversight Committee

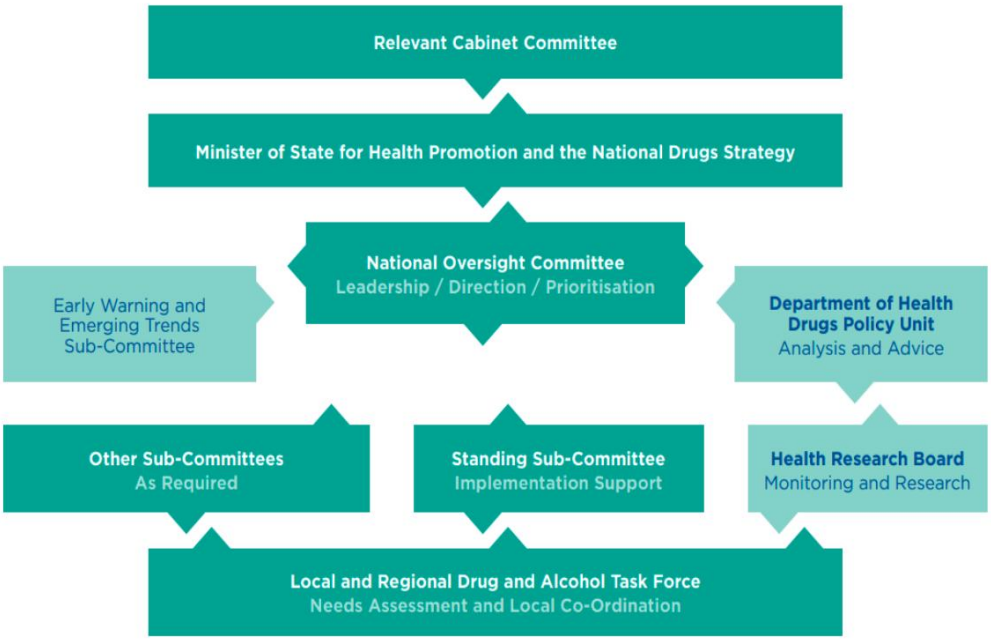
1. *to give leadership, policy direction, prioritisation and mobilisation of resources to support the strategic implementation group*
2. *to measure performance in order to strengthen the delivery of drugs initiatives and to improve the impact on the drug problem*
3. *to monitor the drugs situation and ensure that the lessons drawn from evidence and good practice inform the development of policy and initiatives to address the drug problem oversee*
4. *to ensure good governance and accountability by all partners involved in the implementation of the National Drugs Strategy*
5. *to oversee early warning and emerging needs and research sub-committees*

* https://www.gov.ie/en/department-of-health/publications/national-oversight-committee/#terms-of-reference-for-the-noc-2021-2025

The role of the NACD was officially ended. The task of advising on policy was handed over to a new Drug Policy Unit (DPU) within the Department of Health (see Figure 1.2). The Health Research Board (HRB), which had a longstanding role of active involvement in collation of data related to drug use, drug treatment and drug related health harms, had an enhanced advisory role.

While the subtitle of the current NDS is "A health-led response to drug and alcohol use in Ireland 2017-2025", there was very limited evidence of the presence of real health leadership in the structures, apart from the fact that the NOC was housed within the Department of Health (8). By way of contrast, the societal responses to Covid-19 or to cancer are/were de facto health led. Senior doctors have/had clear leadership roles, advising upon all aspects of policy to these genuinely health led issues. While the NOC has expanded to include some psychiatrists, it is notable that there is no public health doctor present on the NOC.

Figure 1.2. Structures supporting implementation of Reducing Harm, Supporting Recovery



* Copy of Figure 11 from *Reducing harm, Supporting Recovery (8)*

The DPU does not include any doctors. The NDS envisioned a structure whereby the NOC would provide leadership, after considering advice from the DPU (see Figure 1.2). In practice, the DPU has taken the leadership role on drug policy. At best, it consults with the NOC. More accurately, the DPU simply informs the NOC if its decisions. In an accurate organogram depicting how the current structures actually interact, the positions of the NOC & DPU would be reversed, with the NOC being very peripheral to the decision-making process.

By way of simple example, the general population survey (GPS) constituted a key measure of the drug situation in Ireland(9). It has been conducted every four years since 2001 and gave a detailed snapshot of the prevalence and patterns of drug use in Ireland. This permitted examination of key trends over time. The GPS was last conducted in 2019/20(10). On that occasion, it was led by the HRB. Previously, it had been overseen by the NACD. A decision was made to terminate the GPS. While it is not entirely clear who made this decision, it appears to have been made between DPU and HRB. The structures above, and NOC terms of reference, imply that it should have been made by the NOC, but the NOC had no role in this policy change.

In late 2024, the DPU and the Minister informed the NOC that the NOC would not be meeting again. This again highlights the irrelevance of the NOC in practice. Drug problems persist in Ireland. The NOC has no role in deciding upon content of the next NDS, while its own terms of reference (Box 1.1) imply that it should be front and centre of this process.

Figure 1.2 above also implies a prominent role for the Early Warning & Emerging Trends (EWET) subcommittee feeding into the NOC. The EWET is chaired by the Controlled Drugs Unit of the Department of Health. The existence of this committee reflects the very dynamic nature of 'the drug problem' in Ireland, and internationally. The EWET does provide updates to the NOC. Given that the NOC no longer meets, the EWET has not had any meetings since end of 2024. This highlights the apparent inconsequence of EWET. Again, this is the group who are charged with the task of early identification of threats to public health related to drug use. It seems very strange that 'a warning system' such as this would simply be 'turned off' in this manner for over a year.

Two distinct drug related trends and threats emerged in recent years.

Firstly, highly potent synthetic nitazenes became available in late 2023, as adulterants in products being sold as heroin(11). The response to this was led not by EWET but by the HSE National Office of Social Inclusion. The latter rapidly established a new National Response Alert Group (11).

The second health damaging drug trend to emerge was HHC. This drug was being sold in shops, became increasingly available and started causing significant issues with emerging substance use disorders and psychosis in early 2024(12). There was no meaningful response from EWET and a broadly incoherent and indifferent response from Department of Health. In spite of these issues, the recent review of the last NDS by Grant Thornton commended Ireland's early warning systems(13).

During the second half of the recent NDS, the DPU urged the creation of Strategic Implementation Groups(SIG), which fed into the NOC. It is unclear what the purpose of the SIG structure is. They have no governance function and no funding mechanisms to implement actions. They seem to be a mechanism by which the Department has devolved some responsibility for the implementation of the strategy onto the voluntary chairs of these SIG groups.

"Health-led" deserves to be more than a soundbite.

At present, the reality is that we have a civil servant and politically led drug policy. Drug policy should be genuinely health-led. As previously mentioned, psychiatrists view drug policy as primarily a health issue. Our specialist addiction treatment services are led by psychiatrists. We argue that drug policy deserves greater leadership from doctors and other senior health professionals. We note that CPsychI was not asked to nominate representatives to the Steering Group which has been assembled in mid-2025 to draft the next NDS. We believe that a cancer strategy would not be put together without the inclusion of oncologists.

A role for public health in drug policy seems obvious yet input from senior public health personnel is absent at present. Arguably, the Chief Medical Officer (CMO), or their delegate, should have a leadership role regarding all aspects of drug policy. A National Public Health Emergency Team (NPHET) type structure is warranted to provide genuinely health-based, independent, science-led advice on drug policy, from prevention to treatment and recovery. This group would then give advice to a structure such as a NOC that actually provided leadership on policy direction, prioritisation and mobilisation of resources.

EUDA

The EU Drugs Agency (EUDA, previously known as the EMCDDA) has acquired a much more prominent role in Irish drug policy in the last decade. Given that the DPU lacks internal expertise and the Department dismantled its own expert-based advice from the NACD, they have turned increasingly to EUDA to guide policy. Arguably, EUDA is sociology-led, not health led. While the patterns of drug use in Ireland often reflect those of Europe, this is not always the case. Also, drug policy seems to be of lower priority in most European countries compared to Ireland. The primary role of EUDA is the collection of data on drug use and drug related harms across Europe. It does not have a mandate to advise or instruct on policy. For these reasons, we do not have confidence that EUDA can replace a NACD or a NPHET type structure which is bespoke for Ireland.

As noted above, nitazenes posed concerns internationally in 2023. They started to contribute to overdoses in Ireland in late 2023. Ireland adopted a rapid and high-quality response to this challenge, led by doctors who in turn brought in expertise from multiple other disciplines and services (11). The EUDA turned to Ireland for advice on this issue, not the other way around.

With regard to the health & policy challenges posed by HHC, the role of EUDA was that of a passive describer of problems, placing HHC under "intensive monitoring". No direction was offered to nations on how to address HHC. So, each country implemented its own response, most banning sale of HHC in 2024.

A more insidious and slow moving trend of recent years relates to cannabis. As psychiatrists, we have been particularly concerned by the escalation in cannabis use disorders and in mental health problems related to cannabis in the past 15 years (14, 15). These challenges have also occurred across Europe. Like Ireland, cannabis has generated more demand than any other drug for addiction treatment in Europe among new attendees to treatment in the last decade (16). As with the HHC issue, EUDA seems to see its role as simply a describer of problems related to cannabis, as opposed to being an advisor about solutions to prevention and treatment challenges posed by this drug.

If EUDA does not see its own role as that of giving science based advice on drug policy or drug related interventions to countries, then the prominence that it has acquired in influencing drug policy in Ireland seems unwise. On the three practical recent trends noted above, it was of no real assistance.

Moving on from the disproportionate representation by Dublin based, heroin focused stakeholders

Input from the treatment, community & voluntary sectors into the drug policy governance structures should reflect the nature of the current drug problem. It was striking how the configuration of the last NOC at its outset was largely Dublin based (Reducing Harm, Supporting Recovery). The representative services involved were disproportionately those with a focus upon work with people who were heroin dependent.

The drug problem now presents nationwide challenges, rural as well as urban. The drugs now driving new demand for addiction treatment are primarily cocaine and cannabis. Future stakeholder input by service providers must reflect this reality.

Representation of 'lived experience'

There are genuine and substantial challenges in achieving real input into drug policy from those with lived experience.

There are very many groups with relevant lived experience. These include:

- people with a substance use disorder
- people attending addiction treatment services
- people in recovery
- people who have grown up/are growing up in homes adversely impacted by parental drug use
- parents (& other family members) of those with substance use disorders
- victims of crime perpetrated by those with drug problems

These groups will have quite different priorities and different perspectives. It is genuinely challenging to ensure that a person or organisation who claims to represent a group does actually represent the likely disparate views within that one group in a meaningful manner. It is likely to prove difficult to evidence the fact that they have actively sought and obtained the varied opinions of a large group of people and distilled all that information into a democratic consensus of the wider group's views.

What has changed in the lifetime of the current national drugs strategy?

There are important areas of progress which occurred under the recent NDS. There has been an expansion in nationwide provision of adolescent addiction treatment services. This is in the process of being further enhanced at present via the roll out of the Dual Diagnosis Model of Care (DDMoC) for adolescents (17). Two pilot sites have also been identified for the adult component of the DDMoC. Delays with HSE recruitment have hampered the pace of roll out of these new services.

The traditional mental health concerns in the domain of dual diagnosis have been illness such as schizophrenia or depression. More recently there has been a growing awareness of the challenges posed by neurodiversity, especially autism and autistic spectrum disorder (https://www.addiction-ssa.org/features/interview/sabaa-project-and-the-overlap-between-autism-and-addiction-julia-sinclair-talks-to-the-ssa/). People with neurodiversity may be more vulnerable to certain addictions and treatment may need to be modified to better meet the needs of this patient group (18). This requires a staff team in our addiction services who are capable of recognising and working with people with neurodiversity.

Primary Prevention

A key area of failure has been that of primary prevention. The pillar component of primary prevention in Ireland was meant to be the Social Personal & Health Education (SPHE) program in our secondary schools. *Fewer than one in five schools have rolled out the senior cycle SPHE program (19)*. The module on substance use ('*Know the score'*) appears to be one which schools struggle with more than others. A generation have now arrived into adulthood in Ireland with no education at all about drug or alcohol use beyond age 14 years. The need to do better in terms of prevention was acknowledged in the Grant Thornton review of the last NDS(13). Globally, doctors have been leading the call for a pro-active campaign to ensure the public are better informed

about the hazards of cannabis (20-24). Scientifically informed, national media campaigns have been identified as playing a key role in decline in cigarette smoking initiation by youth(25-27).

Cocaine

The rise in cocaine use and cocaine related harms constitutes another striking failure of the current NDS (See Figures 2.7, 2.8, 2.9 & 2.11). The key age of onset of cocaine use in Ireland appears to be aged 18-to-20 years(28). Health and addiction problems related to cocaine are peaking 5-10 years later. Cocaine related addiction treatment episodes and admissions to both medical and psychiatric hospitals have increased four- to eight-fold in the past decade(29). Cocaine now features in many more poisoning deaths than heroin(30). The rise in cocaine use in young adults may well be linked to the lack of priority given to primary prevention noted above.

HHC

Another area of failure has been the response to HHC products. HHC vapes and edibles were openly sold in shops across Ireland and on line 2023-2025. They were widely advertised as having effects like THC (the active drug in cannabis). Psychiatrists began highlighting health problems arising from these products since Autumn 2023(12, 31-33). EUDA gave no direction to EU countries on legislative or regulatory options. Most EU countries opted to step in to protect citizens from this harmful drug by banning it, but Ireland chose to do nothing. Then the UN Commission on Narcotic Drugs (UNCND) added HHC to the UN Conventions on Drugs In March 2025(34). As a signatory of these drug conventions, Ireland finally banned HHC via our Misuse of Drugs Act in August 2025. No direction was provided to shops by either the Department of health or by an Garda Síochána on what to do with their illegal product once it was banned. Ireland had the option of targeting the entrepreneurs selling HHC via the Criminal Justice (Psychoactive Substances) Act, 2010(33). This option was not pursued for reasons that are unclear. Once the UNCND declared it to be a narcotic drug in March, this Act could most definitely have been employed to prosecute shops which continued to sell it. The barriers to its use must be elucidated and addressed. Lessons must be learnt from this overall failure. Pro-active mechanisms must be put in place to ensure a more effective response to the next psychoactive drug which will be sold in shops in the coming years.

New potential routes to drug related harm have emerged in Ireland during the course of the current NDS. Legislation was enacted to allow access to some specific cannabis based products (CBPs) for medical purposes for a very limited number of conditions in 2019(35). The cannabis industry and those intent on wider drug legalisation will continue to push hard for incremental liberalization of the regulations governing these products(36). They will seek to widen the range of conditions for which CBPs can be used, especially hoping to get cannabis approved for pain. Pain specialists in Ireland, in common with their international counterparts, have repeatedly said that cannabis based products do not meet the required standards of effectiveness and safety to be utilised as medicines for the treatment of pain (37, 38). Psychiatrists have been clear that neither cannabis nor any CBP is an effective treatment for any psychiatric disorder(39, 40). The cannabis industry and its proxies will lobby seeking approval for a wider range of CBPs, especially use of smoked cannabis. They will argue that any doctor should be permitted to make such recommendations, not just specialists. Wider access to cannabis increases harms and addiction across the population(41-45). In jurisdictions such as US, which have much more liberal approach to CBPs, most of the young men who use cannabis for medical purposes report symptoms indicating a cannabis use disorder (i.e. addiction)(46). Doctors, not politicians, should determine what is and what is not a medicine(47).

Thirty years ago, the profile of the typical person seeking addiction treatment was a 19-year-old male early school leaver from a very deprived part of Dublin presenting with a heroin use disorder(48). Now, the age profile of new entrants into addiction treatment has widened, all socio-economic groups are encountered, and the main drugs are cocaine and cannabis.

Historically, drug use has been strongly linked to deprivation in Ireland. This was certainly the case for the heroin epidemic which hit Dublin in the 1980s and 1990s(49). While there is a strong link between drugs like heroin and crack cocaine and poverty, there is no strong link between socio-economic status and the drugs which are now causing the most harm to our teenagers and young adults in 2025(9, 28). Drug problems now occur across all of society, rich and poor, urban and rural. The next NDS must acknowledge this reality. Resources should be allocated based on current needs assessment data and not based upon historical funding arrangements.

It would also be wrong to ignore the activities and power of the drug legalisation lobby, which have grown in the past decade. Across Europe, there are dozens of NGOs and research departments funded by billionaires who want to see drugs legalised and commercialised(50). Given that there is now a legal cannabis industry in Canada, we must assume that they will behave in the same manner as other industries which sell addictive drugs and will do all in their power to expand their market (36, 51, 52). While civil servants and public health professionals who deal with tobacco and alcohol policy are well used to dealing with industry lobbying, this constitutes a new challenge for those involved in drug policy. In addition to rolling out sophisticated and sustained pro-cannabis campaigns on social media, the cannabis lobby actively targets and attacks those who highlight the harms of cannabis. These attacks have effectively silenced organisations like “Talk to Frank” in the UK and the HSE’s drugs.ie here in Ireland, neither of which now highlight hazards related to smoked cannabis use.

Returning to the theme of successes, Ireland continues to avoid an ongoing and evolving opioid epidemic amongst youth, such as that seen in Canada & USA(53). This success must not be taken for granted.

Matching staff resource and skill mix to the needs of current treatment attenders

Our society does continue to strive to meet the needs of the large cohort of people who were caught up in the heroin epidemic of 20 to 30 years ago. Our treatment services, especially those in Dublin, have been largely configured around meeting the needs to this patient group, who are now typically in their 40s. The majority of drug poisoning deaths continue to be among those with opioid problems but polydrug use is an increasing driver of these deaths(30). There is evidence of escalating polydrug use amongst those on opioid substitution treatment (OST)(54). The younger cohort of patients accessing addiction treatment generally avoid heroin use (see Figure 2.10 in section on addiction treatment), cocaine and cannabis use disorders predominating. Consequently, there is a requirement for all addiction treatment services to build up their complement of counselling staff, as counselling and ‘talk therapy’ approaches are the core interventions for people with non-opioid related substance use disorders and also a priority intervention for people on OST who have developed an addiction to other substances such as cocaine or alcohol.

So, has there been an increase in the number of staff in addiction services to respond to these escalating needs related to cocaine and cannabis use disorders? The answer is an emphatic “no”. ***A recent staff audit within HSE addiction services found that there were 209 posts either lost in recent years or currently unfilled nationally***. ***This includes an absence of 57 counsellors nationally***. Looking specifically at HSE addiction services in CHO 6 & 7 (covering Kildare, Wicklow & Dublin South), the number of counsellors has fallen by 65% since the first

round of austerity cuts in 2010. There are many addiction treatment clinics in Dublin providing OST where patients do not have access to a counsellor.

A key barrier to recruitment of counsellors in addiction services relates to the disparity in pay rates for counsellors in those services compared to counsellors, with identical qualifications, in other HSE health services. While this unfair and discriminatory pay disparity persists, our addiction treatment services are going to struggle to recruit and retain counselling staff. Consequently, our patients are receiving sub-optimal treatment, frequently being denied access to qualified counsellors.

While numbers of new treatment entrants requiring opioid substitution treatment (OST) has declined, the treatment needs of the older cohort of patients already on OST have changed. With the aging profile, there has been increased medical comorbidity(55, 56). This requires in-reach by specialist medical services into centres providing OST or ongoing efforts to pro-actively link patients on OST with medical supports at primary & secondary care. Polydrug use is increasingly evident among those on OST with cocaine use disorders being prominent. This has grown against a backdrop of reduction in biological screening of drug use by patients attending treatment and the decline in availability of counsellors in HSE addiction clinics noted above.

Ultimately, there should be a national network of multi-disciplinary outpatient services for people struggling with any substance use disorder. Such services for all other health problems are led by consultants. This should also be the case for people with a substance use disorder. The make-up of the staff team should reflect the competencies necessary to meet the needs of the patient group.

Biological drug screening provides useful objective assessment of client progress during treatment. Testing can also assist in early identification of a lapse to drug use during treatment or emergence of a new substance use disorder related to a different substance. The earlier a problem is identified, the easier it is for the patient to address same with service support. The move away from supervised urine drug screens should not mean that screening ceases to be utilised as a component part of routine treatment plans. Non-direct supervision of urine samples can be utilised for screening purposes. Saliva testing was being utilised with increasing frequency before Covid and should be made available as an option for both service providers and for patients once again.

The Citizens Assembly on Drugs

The Citizens Assembly on Drugs (CAD) completed its work in 2023. While their report and its recommendations take a broad view of the many component parts of drug policy, the vast majority of the discourse surrounding the CAD has been on legislation alone. While this was not a citizens assembly on drug legalisation, it has been responded to by many politicians as though it was. Drug legalisation was one of very many areas of policy explored by the CAD. Many champions of legalisation were provided with platforms to talk to the CAD. However, the majority view of the CAD was to reject legalisation. In doing so, the CAD disappointed many legalisation enthusiasts. However, the CAD opinion that drugs should remain illegal was similar to that of a range in major medical organisations globally including the American Medical Association, the Australian Medical Association and the Standing Committee of European Doctors (21, 22, 57).

An Oireachtas Committee on Drugs (OCD) was established in 2024 to advise the Oireachtas on how to best implement the advice of the CAD. Given that the CAD rejected legalisation, it was strange that the committee in 2024 included so many politicians who were vociferous legalisation champions. That OCD proceeded to invite many pro-legalisation organisations to

give evidence. They also invited the main funder of the global drug legalisation movement in on two occasions. The OCD broadly ignored the many other wide ranging drug policy recommendations made by the CAD. With the new Government now well established, the work of the new OCD has commenced, and we would welcome the opportunity to provide an expert perspective as doctors and psychiatrists.

As a College, we expressed grave concern about the possibility of Ireland choosing to legalise cannabis in our 2023 submission to the CAD. In the intervening two years, that concern has only grown. It is increasingly clear that legalisation has coincided with an escalation in cannabis related health harms in those locations which have embarked upon this policy experiment(41, 58-62).

Housing

Housing is a ubiquitous challenge impacting on a multitude of issues in Irish society. It also has relevance to the issue of drug use and drug and alcohol use disorders. Substance use disorders contribute to homelessness. It also can act as an obstacle to resolution of homelessness for some people. The Housing First model (https://www.housingagency.ie/housing-information/housing-first) has been piloted in Ireland in recent years, the Housing Agency being responsible for its roll out (Dept of Housing, 2022 - https://assets.gov.ie/static/documents/housing-first-national-implementation-plan-2022-2026.pdf). This is an impressive model and deserves support.

Section 2

Data on drug use and drug related health Harms

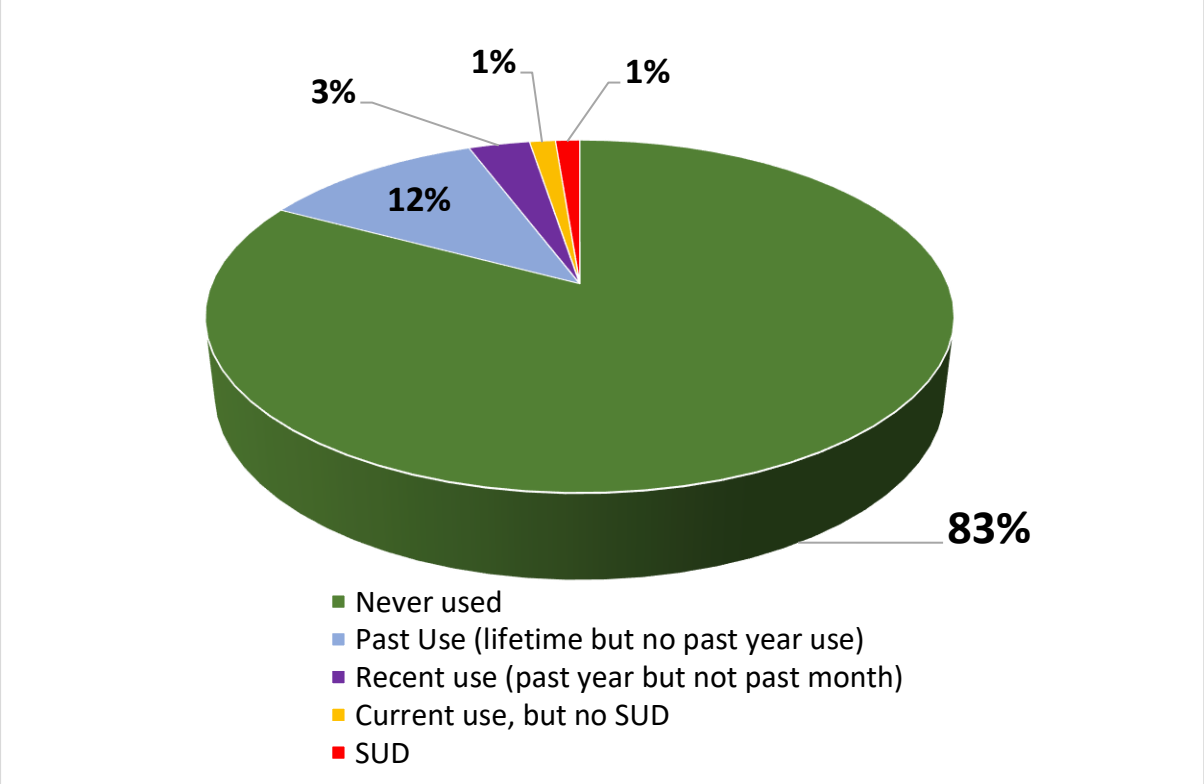
What is the prevalence of drug use in Ireland?

The last general population survey of drug & alcohol use occurred in 2019. A decision was made by the Department of Health to cease this survey. It has been replaced by a module on drug use in the Healthy Ireland (HI) survey. The information in HI is less detailed.

The most recent HI survey which included questions on drug use occurred in 2023. The lifetime prevalence of use of any illegal/illicit drug was 21.3% among people aged 15 years and above. The past year prevalence was 7.1%. This indicates that two-thirds of those with a history of drug use have avoided doing so in the past year. Past year use was higher in men (9%) than in women (5%). The prevalence of past month use was 3.2%.

If we assume that children aged 14 years and below have not used illegal drugs, then this indicates that 94% of people in Ireland have not used a drug in the past year (Figure 2.1). All of the harms that arise from drug use in Ireland in 2023 have their origins in the 5.7% of people who use drugs (PWUD), those harms falling largely upon PWUD themselves, but also impacting across all of society (i.e. harm to others).

Figure 2.1. Distribution of entire population (includes children) by history of illegal drug use, 2023



The age group with the highest prevalence of past year drug use were those aged 15-24yo, where it was 20%. Framed more positively, this indicates that 80% of youth completely avoided drug use in the past year. Much of the wider public narrative in the media creates the impression that

drug use is more commonplace than is actually the case. We know from the Drug Use in Higher Education in Ireland (DUHEI) survey that students over-estimate the extent of drug use amongst their peers and that those who use most frequently are more prone to over-estimation(63). Social norms theory suggests that steps should be taken to inform youth and wider society that prevalence of use is lower than estimated and this simple communication may nudge use downwards.

The most commonly used illegal drugs across the population were cannabis and cocaine with past year prevalence among people aged 15+ years of 5.9% and 1.9% respectively.

Wastewater analysis has been utilised in Ireland and across Europe in recent years to provide further objective evidence about drug use across the populations. The 2024 report from EUDA (https://www.euda.europa.eu/publications/html/pods/waste-water-analysis_en) revealed that Ireland had relatively high levels of cocaine, MDMA & ketamine. We have average levels of cannabis and low levels of amphetamine & methamphetamine.

Population estimates on Drug use disorders (DUD)

There is no national data on the prevalence of drug use disorders (DUD) apart from those related to cannabis and to opioids. Data on cannabis use disorder (CUD) was last obtained in the general population survey of drug & alcohol use in 2019/2020. The prevalence was 1.2% in adults and this generated an estimate of 45,000 people. Prevalence in males was double that of females. The prevalence was five times higher among 15-34yo compared to 35-64yo (2.8% vs 0.5%).

The prevalence of opioid use disorder (OUD) was estimated to be 5.8 per 1000 in 2022, equating to 19460 people (See Table 2.1 below). Again, prevalence in males is double that in females. In contrast to CUD, the prevalence of OUD is much higher in people over 25 years, being about eight times higher than in those aged 15-24yo.

Table 2.1. Total estimated number of problematic opioid users, by age group and sex in 2022*

Variable	Known	Estimate	95% CI	Rate per 1000 population	95% CI
Total	12719	19460	19348–23158	5.79	5.76–6.89
Age group					
15–24 years	264	527 (2.7%)	524–627	0.82	0.81–0.97
25–34 years	2304	4283 (22.0%)	4258–5097	6.82	6.78–8.12
35–64 years	10151	14650 (75.3%)	14566–17434	7.02	6.98–8.35
Sex					
Male	8989	13218 (67.9%)	13142–15730	7.96	7.91–9.47
Female	3730	6242 (32.1%)	6206–7428	3.67	3.65–4.37

* The table above is a copy of Table 3 on p19 from Hanrahan et al (2025) Prevalence of problematic opioid use in Ireland, 2020–2022. HRB. www.drugsandalcohol.ie/42700

There is also evidence of very marked geographical variation in the prevalence of OUD. Prevalence peaks in cities, especially Dublin city. The heroin epidemic hit Dublin most dramatically in the mid-1990s. The peak incidence outside Dublin was lower and occurred about 10-15 years later. This has resulted in a large and older population of people with OUD in Dublin and a younger profile outside Dublin. In the Community Health Office (CHO) areas in Dublin (6, 7 & 9), the prevalence is highest in older people aged 35-64yo (see table 2.2 below). In other CHOs, the prevalence is highest among people aged 25-34yo.

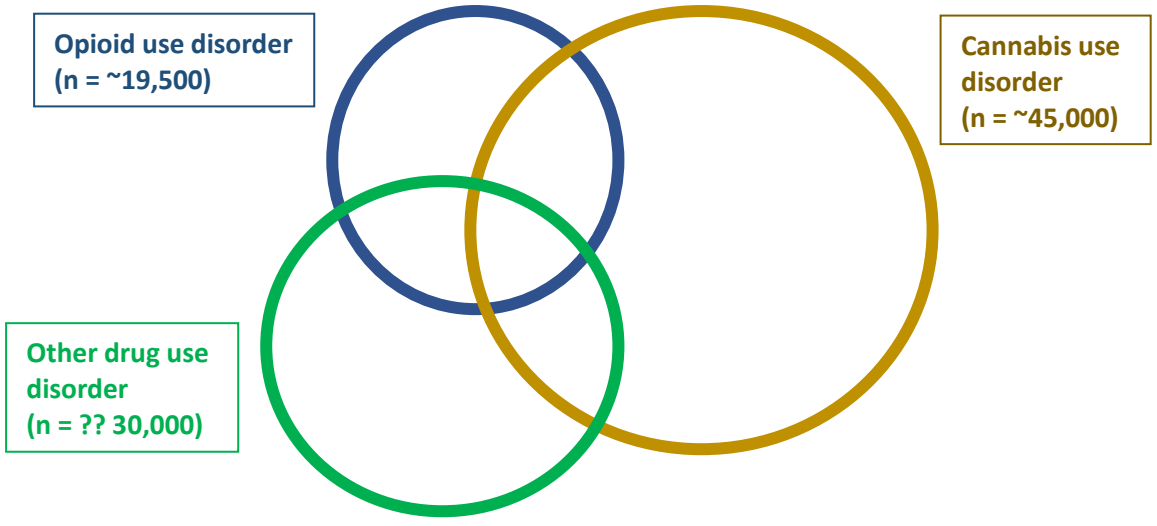
Table 2.2. Estimates of the rate per 1,000 population of problematic opioid users aged 15–64 years, by age group and CHO area in 2022

CHO area	15–24 years		25–34 years		35–64 years	
	Estimate	95% CI	Estimate	95% CI	Estimate	95% CI
CHO 1	0.18	0.14–0.53	2.80	2.25–8.23	1.67	1.34–4.91
CHO 2	0.32	0.25–0.57	3.37	2.63–6.06	2.28	1.79–4.10
CHO 3	0.46	0.40–0.63	6.30	5.62–8.53	3.89	3.47–5.26
CHO 4	0.96	0.89–1.19	5.11	4.74–6.37	2.73	2.53–3.40
CHO 5	1.07	0.98–1.23	6.92	6.32–8.03	3.68	3.36–4.27
CHO 6	0.69	0.63–0.92	10.10	9.22–13.33	12.33	11.27–16.27
CHO 7	1.11	1.04–1.49	7.22	6.78–9.68	12.95	12.18–17.38
CHO 8	0.80	0.72–0.99	7.83	7.03–9.72	5.20	4.68–6.46
CHO 9	1.16	1.05–1.61	8.81	7.93–12.19	15.03	13.53–20.80
Total	**0.82**	**0.81–0.97**	**6.82**	**6.78–8.12**	**7.02**	**6.98–8.35**

* The table above is a copy of Table 11 on p25 from Hanrahan et al (2025) Prevalence of problematic opioid use in Ireland, 2020–2022. HRB. www.drugsandalcohol.ie/42700

So, what is the prevalence of any DUD in Ireland? There will certainly be some overlap between those with CUD & OUD, perhaps half of those with an OUD also having a CUD (Figure 2.2). There are also an unknown number of people with a DUD which does not involve either cannabis or opioids. These cases will most often involve drugs such as cocaine and benzodiazepines, based upon population survey and drug treatment data. Consequently, it seems reasonable to estimate that 70,000 to 90,000 people have a DUD related to a drug other than alcohol in Ireland currently.

Figure 2.2. Estimated prevalence of DUD in Ireland in 2022



The population estimate for an alcohol use disorders (AUD) is vastly higher (see table 2.3). Again, based upon data from the general population survey of drug & alcohol use in 2019/2020, this estimated that 20% of those who used alcohol in the past year had an AUD. In recent years, the proportion of adults who are non-drinkers has increased a little to 30%. This indicates that 14% of people aged 15 years and older have an AUD. This equates to about 600,000 people, among whom about 90,000 have a severe AUD.

Prevalence of AUD is highest in younger age ranges. While there is no gender disparity among people aged 15-24yo, prevalence of AUD is much higher in male drinkers, especially in older age ranges.

Table 2.3 Percentage of drinkers with AUD, by severity of AUD, sex, and age group, 2019–20

		AUD (all drinkers)	Mild AUD	Moderate AUD	Severe AUD
		AUD (all drinkers)	Mild AUD	Moderate AUD	Severe AUD
15–24 years	Male	37.0%	15.0%	14.1%	7.9%
	Female	38.0%	21.6%	7.9%	8.6%
25–34 years	Male	37.1%	14.6%	15.3%	7.1%
	Female	18.1%	14.3%	2.4%	1.4%
35–49 years	Male	26.2%	16.1%	6.5%	3.7%
	Female	13.4%	9.7%	2.9%	0.8%
50–64 years	Male	13.6%	9.4%	1.9%	2.3%
	Female	7.3%	5.0%	1.8%	0.6%
≥65 years	Male	9.7%	7.3%	1.9%	0.4%
	Female	3.7%	2.2%	1.3%	0.2%
	Total	**20.0**	**11.6%**	**5.4%**	**3.1%**

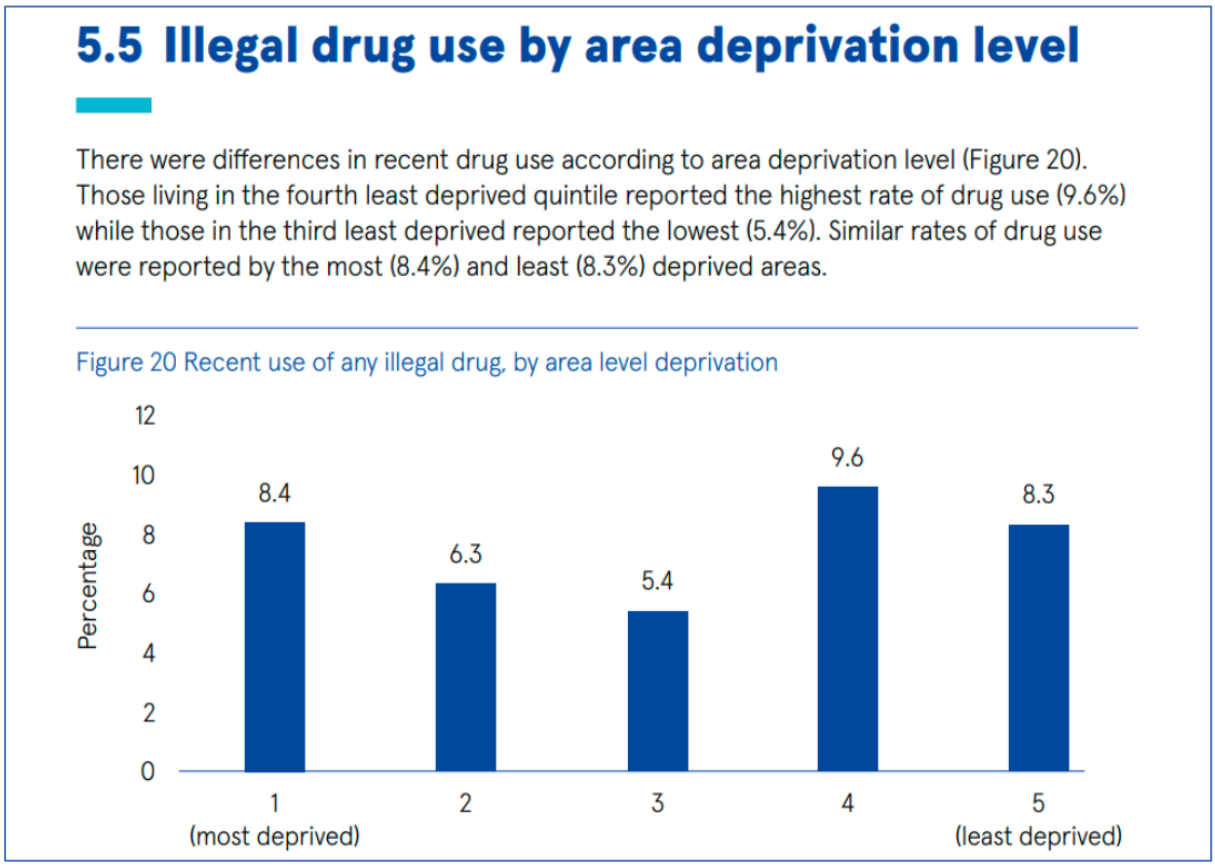
* The table above is a copy of Table 4 on p34 from Doyle A, Mongan D, Galvin B, (2024) Alcohol: availability, affordability, related harm, & policy in Ireland. HRB. https://www.drugsandalcohol.ie/40465

Who uses drugs?

Use of drugs, such as cannabis, MDMA, cocaine and heroin, is more common among males. The gender disparity is less evident in younger age ranges. Apart from heroin, drug use is more common in youth aged 15-24yo. Cocaine use appears to peak at a slightly later age, mid to late 20s.

Drug use occurs across the full socio-economic spectrum, although prevalence of use tends to be slightly higher in the wealthiest 40% of the population (see figure 2.3 below from the 2019/20 General Population survey of drug & alcohol use)(9). This challenges the widely held notion that drug use is related to poverty.

Figure 2.3. Illegal drug use by area derivation level. *



* Figure above taken from Mongan, Millar & Galvin. (2021) The 2019–20 Irish National Drug and Alcohol Survey: main findings. HRB https://www.drugsandalcohol.ie/34287/

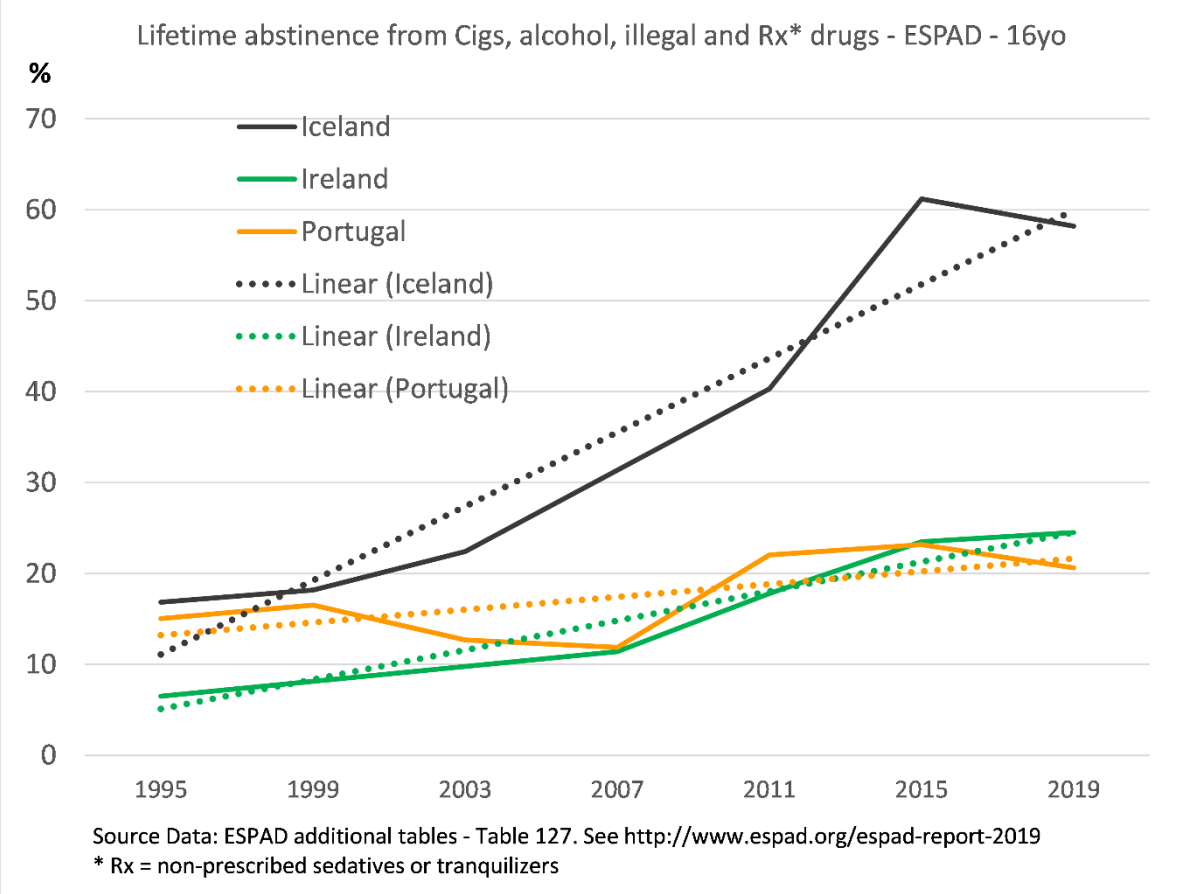
A recent study focusing on cocaine use by Irish 20-year-olds found that deprivation was not predictive of use, but likelihood of use did increase in those with earlier onset drinking(28).

A recent study of cannabis use among 15-16yo reported that peer cannabis use, a casual parental attitude to cannabis use and lower perceived risk of cannabis were independent predictors of cannabis use by teenagers(64).

It is not all bad news

The prevalence of lifetime abstinence from use of addictive substances among Irish 16-year-olds has trebled between 1995 to 2019 (Figure 2.4). This improvement means that Ireland has surpassed countries such as Portugal, but our prevention achievements fall well short of those obtained by Iceland. While EUDA remains unconvinced about the Planet Youth prevention model adopted by Iceland, the improvements that it has delivered there are quite spectacular and appear unequalled by any country globally.

Figure 2.4. Lifetime abstinence from cigarettes, alcohol, illegal and prescription drugs among 16 yo

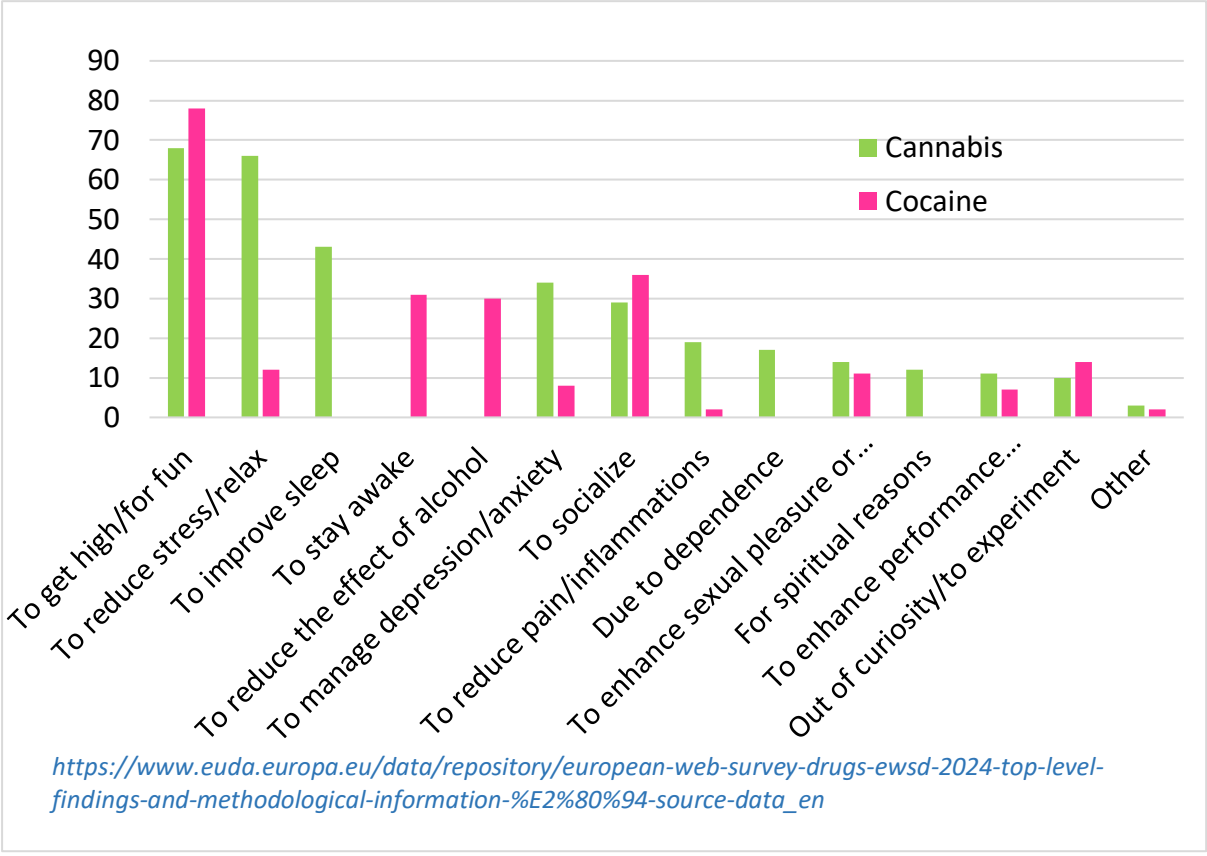


Why do people use drugs?

The two broad categories of motivation for drug use are (1) hedonic / pleasure seeking and (2) coping or 'self-medication'. The EU Web Survey in 2025 outlines self-reported reasons for using a number of different drugs(65). Figure 2.5 below focuses on the two most commonly used illicit drugs, cannabis & cocaine. The most frequently cited reason for use of both drugs was "to get high/for fun". This was also the most common self-reported reason for use of crack cocaine, MDMA, amphetamines and NPS. Similar findings were reported in the survey of Irish students in higher education (DUHEI survey)(63).

Coping motivations (to reduce stress, to improve sleep, to manage depression/anxiety) were common for cannabis and relatively infrequent for cocaine(65). This may be a consequence of the unchallenged and sustained pro-cannabis propaganda disseminated by the cannabis industry and the cannabis lobby on social and mainstream media over the past decade(66-70). This is very worrying as cannabis is not a recommended treatment for any mental health problem(39, 40). Regular cannabis use can cause dependence (reported as the reason for use by 17% in this survey) and withdrawals(65). The most common withdrawal symptoms are irritable mood and insomnia(71, 72). Consequently, many people may be using cannabis in the mistaken belief that it helps mental health symptoms which it may in fact be causing.

Figure 2.5. Self-reported motivation for use of cannabis and cocaine among European Youth

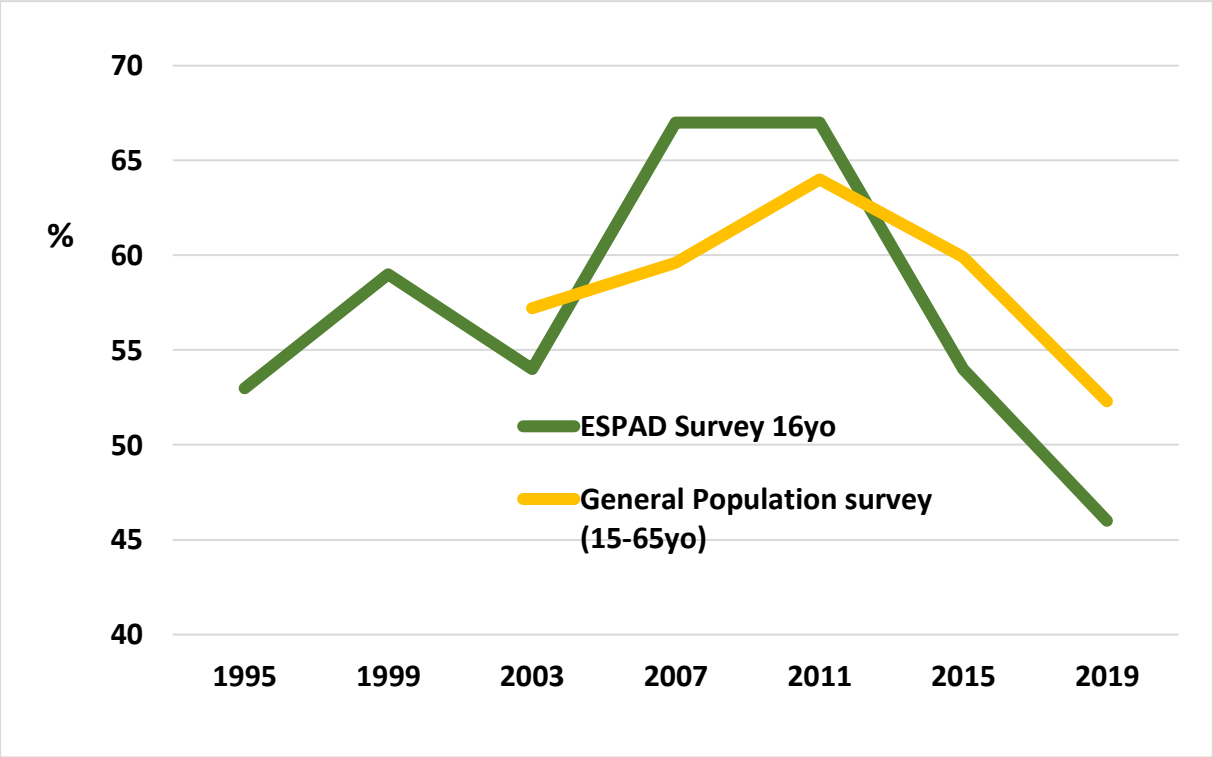


https://www.euda.europa.eu/data/repository/european-web-survey-drugs-ewsd-2024-top-level-findings-and-methodological-information-%E2%80%94-source-data_en

Public perception of drugs

While there have been many surveys exploring the reasons why people use drugs, there have been relatively few examining why people choose not to use drugs. The DUHEI survey did explore this important issue(63). There are many reasons for avoiding use and most people cite multiple factors contributing to their non-use decision. Perceived hazards of use, especially health hazards constitute a very important component of non-use decisions(64, 73). For this reason, the marked decline in perceived risk of cannabis use in Ireland, by both teenagers and by adults (parents) should be a major cause for concern (see Figure 2.6). This decline commenced after 2011, against a backdrop of the “medical” cannabis campaign. If public opinion was shaped by actual evidence of harm and scientific knowledge of the dangers of cannabis, then perceived harm should have increased after 2011, not reduced(14, 72).

Figure 2.6. Perception of regular cannabis use as posing great risk among Irish 16yo & adults



In the current national drug strategy (NDS) 2017-2025, *Reducing Harm Supporting Recovery*, the escalation in cannabis use and related harm in Ireland over the preceding years is noted in a number of chapters(8). This NDS had a stated goal to achieve an *"Increase in knowledge with respect to the harms of alcohol, cannabis and other drugs"* (KPI in Chapter 3, page 32, *Reducing Harm Supporting Recovery*). It has however, completely failed to deliver on this goal with regard to cannabis.

Drugs.ie no longer engages in any communication about the harms of cannabis smoking with the public via its social media channels. HSE Health & Well-being does not engage in primary prevention efforts targeting drug use.

In the survey of third level students (DUHEI), 70% of current users said they did not feel fully informed about risks of drugs use(63).

While SPHE was identified as the pillar intervention for primary prevention targeting adolescents in the current NDS, no targets were set to ensure roll out of the senior cycle SPHE on substance use (the *'Know the score'* module) in schools nationally. It is very concerning to note that fewer than one in five schools implemented this program in 2022(19). As a consequence, a generation of youth have emerged from our school system with no education about substance use beyond age 14 years.

No action has been undertaken to counter the pro-cannabis narrative being undertaken in mainstream and social media by the cannabis industry and the cannabis lobby(66, 69, 70). Against this backdrop of a failure to communicate simple facts to the public, perception of risk has declined since 2011. These oversights and failures must be addressed in the next NDS.

A public health perspective of drug use, drug related harms and human rights issues

Drug use is a risk behaviour which can lead to health problems(74). Examples of other risk behaviours include riding a motorbike without a helmet, using fireworks or drink driving. For each of these behaviours some people, perhaps most, will get away with these activities without any adverse health outcome. Some people will unfortunately suffer problems. Drug use is not a health problem in itself. A SUD is a health problem which can arise for some people who use drugs especially if they engage in frequent drug use.

As Figure 2.1 above shows, the vast majority of people in Ireland have never used a drug. About a quarter of this group, or over 1,000,000, who have never used are children. Arguably, children should be front and centre of drug policy, especially now in the context of the growing discourse about human rights and drug policy. Drugs are specifically mentioned in only one of the UN Conventions on Human Rights, and that occurs in Article 33 of the Convention of the Rights of the Child (CRC) – see Box 2.1(2). CRC is the convention ratified by the largest number of countries globally including Ireland.

Box 2.1.

Article 33 of the Convention of the Rights of the Child:-

"State Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances."

https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

Some children can venture down the path of drug use during adolescence. Article 33 of CRC demands that we must give high priority to primary and secondary drug prevention measures targeted at children to minimise that number. CRC also demands that society should take steps to ensure that children are not adversely affected by adults' use of drugs. Parental drug use constitutes an adverse childhood experience (ACE)(75). Exposure to ACEs in childhood is associated with a wide range of poor health & social outcomes in later adolescence and adulthood, including increased likelihood of subsequently developing a substance use disorder themselves(76, 77).

While children in Ireland appear to play minimal role in drug production, there is increasing concern about the number of children recruited into drug distribution by organized crime groups(78). Ultimately, these gangs exist to cater to the demand for drugs created by the 7% of adults who use drugs each year. These adults exist across the full socio-economic spectrum, although tending to be slightly more prevalent in the wealthiest 40% of the population (see figure 2.3 above). The children most vulnerable to recruitment and exploitation by drug gangs are however those living in settings of very significant material deprivation.

While drug policy must therefore prioritise children, it should also serve all of society. Road safety and driving policy considers everyone, not just people who are engaging in the risky behaviours, such as speeding & drink driving. We have a road safety policy because we are trying to reduce health problems like injuries & deaths. As a society we develop a drug policy for similar reasons

(79, 80). We strive to keep to a minimum the number of people who develop health problems arising from drug use. To achieve this, we act to keep the number of PWUD to an absolute minimum. We want those 1,000,000 children to grow up with minimal use of any drug, while accepting that some will inevitably choose to try drugs. People who run into health problems arising from their drug use such as a substance use disorder, overdose or drug induced psychosis, should get prompt high quality treatment.

Constructing drug policy is consequently very challenging. As with other public health issues, policy should be driven by evidence, not ideology. There are no 'silver bullets' or quick fixes. At one end of the spectrum, policy must endeavour to minimise the number of children who head down the path of drug use as they journey through adolescence and into adulthood, which is referred to as primary prevention. At the other end of the spectrum, policy must provide responsive, accessible, high quality trauma informed health responses to people who have been caught up in very high-risk and severe substance use disorders.

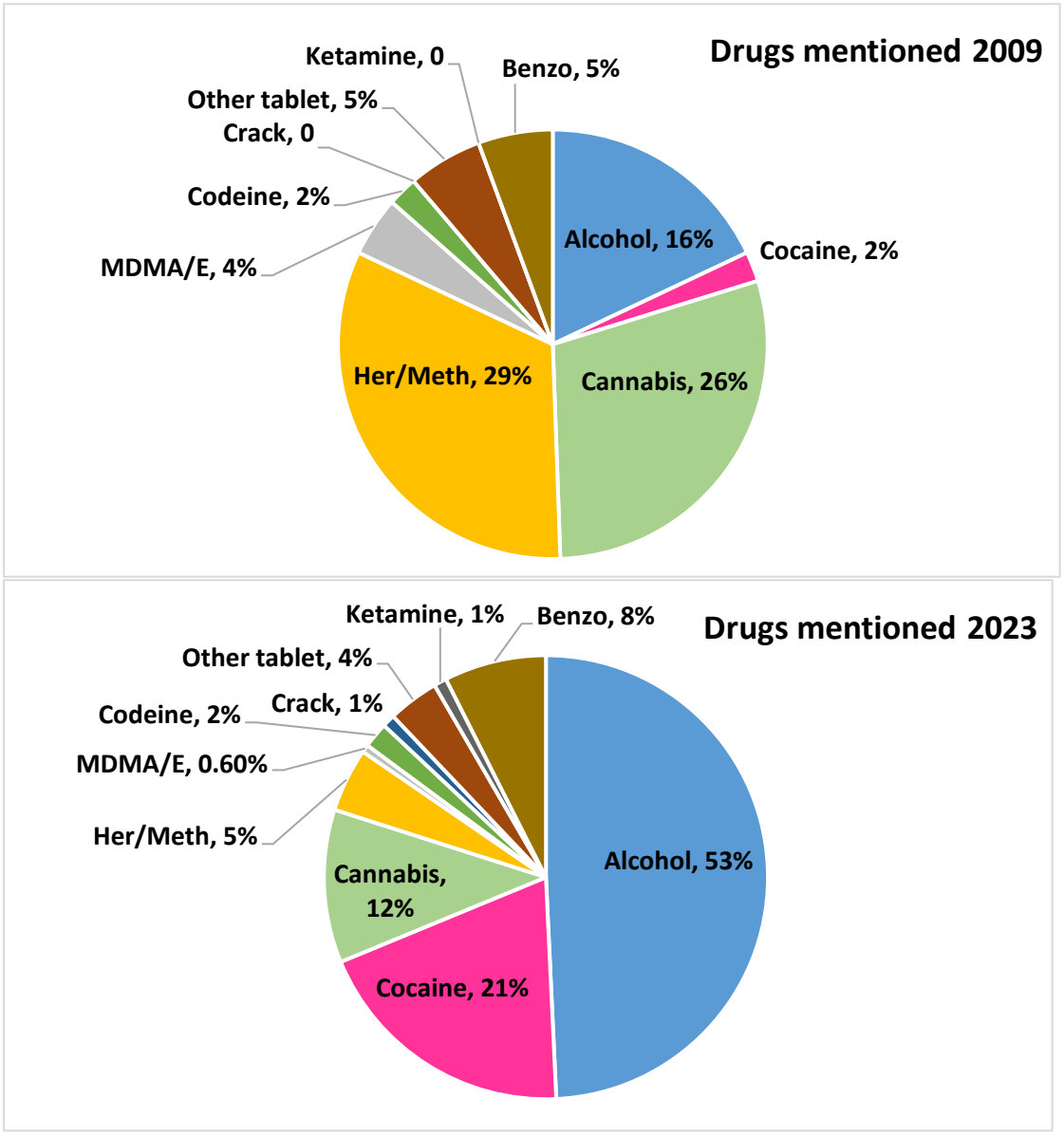
Health Harms related to drug use in Ireland – the latest data

Drug & Alcohol helpline

The HSE drug & alcohol helpline provides a snapshot of the level of need related to drugs and alcohol in the Irish population. The most recent report relates to 2023.

As figure 2.7 below shows, the profile of substances highlighted in contacts to the helpline have changed very substantially from 2009 to 2023. This highlights an increase in proportion of calls related to alcohol, massive increase in the number of calls related to cocaine (from 2% to 21%) and large decline in those related to heroin/methadone (from 29% to 5%).

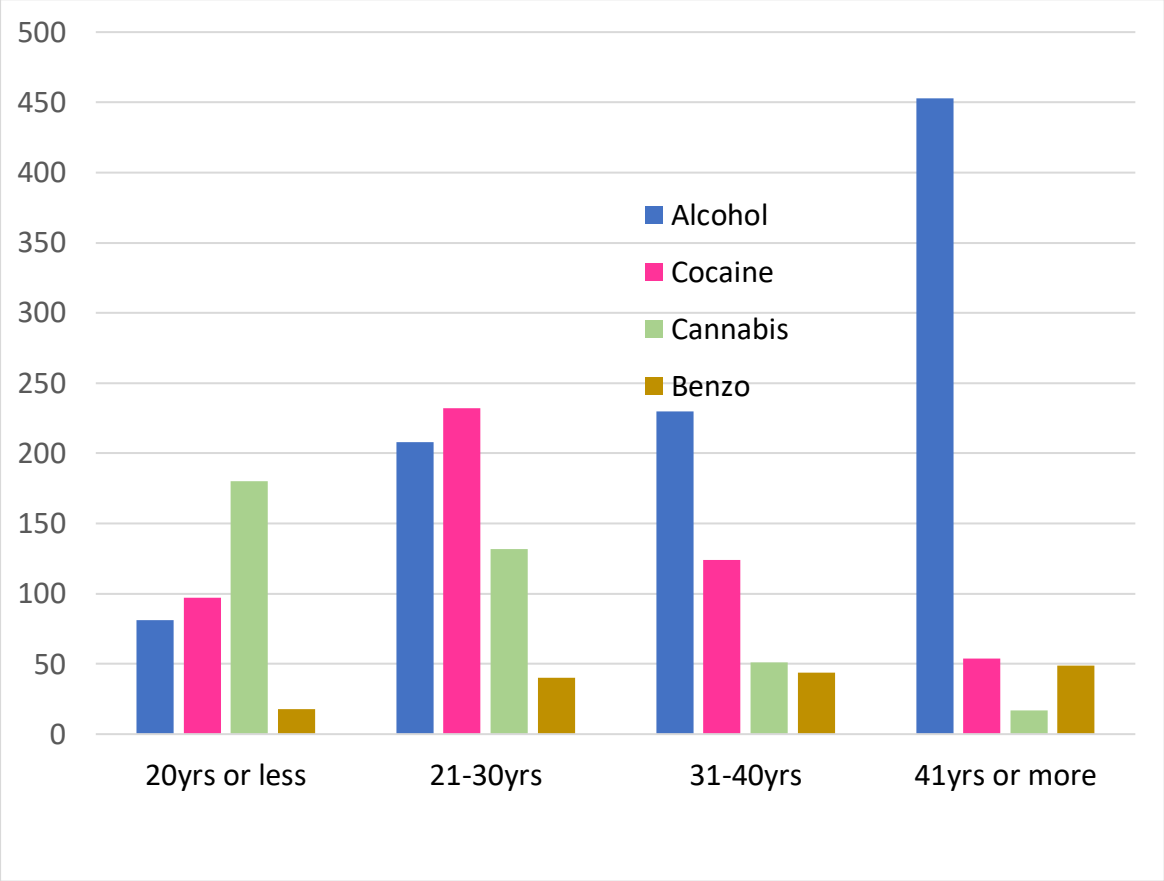
Figure 2.7. Contacts to the HSE Drug & Alcohol Helpline: Contrasting 2009 and 2023*.



* Above is taken from Figure 7.3 on page 7 of Dooley (2025). HSE Drugs & Alcohol Helpline annual report for 2023. https://www.drugsandalcohol.ie/42967/

The substances involved vary substantially by age group. For calls relating to people under 20, the main focus of concern was cannabis (figure 2.8). Among people in their 20s it was cocaine, closely followed by alcohol. Over the age of 30, the most frequent substance of concern was alcohol.

Figure 2.8. Helpline contacts - Age of substance user and substance type in 2023 (N=2628)*

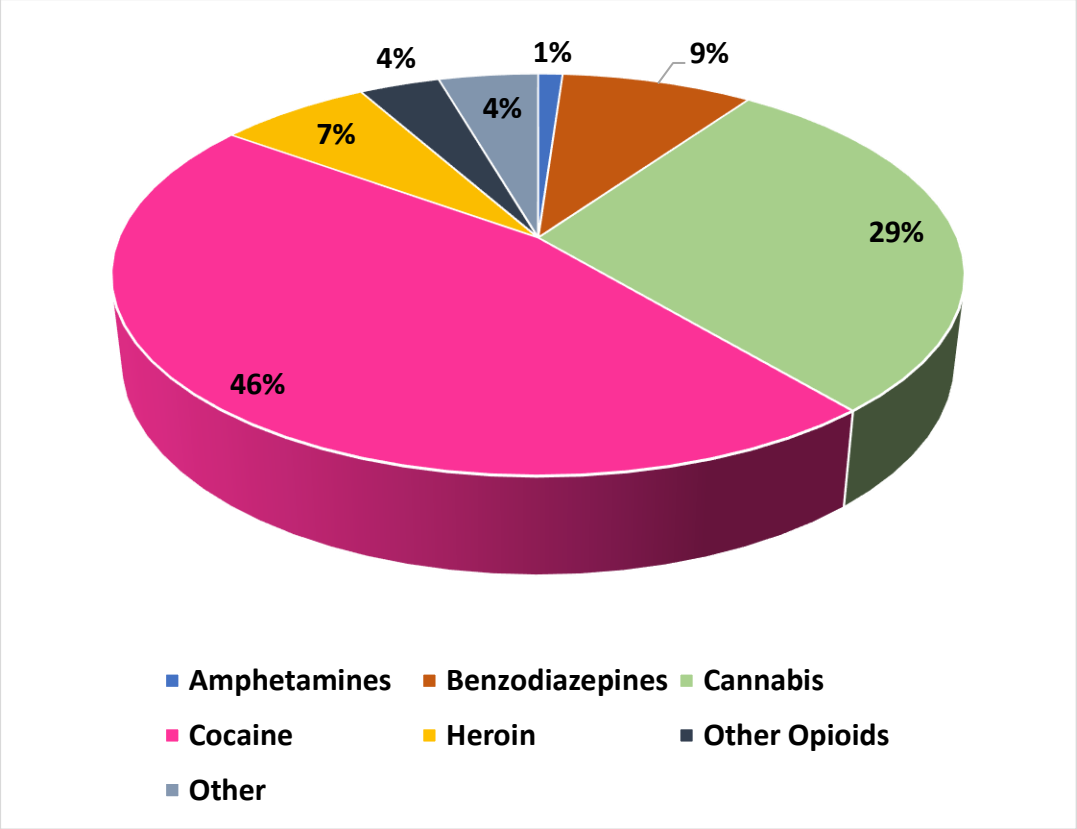


* Above is taken from Figure 7.13 on page 20 of Dooley (2025). HSE Drugs & Alcohol Helpline annual report for 2023. https://www.drugsandalcohol.ie/42967/

New Entrants to Addiction treatment in 2023

The HRB gather data on addiction treatment episodes via the NDTRS system(81). In 2023, alcohol was the most common primary substance use disorder (41%) among people seeking their first episode of addiction treatment. For new treatment entrants with a primary addiction to an illegal drug, cocaine (46%) and cannabis (29%) were the most common primary drugs. Heroin accounted for just 7% of new presentations (Figure 2.9). Twenty years ago, in 2004, the relative contribution of cocaine, cannabis & heroin to new treatment episodes were 11%, 40% and 35% respectively. Mirroring the data on calls to the drug & alcohol helpline (figure 2.7), this confirms a substantial shift in need at the population level, away from heroin and towards cocaine, with cannabis remaining a prominent driver of demand.

Figure 2.9. New entrants (n= 4792) to addiction treatment in 2023, all ages, by primary drug* problem



* Pie chart above focuses on those whose primary addiction was a drug other than alcohol

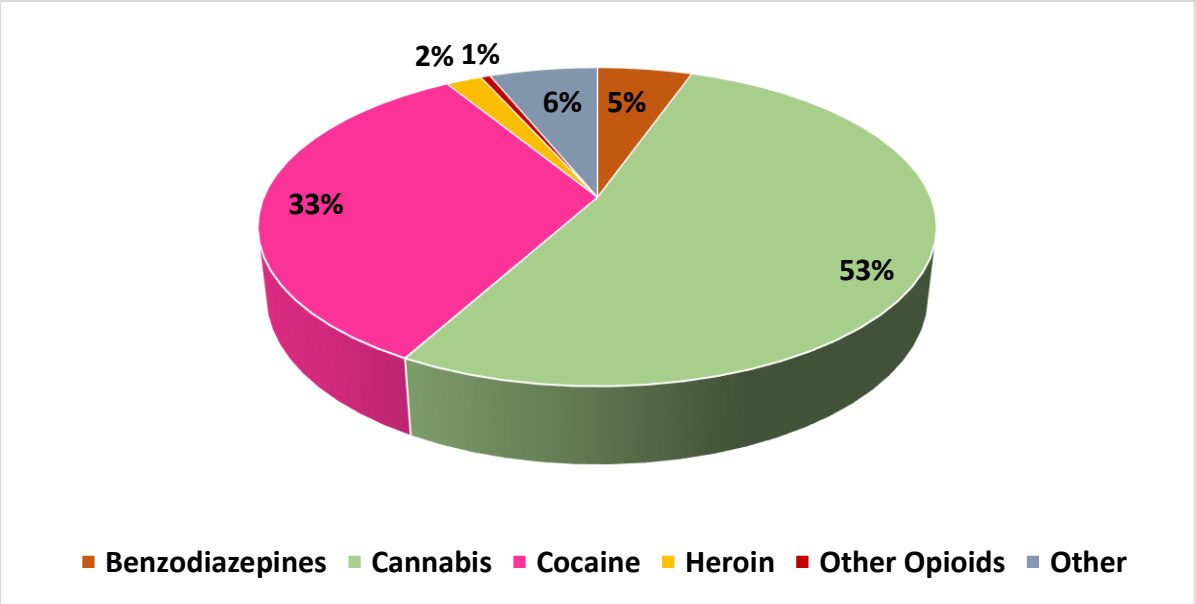
Among new entrants to addiction treatment under the age of 25 years, alcohol was the third most common main substance, accounting for 17% of attendances. Among those with a primary drug addiction, cannabis (53%) and cocaine (33%) predominated (see Figure 2.10). Heroin was the main drug is just 2% of cases in this younger age range. This constitutes a marked change on the patterns evident in 2004, when the proportion of drug addiction presentations in this age range related to heroin & cocaine were 27% and 10% respectively.

While addiction to other opioids (e.g. oxycontin, fentanyl) has been a major source of concern in USA & Canada, Ireland continues to show no evidence of such a trend, non-heroin opioids accounting for just 0.5% of new addiction treatment episodes in youth.

The most common referral sources for young people aged under 25 years into treatment were self (26%), family (26%) and social services (19%). Just 7% of referrals came via the criminal justice system, which includes all court, probation or Garda referrals. This proportion will likely increase when the proposed new Garda referral system comes into full operation.

The NDTRS has just begun to gather data on comorbid mental health diagnoses. This will be useful in guiding service development and better characterising the mental health needs of people accessing addiction treatment in the near future. This will further inform the roll out of the new Dual Diagnosis model of care (17).

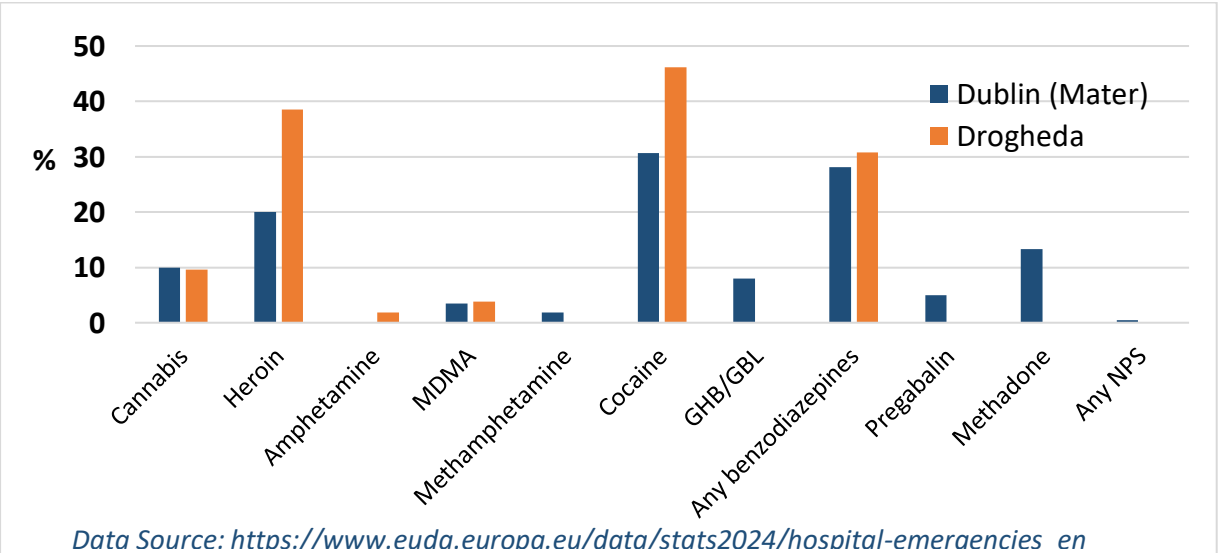
Figure 2.10. Main drug problem among 1672 new entrants to addiction treatment aged under 25yo in 2023



Drug related attendances at Emergency Departments (EDs) in Ireland in 2022

Ireland participates in the Euro-DEN survey of drug related attendances at Emergency Departments (DRAED), two sites being included (North Inner City Dublin [Mater] and Drogheda)(82). There were 617 DRAEDs across these two sites in 2022, one per week in Drogheda and 10-per-week in the Mater. Among these, 75-80% were male. The age profile was younger in Drogheda, where 40% were under 25 years in comparison to 17% in the Mater. The drug involved in the largest number of DRAEDs at both sites was cocaine, followed by heroin and benzodiazepines (Figure 2.11). Alprazolam and diazepam were the most common individual benzodiazepines. The proportion of presentations related to cocaine has almost doubled at each site since data collection began in 2013. Alcohol was a contributory factor in two-thirds of DRAEDs in the Mater and in one-third in Drogheda.

Figure 2.11. Drug Related Attendances at Irish Emergency Departments in 2022 – Euro-DEN Survey



Data Source: https://www.euda.europa.eu/data/stats2024/hospital-emergencies_en

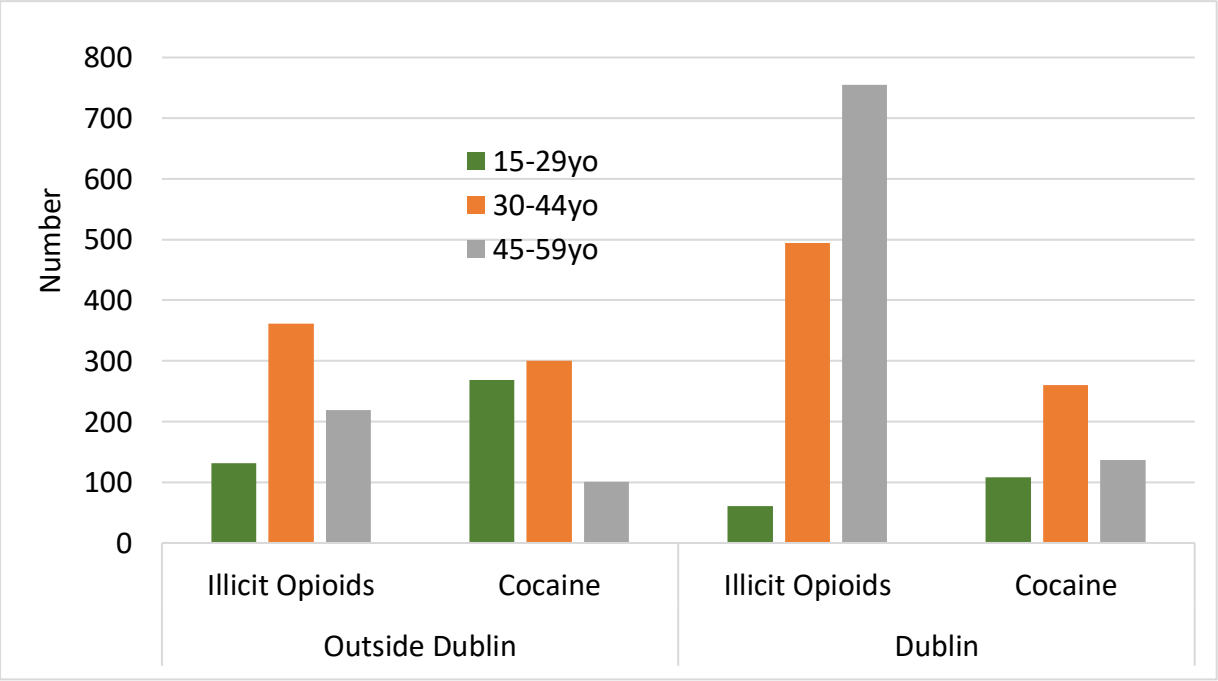
Drug related hospital admissions (DRHA)

International data from the Euro-DEN survey indicates that about 20% of drug related emergency department attendances result in a hospital admission(82). **In 2024, there were 4708 drug related admissions to general hospitals in Ireland**. While Dublin accounts for 28% of the overall Irish population, 53% of these admissions were living in Dublin. There was substantial variation in number and profile of DRHA by age and geography. **The age group with the largest number of presentations (1294) was those in their 40s**. Among the 800 admissions of people in their 50s, 70% were from Dublin. Among the 577 DHRA which occurred in people under 25 years, one-third were from Dublin.

Among DRHA in people under 25 years, the substance category responsible for the largest number (250, 43%) of admissions was cannabinoids (i.e. cannabis, HHC and Synthetic cannabinoid-type products). Cocaine was the most common (38%) substance category for 25-to-29 year olds, followed by cannabinoids (30%). Over the age of 30 years, illicit opioids (and methadone) was the most common category.

While 28% of the Irish population live in Dublin, the vast majority of those admitted with heroin and illicit opioid related health problems are from Dublin, especially in older age ranges (see Figure 2.12). This mirrors the findings from the recent population estimates of problematic opioid use(83). In Dublin the age group showing the largest number (334) of DRHA related to illicit opioids were 40-to-45 years old. This was treble the number (108) of such admissions among the 72% of the population living outside of Dublin. The heroin epidemic peaked in Dublin in the mid 1990s, affecting primarily people in their late teens and early 20s at that time, about fifteen years before the peak incidence of heroin use disorders outside of Dublin. The legacy of this epidemic continues to contribute to acute health problems and demand for ongoing addiction treatment for those who developed heroin use disorders at those times.

Figure 2.12. Drug related hospital admissions* in 2024 by age range, location and drug type



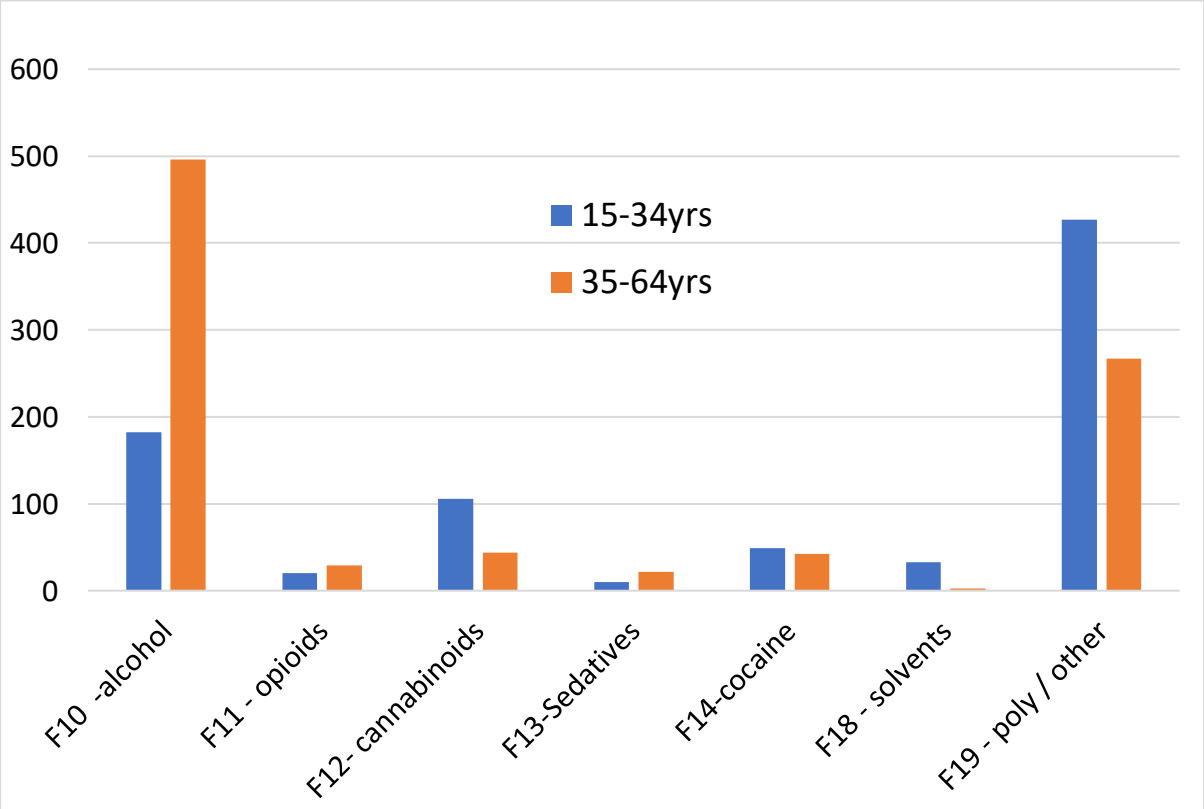
* Data obtained via Hospital Inpatient Enquiry (HIPE) system.

Substance Related Psychiatric admissions (SRPA)

Data is collected by the HRB on admissions to our psychiatric hospitals, in the NPIRS database. The most recent data relates to 2023, and information is provided below on substance related psychiatric admissions (SRPA). **There were 1810 SPRA in 2023, 11.6% of all admissions and accounting for 16.7% (797) of all admissions among 15-34yo.**

The substance involved in the largest number of admissions is alcohol, most of these occurring in people over 35 years-old (Figure 2.13). The largest drug category recorded (54%) is F19 which includes polydrug or multi-substance use. It is unfortunate that individual substance categories contributing to the polysubstance related admissions are not recorded more routinely.

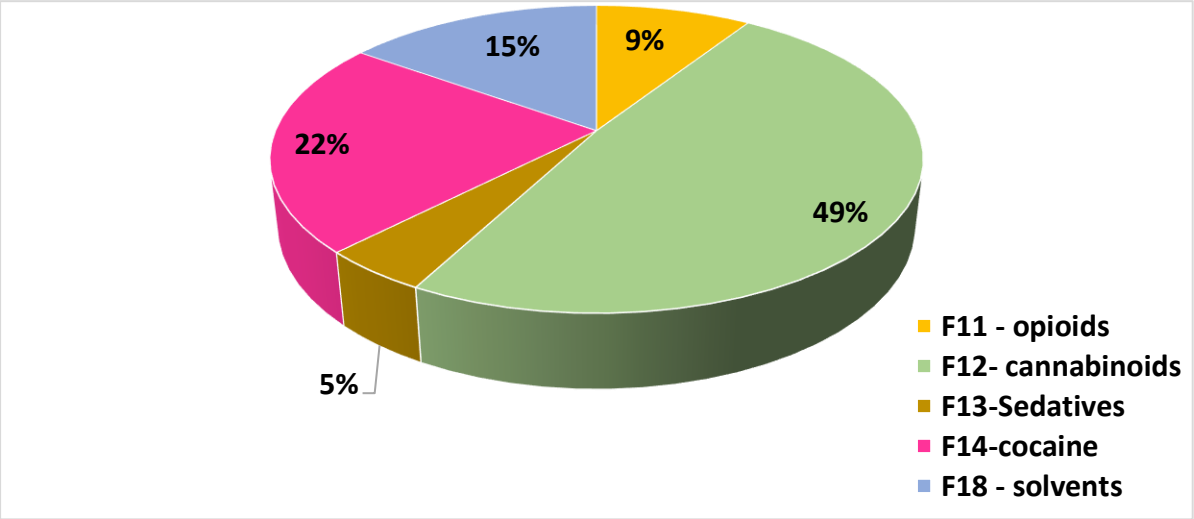
Figure 2.13. Number of Substance Related Psychiatric Admissions in 2023



* Data provided by HRB NPIRS team

The relative contribution of different specific drug categories may be gleaned from the pie-chart below (Figure 2.14). Among people under 35 years, cannabinoids (i.e. cannabis, synthetic cannabinoids & HHC) are the largest individual substance category.

Figure 2.14. Substance categories involved in 218 SRPA among 15-34yo (excludes Poly & alcohol)



Substance use & self-harm

The national self-harm registry is maintained by NOSP(84). The most recent report relates to 2022 and 2023. With regard to illegal drugs, the report focused upon the two most widely used drugs, cannabis and cocaine. **Of the 11,447 self-harm presentations in 2022, cocaine was involved in 5.4% while cannabis was involved in 1.7%. In 2023, this increased such that 6.3% of presentations involved cocaine and 3.2% involved cannabis**. Two thirds of these presentations involved males (See fig 2.15). For both drugs, the majority (61–66%) of presentations were by people aged 20–34 years.

Figure 2.15. Cannabis& Cocaine involvement in self-harm presentations in 2022-23, by gender

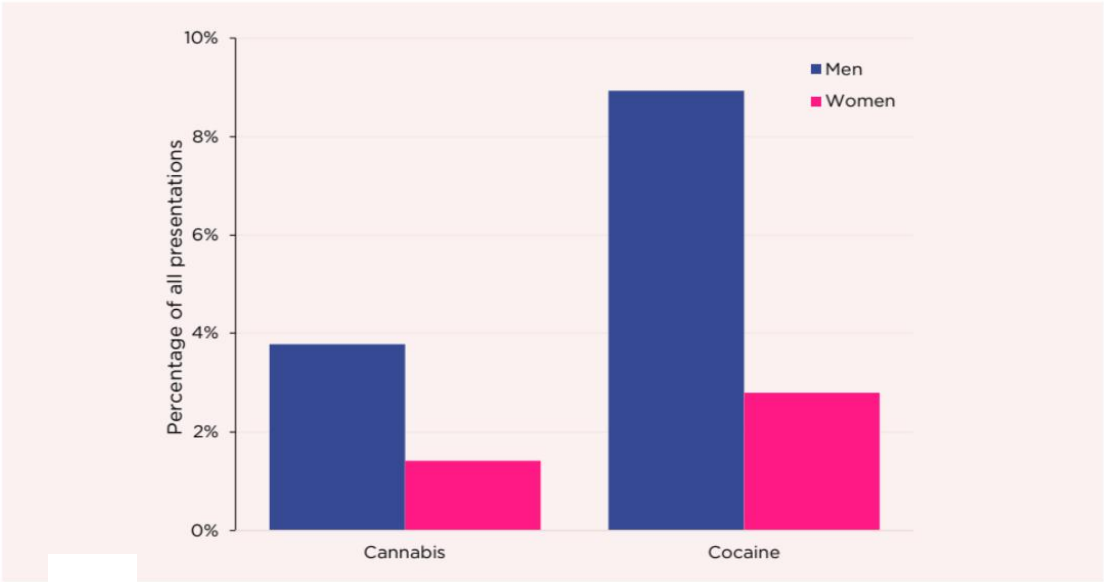


Figure 9: Cannabis and cocaine involvement in male and female self-harm presentations in 2022 and 2023.
https://www.nsrf.ie/wp-content/uploads/2025/03/NSRF-registry-report-2022_23-digital.pdf

Deaths

The HRB maintains a database of deaths among people who have used drugs, this being the National Drug Related Deaths Index (NDRDI)(30, 85). This is probably the most comprehensive database of such deaths in Europe, highlighting the importance that Ireland has attached to such deaths. The most recent report addressing drug poisoning deaths relates to 2021. This report notes **354 overdose deaths in 2021**. The specific drugs most commonly implicated in these deaths were, in rank order: methadone (36%), diazepam (32%), alprazolam (30%), cocaine (30%), alcohol (26%), and pregabalin (23%). There was a five-fold increase in deaths involving alprazolam from 2012 to 2021 and deaths related to pregabalin increased six-fold.

Among the top 15 individual substances contributing to deaths in 2021, only two are illegal, one is regulated (alcohol) and the other 12 are prescription medications. This again highlights the need for careful prescribing, and we welcome the recent guidance from the Irish Medical Council on medications such as pregabalin and benzodiazepines(86).

Polysubstance poisoning was the norm, being evident in 81% of these poisoning deaths. The median age at death was 42 years and 70% had a history of opioid (mainly heroin) dependence. Only 23 (6%) were injecting at the time of death, 40% of whom were living in Dublin.

Previous reports from the NDRDI have looked at non-poisoning deaths. Increase in suicides as a cause of death among people with a history of drug use constitutes a concerning trend in the past decade. The number of deaths by hanging increased by 50% from 2011 to 2020(85). A detailed analysis of deaths by hanging recorded in the NDRDI in 2017 indicated that 78% were male and two-thirds had a history of known mental health problems(87). The most common substance problem related to these deaths were cannabis and then cocaine. These suicides again highlight the issue of dual diagnosis and the importance of the roll out of the new model of care.

Harm to Others

Drug impaired driving.

Drug impaired driving constitutes a major risk to drivers, their passengers and other road users. The most recent annual report from the Medical Bureau of Road Safety relates to 2023(88). For drug intoxicants other than alcohol, the three most commonly detected drugs were again cannabis, cocaine and benzodiazepines. Cannabis was detected almost twice as frequently as cocaine and four-times that of benzodiazepines.

The RSA conducted an analysis of 334 driver fatalities where toxicology was available between 2015-2019(89). Alcohol was detected in 37% of drivers and was over 200mg% in half of these cases**.** The drugs most frequently detected were cocaine (13%), benzos (11%), cannabis (7%) and opioids (7**%).** No data was provided on the number of people killed along with the driver. No data is available on the contribution of alcohol or drugs to deaths and injuries in road traffic collisions where the driver was not fatally injured.

Exposure to alcohol and drugs in utero

Substance use during pregnancy has potential to adversely affect foetal development. Foetal alcohol spectrum disorder is quite common in Ireland by international standards(90). A recent study in Dublin highlighted increases in prevalence of cannabis and cocaine use among pregnant

women in the past decade(91). This is very concerning given the growing literature highlighting adverse development impacts of foetal cannabis exposure during pregnancy(92-96).

Substance use and violence

The role of alcohol as a contributor to violence has been described for decades(97, 98). Drugs can also contribute to violence towards others(99-102). This can occur in the context of acquisitive crime perpetrated in order to fund a person's drug use. It can also occur in the context of drug intoxication. Irritability is a core feature of withdrawal from many substances and can contribute to aggressive behaviour(103). Additionally, drug use, especially use of stimulant drugs and cannabis, can cause psychotic episodes. While people experiencing psychosis do not generally show elevated levels of violence, aggression is certainly elevated in drug induced psychosis (104, 105). A recent review of this issue suggested that cannabis use may be particularly associated with violence in the context of psychosis(106). There have been a number of murder and manslaughter cases before Irish courts over the 2022-2024 period where the act was perpetrated by a person experiencing cannabis intoxication or cannabis induced psychosis.

Child neglect, domestic violence and drug use

Parental drug use or alcohol problems constitute as an adverse childhood experience(75, 77, 107). Recent reports from the Child Law Project and from the Special Rapporteur on Child Protection highlight parental drug and alcohol problems as a major driver of child abuse and neglect in Ireland(108, 109). In the Child Law Project report, addiction was the second most common parental issue contributing to cases(108). A previous audit of the exercise by An Garda Síochána of emergency measures to take children into care found that parental intoxication was a very frequent contributor to such events(110). While hard data is difficult to source, there are increasing anecdotes indicating a growing contribution by cocaine to both child neglect & domestic violence cases in Ireland (https://www.irishlegal.com/articles/cocaine-use-rampant-in-family-court-cases).

Drug use disorders leading to debts for one family member can result in violent threats against the entire family. This can be frightening for younger children. The DRIVE project (https://driveproject.ie/) has been developed as a response to this issue nationally.

Section 3

Recommendations

Structural issues and governance

1. Involve CMO, or a deputy CMO, in provision of advice and leadership from a doctor within the Department of Health on drug policy issues.
2. Employ a public health doctor within HSE to provide public health leadership on drug related problems. Drug related harm should be a priority area for Public Health in Ireland. (Current HSE National Clinical Lead on addiction will still lead on treatment & recovery.)
3. The Early Warning & Emerging Trends (EWET) systems, chaired by the Controlled Drugs Unit in Department of Health, completely failed with regard to HHC. There is a need to put in place a health-led system, such as the National Response Alert Group developed during the Nitazine crisis, to ensure new drugs which are openly sold & widely used get rapid assessment and rapid response. As a country we must do better than we did with HHC.
4. Given the failure to use the Criminal Justice (Psychoactive Substances) Act, 2010 to address the selling of HHC in Irish shops, there is a need to examine why this did not occur and to put in place measures to ensure it can be effectively used in future similar scenarios.
5. Ensure there is transparency on major drug policy decisions. While the last NDS envisaged the National Oversight Committee as the key forum of decision making, the drug policy unit (DPU) in the Department of Health has taken that lead role in policy decisions. It is unclear where or from whom the DPU obtains its expert advice since the demise of the National Advisory Committee on Drugs.
6. The use of Strategic Implementation Groups (SIGs) to oversee delivery of key actions in the National Drugs Strategy appears problematic. SIGs had responsibility without having any actual authority. This approach should be seriously re-evaluated in any new strategy. Responsibility for implementation of a health-led strategy should rest clearly with the Department of Health at a high level group, which has both responsibility and authority.
7. Develop a NPHET-type structure to give independent science-based advice on drug policy from senior health professionals including addiction psychiatrists.
8. NGO actors operating in the 'civil society' space should demonstrate full transparency regarding their funding sources, as a small number of very wealthy men are distorting the European wide drug policy conversation, funding NGOs to progress their ambition to legalize and commercialise currently illegal drugs. Cannabis corporations, and their alcohol and tobacco industry backers, are also seeking to influence the wider drug policy narrative to benefit their shareholders. We should ensure civil society is not captured by either billionaires or corporate interests.
9. "Harm reduction" is increasingly being used internationally to describe numerous unproven interventions which may in fact be harm escalating. We should fully support all interventions across the policy spectrum which are <u>proven</u> to actually reduce harms related to drug use & drug use disorders (i.e. evidence-based health focused interventions).
10. Curtail access to 'over the counter' opioids.
11. Insist that medical products derived from the cannabis plant and cannabinoids are required to adhere to the same regulatory standards of safety & efficacy as that used for all other medical products. Such products should be subject to regulation and monitoring

by the Health Products Regulatory Authority (HPRA). These products should not be referred to as "medical cannabis".

12. Identify and pro-actively utilise a key set of health-related metrics on drug related harm. These should be included in an annual report on the NDS & serve as contemporaneous feedback on successes, failures & new challenges for the NDS. This could include data on addiction treatment (NDTRS), psychiatric admissions (NPIRS), ED attendances (Euro-DEN), general hospital admissions (HIPE), PULSE, mortality data (NDRDI), annual report from drug & alcohol helpline, national self-harm registry, general population survey data (Healthy Ireland), survey data on other key groups (3rd level [DUHEI survey], ESPAD, HBSC and County level Planet Youth surveys).
13. People with drug use disorders should be included in policy discussions related to treatment and recovery. Lived Experience of Recovery Organisations (LERO) type organisations, such as Better Together (https://better-together.ie/), appear best positioned to provide such a role. While LEROs are quite well developed in UK and are evolving in Ireland, they should be supported to grow further in Ireland. Their membership has useful experience of every stage in the potential drug use journey, from experimentation, to regular use, to substance use disorder, to treatment and to recovery.
14. Efforts to include lived experience must capture the voice of children who have grown up in homes negatively affected by parental drug use and drug use disorders, consistent with our obligations under article 33 of the UN Convention on the Rights of the Child. The experience of parents and partners of those with substance use disorders should also be included.
15. The specific group of people who inject drugs should be meaningfully consulted on any targeted intervention aimed at those who inject (e.g. the Supervised Injecting Facility).
16. Address the ongoing failure to have a national alcohol strategy. Alcohol causes more deaths and more health harms than those related to all illegal drugs combined. There must be a national alcohol strategy to address this.
17. Actively support roll out of the Housing First, National Implementation Plan 2022-26.
18. Local Drug Task Forces were created in a number of discreet geographical areas, almost exclusively in Dublin, in response to the heroin epidemic in 1997. While those communities still have disproportionately high level of need, the drug problem and those needs have changed enormously in the intervening 28 years. Therefore, the roles and functions of both LDTFs and RDTFs should be comprehensively reviewed.

Public Information and prevention

19. Inform the public of the reasons why we issue health advice to avoid drug use. Include parents as targets for information. Use multi-modal campaigns including social media.
20. Increase public understanding of the hazards and harms of cannabis and actively counter the mis-information about putative therapeutic benefits of cannabis related products. Disseminate advice such as that provided by Health Canada (https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/laws-regulations/regulations-support-cannabis-act/health-warning-messages.html).
21. Fund HSE Health & Well-being to lead on Primary prevention (and on early secondary prevention) of drug use, targeting especially those in second & third level education.
22. Ensure roll out of drug and alcohol modules as part of SPHE at both junior & senior cycle, expecting the Dept of Education to accept accountability for its delivery.
23. Develop drug free campuses at 3rd level education, similar to 'smoke free campuses' (https://www.sciencedirect.com/science/article/pii/S2950433324003306) .

24. Give priority to efforts to curtail access to psychoactive substances, including psychoactive pharmaceutical products, via the internet/dark web.

Treatment and service delivery

25. Develop a national network of tier 3 multi-disciplinary outpatient addiction treatment teams, led by consultant psychiatrists, to provide specialist psychosocial treatment for those with moderate to severe SUDs.
26. Ensure all addiction treatment services have an adequate number of counsellors available to patients. Address the pay disparity for counsellors working in addiction services, to permit those services to recruit and retain counsellors.
27. Fund a university department to roll out regular (e.g. once a fortnight) webinars on topics relevant for front line staff working in addiction services nationally, to skill up the workforce.
28. Build competencies into the multi-disciplinary teams working in treatment services to assess & address neurodiversity, and build awareness of need for service modifications to better meet the needs of people with substance use disorders who are living with neurodiversity.
29. Prioritise full roll out of the dual diagnosis model of care and resource an inpatient dual diagnosis unit.
30. Support and resource the implementation of the recent guidance from the Irish Medical Council on prudent prescribing of benzodiazepines, Z drugs & gabapentinoids.
31. Improve access to all primary care counselling services (e.g. Counselling in Primary Care [CIPC]) for people with SUDs. Ensure all counsellors working in primary care services have the ability to work with clients who have substance use problems.
32. Gambling & Gaming appear to be appropriate problems which could be addressed by addiction treatment services. However, if services are to take on this additional patient group, then resources will need to be provided. The cost of same could & should be covered by the social impact fund being levied on gambling by the Gambling Regulatory Authority of Ireland (i.e. adopt a 'polluter pays' model).

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