



Rialtas na hÉireann
Government of Ireland



National Drugs Strategy 2026-2030

*An integrated, equitable and evidence-based
response to the harms of drug and alcohol use*



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Foreword by the Minister for Health



Foreword Minister for Health Jennifer Carroll MacNeill, TD

As Minister for Health, one of my priorities is to improve timely and fair access to drug and alcohol services. I want people in every health region to have equal access to services, while recognising that some people need services tailored to suit their individual health needs.

The National Drugs Strategy 2026–2030 takes a health-led approach to drug use and reflects the principles of Sláintecare, the Government’s programme to transform how we deliver healthcare. It will guide the Government’s drugs policy over the next four years.

The focus of the strategy is on providing services that respond to the different needs of women and men when they need support through drug and alcohol health services.

Community-based services are central to Sláintecare’s aim of providing the right care, in the right place, at the right time. We must give these services the funding and staff they need to grow. Targeted investment through the additional funding provided under the Women’s Health Action Plan will strengthen services for marginalised women with complex needs. We must also support them to respond to changing needs and reach people beyond traditional geographic boundaries. The integrated service delivery model in HSE South West shows how this can work. It brings together HSE addiction services, drug and alcohol task forces and voluntary providers. This makes community services easier to navigate and gives service users, family members and referring partners clear ways to access support.

Drug and alcohol use causes harm across society and places significant demands on public services. That is why the Government sought a wide range of views when developing this strategy. The Citizens' Assembly on Drug Use and the Oireachtas Joint Committee on Drug Use made important contributions to this work.

This Government is fully committed to the delivery of the action plan at national, regional and local levels. Successful implementation of the National Drugs Strategy and its action plan will require strong collaboration, governance and coordination. Clear leadership and a supportive culture will be essential if we are to achieve the strategy's objectives.

Our strategic approach brings together prevention policies, systems and initiatives and aligns them with the Healthy Ireland Framework. This means prevention for the whole population, alongside targeted, evidence-based support for groups at greater risk.

Prevention is a core part of public health. Drug prevention is the critical first step in protecting individuals, children, families and communities from the harm caused by drug and alcohol use.

Minister for Health
Jennifer Carroll MacNeill, TD

Foreword by the Minister of State



Foreword Minister of State Jennifer Murnane O'Connor with special responsibility for Public Health, Wellbeing and the National Drugs Strategy

I am pleased to publish the National Drugs Strategy 2026–2030 and associated Action Plan 2026-2028. This strategy matters because behind every statistic on drug and alcohol use there are people, families and communities whose lives are affected. The strategy sets out our shared ambition to reduce harm and to ensure that people can access high quality, person-centred, integrated and compassionate health and social care where and when they need it.

Over the course of developing this strategy I have heard directly from people with lived and living experience, from Drug and Alcohol Task Forces, communities, families, and from frontline workers about the impact of drug and alcohol-related harm. Their experience reminds us that this is not an abstract policy issue. It is about health, safety, dignity, opportunity and hope. It is also about recognising the links between drug and alcohol use and poverty, trauma, homelessness, mental health difficulties, social exclusion and contact with the criminal justice system.

That is why this strategy is firmly health-led and a whole-of-government response. It prioritises prevention, harm reduction, treatment, recovery and social integration. It recognises the right to health of people affected by drug and alcohol use, that they should be treated equally, with dignity and respect, and should be supported rather than stigmatised. It also commits us to strengthening early intervention and to supporting alternatives to criminal sanctions where appropriate.

I have deliberately taken time to develop this strategy to ensure that the views of all stakeholders have been considered. I am grateful to everyone who contributed to the development of this strategy, particularly those who shared personal experiences that were difficult, honest and deeply valuable. I want to acknowledge the contribution of the Citizens' Assembly on Drug Use and the Oireachtas Joint Committee on Drugs to the development of the strategy.

I also want to thank the Chairs Dr. Sarah Morton and Pauline McKeown along with the members of the Steering Group and Reference Group for their expertise, commitment and constructive engagement throughout the development of the strategy.

The challenges we face are constantly changing. Ireland is seeing increased cocaine use, polydrug use, harmful alcohol use, use of synthetic substances, as well as drug-related deaths, intimidation and violence, and the devastating impact of drug markets on local communities. Responding to these challenges requires compassion, urgency and practical action across Government, including health, justice, education, housing, social protection, community safety and local development.

The publication of a strategy is only the beginning. What matters most is ensuring its delivery. This strategy provides a framework for action on prevention, equitable access to services, recovery and social integration, health supports including for people in contact with the criminal justice system, preparedness for emerging drug threats, leadership, collaboration, community participation, investment and evidence. Its success will depend on continued partnership with communities, clear governance, sustained investment and ongoing monitoring and evaluation.

I am committed to working with all partners to ensure that the National Drugs Strategy 2026–2030 is implemented effectively and makes a real difference in people's lives and this includes Drug and Alcohol Task Forces, community and voluntary organisations and people with lived and living experience.

Is mise le meas, Jennifer Murnane O'Connor

Executive Summary

The purpose of the National Drugs Strategy 2026–2030 is to deliver *an integrated, equitable and evidence-based response to the harms of drug and alcohol use*. The content of the strategy reflects the Government commitment to a health-led approach to drug use. It builds on the previous drugs strategy, *Reducing Harm, Supporting Recovery (1)*, which was independently evaluated in 2025 (2).

It is informed by trends in drug and alcohol use and developments in the European drugs market. It takes into account the recommendations of the Citizens' Assembly on Drug Use (3). Following publication of the draft strategy in February 2026 (4), it has been revised based on the report of the Joint Oireachtas Committee on Drug Use (5), an online public consultation (6) and an engagement process involving all relevant stakeholders, including the Health Service Executive (HSE), community and voluntary sector, Drug and Alcohol Task Forces, and other Government Departments and Agencies to consider stakeholder engagement in the National Drugs Strategy within the new HSE Health Regions (7).

This strategy marks a further evolution in the health-led response. It puts a major focus on the prevention and early intervention of drug and alcohol use, actively refers people in possession of drugs for personal use to the health services and expands alternatives to criminal sanctions. The strategy recognises that the problems that individuals and communities face because of the harms of drugs and alcohol use are complex and are inextricably linked with other critical health and social challenges. This means that the strategy, to be effective, is multi-faceted and comprehensive, with actions that work together to create a responsive and person-centred system of care and support. Addressing the social determinants of drug and alcohol use and supporting long-term recovery and social integration are important elements of this integrated approach.

The strategy presents an integrated response to drug and alcohol use that seeks to reduce the harms of all substances and acknowledges the overlap between drug and alcohol use. It promotes health equity, ensuring those impacted by the harms of drug or alcohol use can access healthcare services and are offered supports to aid their recovery and social integration.

It also creates synergies with policies and actions across the health domain as well as other public policies, like housing, education, employment support and the criminal justice system. It contains an integrated mix of interventions, services and supports, that is both complementary and responsive to differing needs and conditions and encompass a comprehensive set of policy measures that respond effectively to the contemporary challenges of drug and alcohol use.

The strategy sets out five strategic pillars, including protection from harm, provision of quality treatment services, promotion of recovery, prioritisation of health supports over criminal sanctions, and preparedness for global drug threats. It also has four enabling measures, covering leadership, community participation, monitoring and evaluation, and collaborative partnerships. The strategy is accompanied by a two-year action plan (2026–2028), with thirty-three (33) specific actions, which are outlined using the RE-AIM framework (59-65). A new set of actions is envisaged for the final two years of the strategy, 2029–2030.

Effective governance and implementation are critical to the success of the strategy. This requires a major step change in how the state responds to the harms of drug and alcohol use. The strategy is complemented and supported by Government policies that address the wider determinants of health and wellbeing, including housing, education, employment, social protection, justice, mental health and community safety.

The strategy was developed by an expert Steering Group, supported by a Reference Group of frontline service providers and people with lived and living experience. In drafting the strategy, the Steering Group drew on extensive public consultations and expert analyses available nationally and internationally.



National Drugs Strategy 2026-2030

An integrated, equitable and evidence-based response to the harms of drug and alcohol use

Vision

A society where the harms from drug and alcohol use are minimised for individuals, children, families and communities and where health and social care for those affected is high quality, accessible, equitable, person-centred and integrated, and recovery and social integration are supported.



Protect

Protect individuals, children, families and communities from the harmful effects of drug and alcohol use



Provide

Provide equitable access to high quality drug and alcohol services across Health Regions and population groups



Champion

Champion recovery and social integration in drug and alcohol treatment, community services and public policies



Prioritise

Prioritise health supports for people in contact with the criminal justice system due to drug use



Prepare

Prepare for and respond effectively to a more volatile and dynamic global drugs market

Introduction

Policy background and stakeholder engagement

The *Programme for Government: Securing Ireland's Future 2025* (8) commits to a health-led approach to drug use. It includes specific actions to divert those found in possession of drugs for personal use to health services, increase funding for drug addiction services to improve their effectiveness, launch an awareness campaign on the impact of drugs, explore the establishment of additional supervised injection facilities and increase the availability of naloxone.

Sláintecare (9) provides the overarching framework for the reform of health and social care in Ireland and is central to the policy context for this strategy. Its emphasis on universal access, care closer to home, integrated services, prevention, population health planning and reducing health inequalities aligns closely with the objectives of the National Drugs Strategy. In this context, the strategy supports the *Sláintecare* ambition to provide universal, accessible, affordable, person-centred, safe and high-quality health and social care.

This strategy has been developed in the context of a wider range of Government policies that intersect with and support the objectives of the National Drugs Strategy. Central to this is the *Roadmap for Social Inclusion 2026–2030* (10), which outlines the Government's plan to reduce poverty and improve social inclusion, with a specific focus on building inclusive communities. Other relevant policy areas include mental health, children and young people, educational disadvantage, homelessness, access to employment, community safety, rural and community development, equality and social protection. A non-exhaustive list of relevant intersecting policies is included at [Appendix 1](#).

The strategy is also informed by related policy developments across Government that address the wider determinants of drug and alcohol-related harm. These include work led by the Department of Children, Disability and Equality on informal kinship care (11) and prevention and early intervention for children and families (12), and the Department of Social Protection's *Community Employment Drug Rehabilitation Framework* (13), which supports personal development, training and progression as part of recovery. These policy areas reinforce the need for an integrated, whole-of-government response that supports individuals, children, families and communities.

Government policy on artificial intelligence (14) provides an important wider context for the strategy, particularly in relation to innovation, data use, service planning and public trust. Ireland's approach emphasises the responsible, ethical and human-centred use of AI, with strong safeguards for privacy, transparency, accountability and human oversight. In the context of the National Drugs Strategy, these principles are relevant to the use of data and digital tools to support prevention, early warning systems, service planning, monitoring and evaluation, while ensuring that technology supports, rather than replaces, person-centred, equitable and rights-based responses to drug and alcohol-related harm.

The strategy was developed through a three-phase, evidence-based process of consultation, analysis and collaboration. From the outset, the aim was to ensure that the new strategy would build on what had been learned under *Reducing Harm, Supporting Recovery* (1), respond to the current reality of drug and alcohol-related harm in Ireland, and provide a clear framework for action over the period 2026–2030. The process recognised that drug and alcohol use affects people, families and communities in different ways, and that an effective national response must be grounded in lived and living experience, frontline practice, community participation, robust evidence and cross-government collaboration.

Phase 1 focused on learning from the previous strategy and listening to those most affected. This included the independent *Evaluation of Reducing Harm, Supporting Recovery*, the National Drugs Strategy for 2017–2025 (2), and a programme of independently facilitated stakeholder consultations in early 2025 (15). More than 240 people contributed to these consultations, including people with lived and living experience, family members, Drug and Alcohol Task Forces, community and voluntary organisations, statutory services and frontline workers. These discussions identified progress made under the previous strategy, while also highlighting continuing gaps and pressures, including the need for stronger prevention, more timely and equitable access to services, better supports for children, young people and families, and more meaningful participation by people with lived and living experience in policy and service development.

Phase 1 also drew on key national and international policy inputs, including the findings and recommendations of the *Citizens' Assembly on Drug Use* (3), the *Interim Report of the Joint Oireachtas Committee on Drug Use* (16), and the *EU Drugs Strategy* (17). These inputs helped to frame the emerging priorities for the new strategy, including the need for a stronger health-led approach, improved prevention and early intervention, better access to treatment and harm reduction services, recovery and social integration, alternatives to criminal sanctions, and stronger governance and implementation arrangements.

Phase 2 The findings of Phase 1 were considered by a Steering Group of national and international experts, supported by a Reference Group of people from frontline services and people with lived and living experience ([Appendix 2](#)). These findings, together with national and international analysis on drug and alcohol use, related harms, service responses and effective policy approaches, informed the development of the draft strategy, including the proposed vision, principles, strategic pillars, enabling measures, actions and governance arrangements. This phase culminated in the publication of the *Draft National Drugs Strategy* (4) in February 2026, enabling the public, stakeholders and the Oireachtas to consider and respond to the proposed direction of the new strategy.

Phase 3 involved further stakeholder engagement and finalisation of the strategy. This included *Public Consultation on the Draft National Drugs Strategy* (6), stakeholder engagement in the strategy within the new regional health structures (7) consideration of the *Final Report of the Joint Oireachtas Committee on Drug Use* (5).

Over 320 individuals and organisations engaged with the public consultation. The findings indicated strong support for the health-led approach, the vision and principles of the strategy, the strategic pillars and the enabling measures, while also emphasising the need for effective implementation, locally responsive services, meaningful community participation and sustained involvement of people with lived and living experience.

A significant part of Phase 3 was the engagement process on new regional structures to support implementation of the strategy. This process considered how drug and alcohol services should be planned, funded and delivered in the HSE Health Regions, and how Drug and Alcohol Task Forces, community and voluntary organisations, statutory services and people with lived and living experience should be involved in decision-making. The engagement generated broad consensus on the need for inclusive, transparent and accountable regional arrangements that support a whole-system, health-led response, strengthen prevention, improve equity of access, and connect national policy priorities with local and regional implementation.

The *Joint Oireachtas Committee on Drug Use* (5) also made an important contribution to the final development phase. The Committee was established to consider the recommendations of the *Citizens' Assembly on Drug Use* (3) and to provide a reasoned response to each recommendation. It produced an interim report in October 2024 and a final report in June 2026. The Minister of State for the National Drugs Strategy provided the Committee with the *Draft National Drugs Strategy* (4) in February 2026 and committed to taking account of the Committee's final recommendations in finalising the strategy.

The Committee's recommendations have been carefully considered in finalising the National Drugs Strategy and are reflected, where appropriate, in the two-year action plan supporting its implementation. Areas addressed include family and community supports, drug prevention, services for women, minority groups and people with disability and neurodiversity, stigma reduction, the Health Referral Scheme, and responses to nitrous oxide and other emerging products. Other recommendations require further consideration across Government, particularly where they relate to policy areas outside the direct scope of the National Drugs Strategy.

Phase 3 was also informed by the *Health Research Board and Pobal Analysis of the relationship between addiction treatment demand and deprivation* (18). This research provides important evidence on how treatment demand is shaped by social and geographic disadvantage. While demand for addiction treatment is evident across all social groups, disadvantaged communities account for a disproportionate share of those in treatment. This reinforces the need for services to be planned around people, place and fairness, in line with *Sláintecare* (9) and wider public health priorities.

Taken together, these phases have shaped a strategy that is evidence-based, practical and informed by people's experience of what is working, what is missing and what needs to change. The process has reinforced the importance of compassion, dignity, equity and partnership across Government, statutory agencies, Drug and Alcohol Task Forces, community and voluntary organisations, frontline services, families and people with lived and living experience. Further details on the key inputs to the strategy are provided in [Appendix 3](#).

The National Drugs Strategy 2026–2030 is therefore not only a statement of policy intent. It is the product of an inclusive process of consultation, reflection and collaboration, and provides a shared framework for action to reduce harm and improve outcomes for individuals, children, families and communities across Ireland. Its successful implementation will require sustained leadership, clear governance, adequate resourcing, meaningful community participation and continued engagement with those most affected by drug and alcohol-related harm.

New and emerging trends in drug use

The distribution and consumption of illicit drugs present significant health and security risks for all European countries. Patterns of importation, production and distribution adapt rapidly to geopolitical and technological changes. Shifts in traditional drug trafficking routes and increasing sophistication in the operations of organised crime groups presents challenges that require an increasingly integrated response from law enforcement and judicial systems.

While large scale seizures receive public attention, the impact of drug markets is felt most keenly at the local level through undermining of public safety and the recruitment of children and young people into criminal networks. While traditional plant-based drugs continue to harm individuals and communities, the EU Drugs Agency now monitors over 1,000 new psychoactive substances (NPS), many with high potency and purity which both eases transportation and increases risks for those who consume them (19).

These changes in the international drug landscape have accelerated during the period of *Reducing Harm, Supporting Recovery*(1), and are apparent in Ireland as both the demographics of drug use and drug use patterns, such as polydrug use, conform to European trends. Ireland has emerged from a lengthy period dominated by problematic opioid use and the need to provide effective interventions to deal with high levels of opioid dependency and chronic use. While the number of opioid users has remained stable since 2014, this group is particularly vulnerable to risks from new drugs, including synthetic opioids such as nitazenes and orphines, and diverted or illegally produced benzodiazepines. This cohort of people, although stable, is ageing and therefore more vulnerable from the perspective of physical and psychological co-morbidities. The increased use of crack cocaine among opioid users is also a cause of concern.

Drug use now occurs across all strands of Irish society as is evident from population prevalence studies. Many new user groups have emerged that are more broadly representative of Irish social demographics. Patterns of drug use behaviour are rapidly changing, and the problems associated with high levels of stimulant consumption, cocaine in particular, polydrug use including alcohol, and greater prevalence in the use of dissociative substances presents a new set of challenges for policy makers and service planners (19,20).

The dangers posed by newer patterns of drug use and the emergence of new synthetic drugs means that Ireland will need to develop more timely sources of information, linked to early warning, alert and communication systems, more responsive prevention and harm reduction strategies, particularly in recreational settings, and effective treatment and reintegration.

There is a growing concern about the overprescribing of controlled drugs, benzodiazepines, z-drugs, and gabapentinoids, which are all medications commonly prescribed to alleviate symptoms associated with various neurological and psychological conditions. These drugs are primarily used for short periods of time and can improve the quality of life for patients. The overprescribing of benzodiazepines, z-drugs, and gabapentinoids is a critical issue that affects patient safety and has significant implications for public health (21). While the majority of the drugs examined are on the controlled drugs list, pregabalin and gabapentin are not. In addition, the harms associated with the prolonged use of over-the-counter codeine containing medications have been recognised and are addressed in Strategic Pillar 2.

Further information on trends and developments in relation to psychoactive substances, cannabis, cocaine, and other emerging trends including ketamine, polydrug use and misuse of prescribed drugs, and drug use among children and adolescents can be found at [Appendix 4](#).

A series of emerging trend projects were developed under 'Reducing Harm Supporting Recovery' and several epidemiological monitoring techniques, public health reporting and communications initiatives piloted. There have been several important analytical developments. These have included: analysis of syringe residues; estimates of community drug use through analysis of municipal wastewater systems; the HSE's 'back of house' drug checking service at selected festivals, which has newly identified NPS in circulation in Ireland; and web surveys of people who use drugs, providing insight into current drug trends and markets.

An Garda Síochána's continued support and cooperation is vital to initiatives under the National Drugs Strategy such as the Supervised Injection Facility, the HSE Safer Nightlife Programme, the Drug Related Intimidation and Violence Engagement (DRIVE) Project, the Early Warning Emerging Trends Committee and in the national response to nitazene overdoses in 2023-24. In addition, An Garda Síochána¹, Revenue Commissioners², and the Health Products Regulatory Authority³ all play crucial roles in preventing the smuggling of illicit drugs, enforcing laws against illicit drug trafficking and organised crime, and in safeguarding public health from the harmful effects of drug use. Further information on seizures can be found at [Appendix 5](#).

The Irish drug market is a subsidiary of a European and global drug market. It is evolving rapidly as both suppliers and consumers are finding ways to adapt to geopolitical instability, globalisation and technological advances. This appears to be resulting in the availability of a more diverse range of substances, often of high potency and purity, which are posing new risks to public health. At the same time global events threaten to push Europe's response capacities to the limit, as the complexity and scale of the problem continue to grow (19). These developments also have implications for Ireland's preparedness and response arrangements (20).

1. The functions of An Garda Síochána are as set out at Section 9 of the Policing, Security and Community Safety Act 2024.

2. The Office of the Revenue Commissioners was established by Government Order in 1923, and its core functions include working with other state agencies in the fight against drugs.

3. The functions of the HPRA are set out in the Irish Medicines Board Acts 1995 and 2006 and in the Irish Statutory Instruments which govern its operations.

The impact of the developments we are seeing means that everyone is in some way likely to be affected by illicit drug use, the operation of the drug market and the problems associated with it. Directly, those who develop problems and need treatment or other services. Indirectly, the recruitment into criminality of vulnerable young people, the strain on health budgets, and the social costs for communities that feel unsafe or where institutions or businesses are undermined by corruption or criminal practices.

Almost everything with psychoactive properties can appear on the drug market, often mislabelled or in mixtures, leaving consumers potentially unaware of what they are using, increasing health risks and creating new law-enforcement and regulatory challenges.

Sudden shifts in the substances available on local drug markets are more likely to occur than in the past, leading to greater uncertainty about the harms to which people taking them may be exposed. New substances have become increasingly integrated into the Irish and European drug market, targeting a wide range of consumers, from the episodic and socially integrated to those with problematic patterns of use and experiencing social marginalisation.

Analysis of supply-related indicators for illicit drugs in the European Union suggests that drug flows appear to be resilient to many market changes, with availability remaining high across all substance types. There is widespread availability of a broader range of drugs, often of high potency or purity, where knowledge about health risks is limited. For some drugs, for example cannabis, there is a growing diversification of consumer products available on the market (such as oils, extracts, edibles and vaping products). For cocaine, the levels of reported seizures in Europe have continued to increase year on year. For synthetic drugs, such as amphetamines, methylenedioxymethamphetamine (MDMA) and cathinones, there is evidence of increased production within Europe, and concerns exist that this local production, closer to consumer markets, may trigger more rapid shifts in consumption trends. The increased integration of new stimulants into the illicit drug market, alongside more commonly used illicit substances, poses evolving challenges in terms of the sensitivity of existing monitoring systems to emerging harms and the appropriateness of existing responses (19, 22).

Role of Alcohol in the National Drugs Strategy

The focus on alcohol treatment and prevention in the strategy will be complemented by public health alcohol policy - regulations, health promotion and low-risk guidelines - to reduce the consumption of alcohol across the population.

In 2023, per capita alcohol use per person aged 15 years and over in Ireland was 9.9 litres of pure alcohol. Survey data indicates that approximately one-third of the population of Ireland abstains from alcohol completely, and that those who drink alcohol are consuming even greater quantities than what is indicated by per capita estimates. Ireland's per capita alcohol use has dropped from the 9th highest to the 16th highest among the OECD. Approximately one-half of drinkers can be classified as hazardous drinkers (65.7% of males and 36.5% of females) (23).

There has been a delay in the initiation of alcohol use among children, from 15.6 years of age to 16.6 years, between 2002 and 2019. A decline in the share of young people who drink has also been observed during this period: in 2002, 17.7% of 15–24-year-olds were non-drinkers compared with 28.2% in 2019, and not drinking was more common among females (31.5%) than males (25.0%) in this age group.

A high percentage (64%) of young people drink in a hazardous manner (a pattern of alcohol use that places the individual at risk of adverse health events), and 46% reported heavy episodic drinking (HED) on a typical drinking occasion. Among a sample of adolescents aged 14–16 years, 29% reported that they had been drunk in their lifetime and 13% reported being drunk in the previous month. Of those aged 15–24 years, 37.5% can be classified as having an alcohol use disorder (AUD).

Alcohol-related harm can be caused not only by the volume of alcohol consumed, but also by patterns of drinking, and can include harms to health, violence, and social harms.

Alcohol has a key role in the National Drugs Strategy in two main ways. First, the strategy will enhance treatment services for harmful alcohol use and ensure equity of access across Health Regions and social groups. It will also respond to co-occurring harms from drug and alcohol use in an integrated and coordinated manner.

Second, the strategy will seek to prevent or delay the initiation of alcohol use by children and young people through school and community programmes. There are strong proven links between early initiation of alcohol use and drug use. The strategy will support the development of evidence-based digital interventions that support people concerned about their alcohol and drug use.

The strategy also recognises the lifelong harms associated with prenatal drug and alcohol exposure and will seek to address these in the successor National Maternity Strategy (24).

Demand for drug and alcohol treatment services

Treatment demand is influenced by the availability of services, as well as patterns of drug or alcohol use. In 2025, there were in excess of 24,000 cases treated for problem drug or alcohol use (25). Almost two-thirds of cases (15,400) relate to problem drug use (55) and a third to problem alcohol use (8,800). The 2025 figure represents an increase of 8,000 cases – almost 50 percent - over the lifetime of the previous National Drugs Strategy. The bulk of the additional cases are for problem drug use (almost 6,500 more cases), with cases for problem alcohol use growing by 1,500.

As well as the greatly increased number of treated cases for problem drug use, there is also a change in the type of drugs. Cocaine is the most common drug reported, accounting for 6,500 cases, up from 1,700 in 2017. As a result, cocaine is now the most common drug among treated cases, at 42 per cent of the total. A further trend is with regard to polydrug use - there were 6,800 cases reporting polydrug use in 2025, that is 28 per cent of all cases. Almost all cases involved both drugs and alcohol.

The profile of treated cases continues to evolve as drug patterns change. The median age of drug treatment cases is 35 years, with some evidence of an ageing treatment population. The median age of alcohol treatment cases is significantly older, at 43 years. Men are more likely to attend treatment than women (61 per cent for alcohol, 69 per cent for drugs). While a majority of cases are unemployed (50 – 60 per cent), significant numbers are in employment (21 per cent for drugs, 34 per cent for alcohol). People experiencing homelessness and the Irish Traveller population are over-represented in the data. There are a considerable number of people in treatment with children aged under 17 years – 9,200 in total. In approximately 4,000 cases, the children are residing with those in treatment.

The demand for access to drug and alcohol treatment services is unequal across the country. This is illustrated in the two maps of the prevalence of treated problem drug and alcohol use per 100,000 population.⁴ The first map, based on Health Regions, shows a hierarchy in treatment prevalence. Dublin and North East has the highest prevalence rate at 863 per 100,000. There are three Health Regions with a prevalence rate in the mid-600s (Dublin and South East, Dublin and Midlands and Mid-West). The lowest prevalence rates of c 400 (half the best performing health region) are in West and North West and the South West.

Regional disparities in the prevalence rates for treated problem drug and alcohol use are intensified when analysed by integrated health area (IHA), which is a subset of the Health Regions (20 areas in all).

4. The Health Research Board (HRB) reports on treatment demand through the National Drug Treatment Reporting System. The maps are based on data from the National Drug Treatment Reporting System (NDTRS), compiled by the Health Research Board. Location is based on the residence of treated cases. It includes residence in institutional settings, such as prison or homeless services. Prevalence refers to the number of treated cases per 100,000 of the population. Prevalence is calculated using the number of treatment cases commenced each year. It includes those treated for the first time and those returning for treatment within the given treatment year.

Figure 1 Map of prevalence of treated problem drug and alcohol use per 100,000 population by HSE Health Region: hierarchy in treatment prevalence.

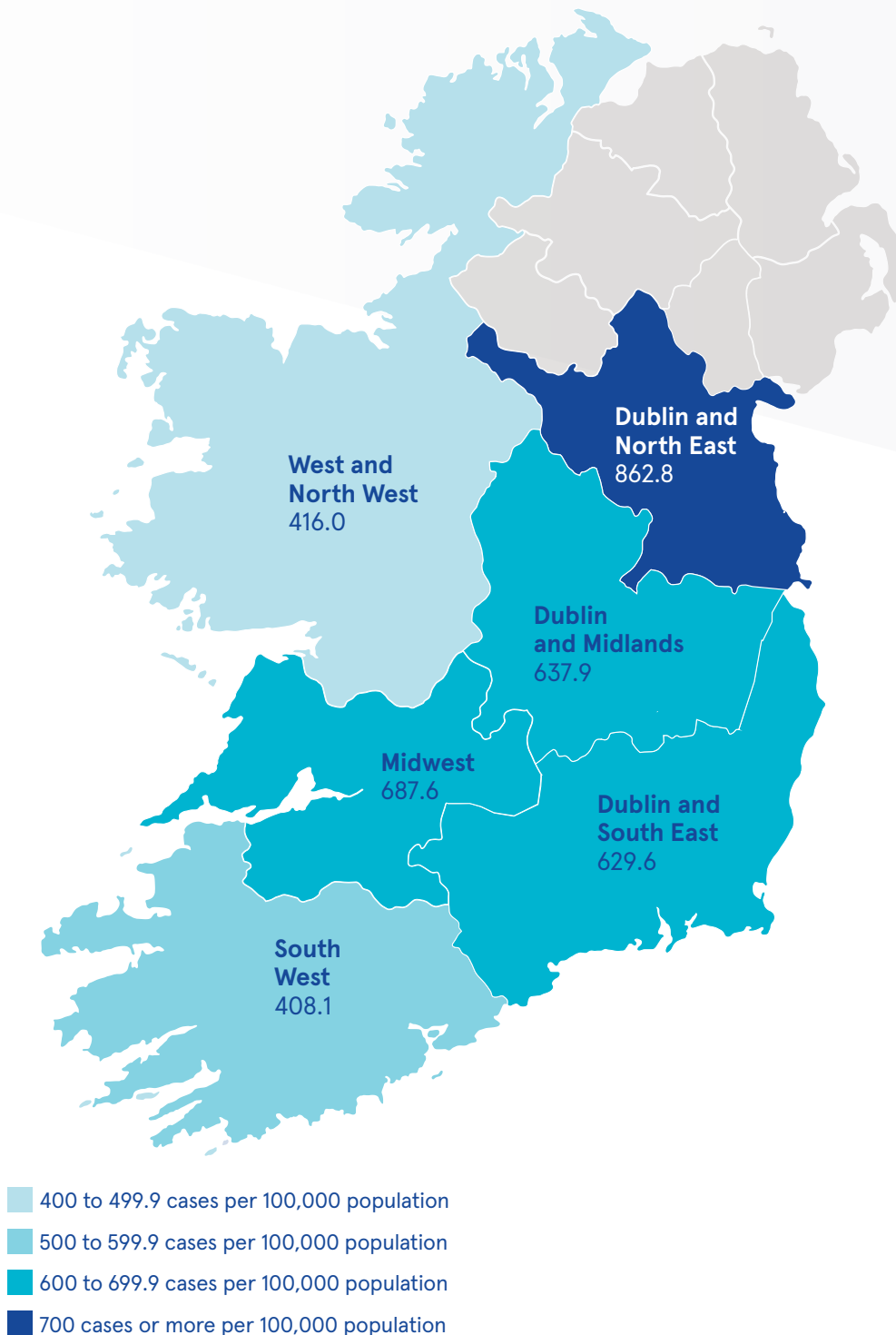
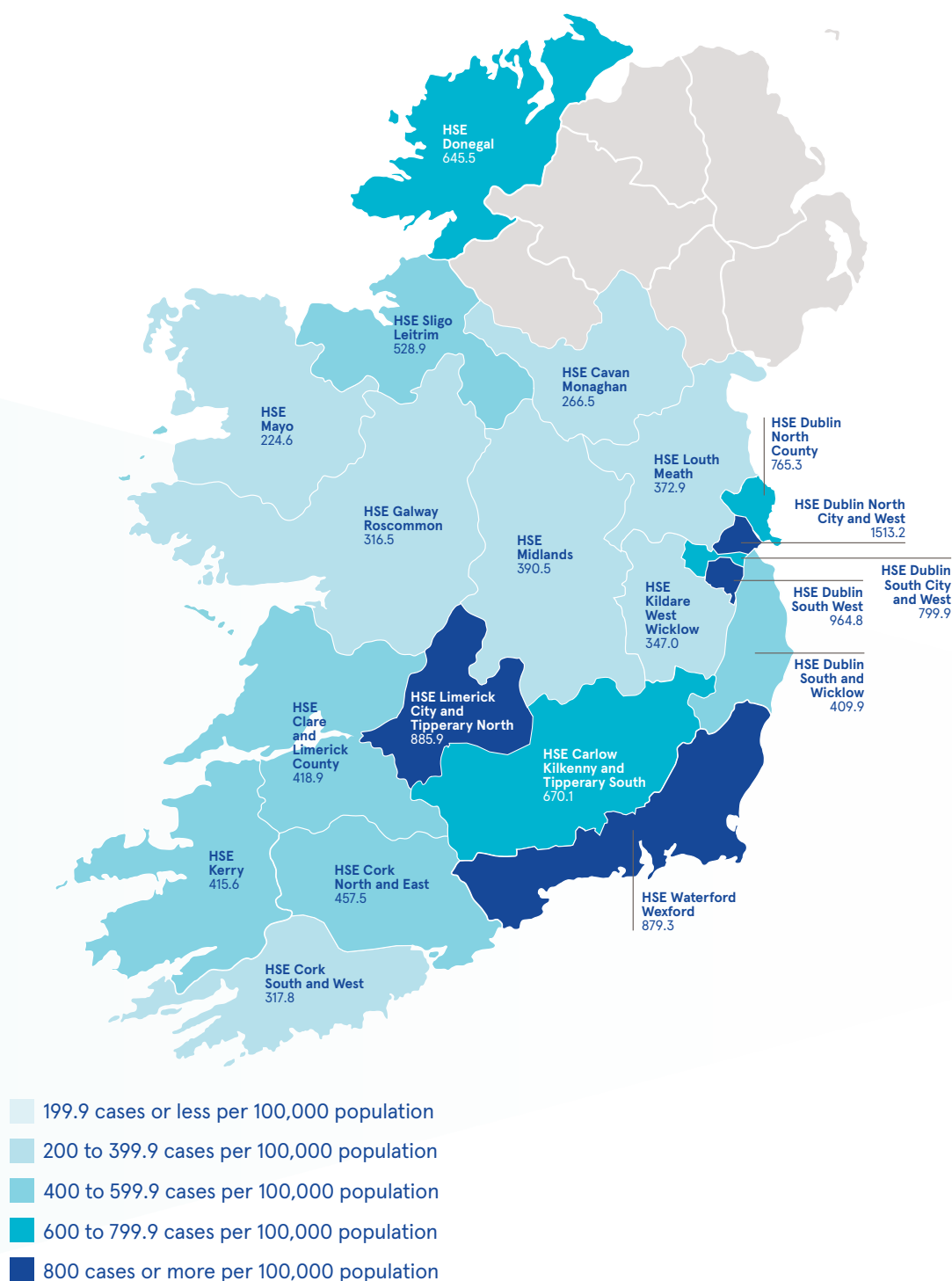


Figure 2 shows the differential is over 10 times between the highest and lowest prevalence rate. Dublin North City and West has by far the highest prevalence rate at 1,500 per 100,000 population. This is followed by a group of five IHAs with a prevalence rate of c. 800 (areas in Dublin, Limerick and north Tipperary, and Waterford/Wexford). There are two more IHAs with prevalence rates over 600 (Donegal and Carlow/Kilkenny).

A further four IHAs are between 400 and 530 (four counties in Munster and Sligo/Leitrim). The remaining 8 IHAs have prevalence rates ranging from 230 and 370, mainly western and midland counties. This map of treatment prevalence closely mirrors the pattern based on task force boundaries grouped by region.

Figure 2 Map of prevalence of treated problem drug and alcohol use per 100,000 population by Integrated Health Area within the HSE Health Region: hierarchy in treatment prevalence.



The impact of drugs on individuals, families and communities

The Health Research Board compiles the national drug-related deaths index. The purpose of the index is to provide the evidence base for policy and other measures to reduce drug poisoning deaths and to monitor their implementation and impact. Reducing drug-related deaths is a strategic focus of the national drug strategy.

In 2022, 343 drug poisoning deaths were recorded, a decrease of 30 from 2021 (-8 per cent). The main drugs implicated in the poisoning deaths were opioids (65 per cent), benzodiazepines (48 per cent) and cocaine (34 per cent). This figure included 65 deaths where alcohol was part of polysubstance poisoning. The median age at death was 45 years. The total number of alcohol-related poisoning deaths recorded was 132, including 65 deaths where alcohol was used with other drugs and 67 alcohol-only deaths. The median age of those who died due to alcohol-related poisoning was 50 years (26).

A study commissioned by the Department of Health has looked at the relationship between drug treatment demand and deprivation (18). The joint Pobal and HRB study combines micro-level data on deprivation from the Census of Population (2022) (27) with the residence details of cases treated for problem drug or alcohol use (2024)(25). The findings show that the rate of drug treatment cases in disadvantaged areas is between two and four times the proportion of the population in these areas. At the other end of the deprivation scale, affluent areas, the number of cases is less than half their share of the population. The respective figures vary depending on form of drug or alcohol use, with less variation for alcohol and greater variation for heroin.

When analysed taking into account population size within the deprivation categories, the difference in prevalence of treatment is intensified, with a differential of up to 13 times between the most disadvantaged and the most affluent. However, these extremes represent less than 5 per cent of the total population. When looked at for the main population groups (around average and affluent), the variation is less than double.

Looking at the overall share of treatment cases in disadvantaged areas, they account for 35 per cent of all cases. Over half of cases are located in areas marginally above or below the average, while 8 per cent of cases are in affluent areas.

The study presents data on treatment prevalence rates by deprivation band across the six HSE Health Regions. These data show a division between the six Health Regions. The three Dublin-based Health Regions have the strongest correlation between level of disadvantage and rate of treatment (up to 15 times), while the South West, Midwest and West and North West which have the weakest correlation (up to six times). The possible reasons for this pattern relate to both the prevalence rates for different types of drugs, and the varying access to treatment services across the regions.

The study also reveals variation in prevalence rates by settlement classification, with lower rates in rural areas and higher rates in cities and towns. Across all settlement types, the most common treated drug is alcohol, especially in rural areas, with alcohol accounting for between a half and two-thirds of all cases. The spatial disparities in the prevalence of treatment reflect the historical focus on drug use as an urban phenomenon combined with the underdeveloped nature of services in rural areas.

Combining deprivation levels and settlement classification, a clear pattern emerges. The degree of deprivation is most apparent as a factor in treatment rates in urban areas. It is far less significant in rural areas, with only a modest influence on prevalence rates. Finally, the study reports on distance travelled to access a treatment service. The median distance travelled is highest in rural areas (19-27 kms) and lowest in towns and cities (2-18 kms). It also details time of referral to treatment. The longest referral times for outpatient services were for alcohol (20 days) and the shortest were for crack cocaine and heroin.

A variety of factors contribute to drug and alcohol use, both individual and societal⁵. The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (28, 29). A life course perspective is critical to understanding the development of problems, rather than focusing only on the initiation of drug use.

The research literature indicates that low socio-economic status and poverty are often associated with poor health and well-being, with drug and alcohol use a mediating factor. Low socio-economic status tends to be geographically concentrated and experienced disproportionately by particular demographic groups, such as ethnic minorities, including travellers and Roma (54), and lone parents. Problems such as trauma are likely to be concentrated among disadvantaged groups/communities and to be transmitted between generations.

Poverty can affect drug use and related harms in a number of ways, such as chronic stress and reduced access to resources. Children raised in poverty are particularly vulnerable to adverse childhood experiences, which can be conducive to the development of drug use problems. Disadvantaged communities including migrant and ethnic groups often suffer greater drug availability and are more likely to live amongst criminal gangs, which provide a cultural environment that is conducive to problem drug use. Similarly, there can be greater access to alcohol.

Other social factors that influence drug and alcohol use are human development, social relationships and culture. Human development is a complex interplay of individual and environmental factors across the life course. It is shaped by a number of institutions throughout life, including the family, the childcare system, the education system, youth services and sport activities.

5. This analysis draws heavily on Spooner and Hetherington (2004) *The social determinants of drug use* (27)

To mitigate the risks of drug use during human development, policies and services are required to support healthy child, youth and adult development throughout the life course. In addition, early interventions should be provided for those who are beginning a potentially negative pathway (for example, children not doing well at school). Finally, services should be provided during challenging situations, e.g. people leaving prison, homelessness or pregnancy for drug-dependent individuals (29).

Culture includes drug-specific and non-drug-specific cultural influences on drug use. Drug-specific cultural influences are norms regarding acceptable patterns of drug use while non-specific cultural influences refer to general attitudes and norms. Social categories such as class, gender and race can influence access to resources, exposure to marginalisation, roles and expectations. For example, people who suffer deprivation have poorer health and are more likely to use tobacco, to drink alcohol in a high-risk manner and to use illicit drugs.

An extreme form of social exclusion that is of increasing significance for drug use is homelessness. There are over 17,000 individuals recorded as homeless, of which 8,000 are single adults (30). The latter are a high risk population for drug use due to the stress and stigma of being homeless and the exposure to drug-using behaviours on the streets and in homeless services.

The Government has developed the *Roadmap for Social Inclusion* (10) to reduce the level of poverty and deprivation to 2 per cent or less by 2030. The Roadmap includes interventions at different points along the lifecycle, such as income supports, employment programmes and education policies. In addition, targeted programmes prioritise disadvantaged groups and communities, such as the Social Inclusion Community Activation Programme, the Family Resource Centre Programme, the Inspiring Communities Programme, the Community Development Programme and the UBU Your Place Your Space youth services programme. These targeted programmes, together with health-led initiatives such as the Sláintecare Healthy Communities Programme and the *National Traveller Health Action Plan* (31), all contribute to addressing the social determinants of health and reduce the risk of drug and alcohol use.

A Framework for Change

This strategy provides a framework for change, guiding collective action to address the challenges associated with drug use in Ireland. The sections that follow outline the vision, principles, strategic priorities, delivery structures and actions that will guide implementation over the lifetime of the strategy. At its core is a vision of reducing the harms associated with drug and alcohol use and ensuring access to high-quality, person-centred services and supports.

The vision for the National Drugs Strategy has two components: reducing the harm from drug and alcohol use and providing high-quality treatment services. Reducing the harm of drugs was a core message from the Citizens' Assembly on Drug Use (3). Alcohol use can also cause harms for individuals and their families.

The harms for individuals can be both physical and psychological, while those for families, children and communities can be less visible, but equally profound, as family relationships are damaged and personal health and safety are undermined. Policy responses to drug use can also contribute to harm, where people feel stigmatised, socially excluded or even criminalised because of drug problems or behaviour related to their alcohol use. The focus on high-quality health and social care reflects the strategic priorities in *Sláintecare 2025+* (32). Care should also incorporate recovery and social integration, given the social causes and consequences of drug use.



Vision

A society where the harms from drug and alcohol use are minimised for individuals, children, families and communities and where health and social care for those affected is high quality, accessible, equitable, person-centred and integrated, and recovery and social integration are supported.

The strategic pillars are underpinned by the following principles:

- Respond to drug use from a health perspective, with an emphasis on prevention, harm reduction and treatment;
- Commitment to health equity and a human rights-based approach, including the right to health for people who use drugs and the right of the child to be protected from the harmful effects of drug and alcohol use;
- Engagement with people with lived and living experience in the design and delivery of services, including measures to reduce stigma;

- Collaborative working within Government and between Government, state agencies, civil society and impacted communities to address both the causes and consequences of drug use;
- Recognition of the diverse social and cultural needs of women and minority groups impacted by drug and harmful alcohol use and for mainstreaming of gender-sensitive responses and interventions;
- Integrated responses to the harms of alcohol and drug use, with a particular focus on the treatment of polydrug use.

The National Drugs Strategy 2026-2030 provides a framework for change, built around five Strategic Pillars and supported by a set of Enabling Measures that will strengthen delivery, accountability and impact. Together, they provide a coherent and integrated approach to achieving the vision and objectives of the Strategy. The following sections outline the rationale underpinning each Strategic Pillar and the priority actions that will support implementation over the lifetime of the Strategy.

The five strategic pillars are:

1. Protect individuals, children, families and communities from drug and alcohol use.
2. Provide equitable access to high-quality drug and alcohol services across Health Regions and population groups.
3. Champion recovery and social integration in drug and alcohol treatment, community services and in public policies.
4. Prioritise health supports for people in contact with the criminal justice system due to drug use.
5. Prepare for and respond effectively to a more volatile and dynamic global drugs market.

The strategic pillars are supported by four enabling measures for the effective delivery of the strategy.

- A. Provide leadership and investment to build capacity to implement the National Drugs Strategy;
- B. Support communities to participate in local and regional responses to drugs;
- C. Use evidence to inform, monitor and evaluate drug policies and practices;
- D. Develop collaborative and integrated partnerships to address the impacts of the global drugs challenge.

Strategic Pillars



Protect

Protect individuals, children, families and communities from the harmful effects of drug and alcohol use



Provide

Provide equitable access to high quality drug and alcohol services across Health Regions and population groups



Champion

Champion recovery and social integration in drug and alcohol treatment, community services and in public policies



Prioritise

Prioritise health supports for people in contact with the criminal justice system due to drug use



Prepare

Prepare for and respond effectively to a more volatile and dynamic global drugs market



1

Protect individuals, children, families and communities from drug and alcohol use

Prevention is the critical first step in protecting individuals, children, families and communities from the harms of drug and alcohol use. The policy approach to the provision of drug and alcohol prevention, however, is underdeveloped and a comprehensive approach is lacking.

Actions

No.	Action	Lead
1.1	Develop a coherent, coordinated and quality-based national drug prevention system, building on existing strengths and supporting new measures where gaps exist.	Department of Health, Health Service Executive
1.2	Prevent and delay the onset of the use of drugs and alcohol among children and young people through interventions delivered in educational, youth, and community settings.	Department of Health, Health Service Executive
1.3	Deliver interventions that support psychosocial wellbeing and healthy behaviours among groups at risk of drug and alcohol use.	Department of Health, Health Service Executive
1.4	Enhance services to address hidden harm for children, young people and families impacted by parental and familial drug and alcohol use.	Health Service Executive, Tusla
1.5	Develop and deliver a digital platform as a tool to engage with individuals about their drug and alcohol use.	Department of Health, Health Service Executive
1.6	Develop drug and alcohol prevention strategies in Higher Education Institutes, sporting and recreational settings.	Department of Health, Health Service Executive

A strategic approach is required, which looks both at systems and initiatives. Prevention has different components, beginning with universal prevention that aims at the population level to help young people in particular build the resilience and skills necessary to make positive and informed decisions about their health. This needs to be accompanied by more targeted selective and indicated evidence-based prevention interventions.

The Citizens' Assembly recommended the development of an action plan to enhance the prevention of drug use. Similarly, the Joint Committee proposed a whole-system approach to prevention ('a primary prevention system'), involving schools, youth services, healthcare providers, local authorities, sporting bodies and community groups. To strengthen the national approach to drug prevention, the Department of Health commissioned the Health Research Board to review Ireland's approach to drug prevention and to highlight areas of strength and weakness. The report (58) found that the national prevention system has many strengths but remains fragmented and variable and falls short of a coherent and fully effective prevention system. HSE Public Health is also preparing a report on drug and alcohol prevention needs assessment. These reports provide the basis for the development of a national drug prevention system.

To be effective, a systemic approach to drug prevention should be embedded across society, with a particular focus on young people and the communities and environments where they develop and socialise, such as schools and recreational settings. In this regard, Citizens' Assembly recommended a comprehensive, age-appropriate school-based drug prevention strategy, within the framework of the social, personal and health education curriculum. In addition, the Joint Committee proposed the expansion of prevention initiatives in youth and sports settings, with a view to tackling harmful cultural norms around drug and alcohol use. Other opportunities for targeted prevention initiatives include third-level institutions and the night-time economy.

The *EU Drugs Strategy* (17) encourages member states to implement environmental prevention measures, which reduce exposure to drugs and other substances, such as alcohol and tobacco. Current Irish examples include the WHO Safer programme (implemented by Irish Community Action on Alcohol Network), Communities that Care, and the Public Health (Tobacco Products and Nicotine Inhaling Products) Act 2023.

The strategy also calls for the implementation of evidence-based prevention programmes. These programmes should be based on the guidance provided by the European Drug Prevention Quality Standards and the European Prevention Curriculum. The provision of training modules for prevention practitioners, health professions, law enforcement and educationalists, is seen as key to improving the quality of prevention.

Reducing the impact of familial drug and alcohol use on children (often referred to as hidden harm) is a particular aspect of protection. Tusla-Child and Family Agency and the HSE have developed training resources for health and social service staff to tackle the problems children face because of familial use of drugs and alcohol. These resources should be supplemented with enhanced services.

Digital platforms, including social media, have the potential to contribute to prevention efforts and require greater support and development. With funding under the Sláintecare Integration Innovation Fund, the HSE has developed an innovative digital tool to support individuals to reduce or stop their alcohol and/or drug use using evidence-based behaviour change techniques. The intervention is designed to overcome common barriers to seeking help, including stigma, shame, geographic isolation, time constraints, and waiting lists for inperson services. By co-developing the initiative with people who have lived and living experience and community and civil society partners, it places health equity at the centre of digital prevention.

The development of public awareness campaigns on drugs is highlighted in the Programme for Government, the Citizens' Assembly and the Joint Committee. One component of these campaigns would be to reduce stigma among people who use drugs and to remove barriers to seeking help. The HSE is the lead body for health promotion and awareness initiatives through Drugs.ie and Health and Wellbeing. The evidence for effective awareness campaigns on drug use is limited and careful consideration is required to achieve positive outcomes and to avoid unintentionally increasing interest in substances (as advised by the Joint Committee). Ireland should draw on the expertise of the European Drugs Agency to develop effective awareness-raising activities, targeting priority issues, including cocaine and synthetic drugs.

Prevention of drug use should be seen as part of a public health strategy to enhance resilience, mental health and physical wellbeing among the population, and to support people dealing with trauma and adverse childhood experiences, as recommended by the Joint Committee and Citizens' Assembly. *Pathways to Wellbeing* (33) the national mental health promotion plan (34), and the successor *Healthy Ireland Framework* (35), are key initiatives in this regard. The former seeks to strengthen foundations for positive mental health in early years and to enhance the social and emotional development of children and young people. Under the forthcoming *Healthy Ireland Framework*, sport and physical activity should be promoted as a component of a health-led alternative to drug and alcohol use.



2 Provide equitable access to high-quality drug and alcohol services across Health Regions and population groups

The provision of treatment services for problem drug and alcohol use is a key policy response to drugs, with the aims of minimising the harms for individuals and reducing the overall demand for drugs. The main provider of services is the HSE, either directly by HSE staff or through GPs and pharmacies.

Actions

No.	Action	Lead
2.1	Support the mandate of the HSE Health Regions to coordinate and fund the provision and delivery of high-quality drug and alcohol treatment services, based on population need and geographic equity.	Department of Health, Health Service Executive
2.2	Expand treatment services, taking into account changing patterns of drug use, the ageing profile of OAT service users, the needs of underserved and marginalised communities, prior experiences of trauma and adverse childhood events, and integrated models of service delivery based on partnership & co-design.	Department of Health, Health Service Executive
2.3	Establish a national framework based on quality standards to monitor treatment services as to demand, quality, and effectiveness.	Department of Health, Health Service Executive
2.4	Embed an active role for those with lived and living experience of drug and harmful alcohol use, including families, in the planning, delivery, and review of services.	Health Service Executive

No.	Action	Lead
2.5	Expand evidence-based harm reduction responses for all types of drugs and explore the establishment of additional supervised injection facilities in areas of need.	Department of Health, Health Service Executive
2.6	Increase the availability of Naloxone and review prescription controls on the drug.	Department of Health
2.7	Provide tailored services for people with dual diagnosis led from a mental health perspective, and for those who experience homelessness, domestic or sexual violence and gambling addiction and ensure services are sensitive to emerging evidence on the links between neurodiversity and substance use.	Department of Health, Health Service Executive
2.8	Develop and implement youth-specific service pathways across all regions.	Health Service Executive
2.9	Integrate gender-responsive and gender-transformative approaches in drug policy and across integrated service pathways.	Department of Health, Health Service Executive
2.10	Ensure services are accessible and culturally appropriate for marginalised groups, including the Traveller community, migrants and the LGBTQI+ community, ensuring their inclusion in service design and delivery.	Department of Health, Health Service Executive

This is complemented by community-based services, provided by community and voluntary organisations and coordinated by Local and Regional Drug and Alcohol Task Forces with ring-fenced funding. In all, there is a total of 460 organisations providing treatment services. The vast bulk of these are community-based services, often servicing specific geographical areas. Historically, drug services have prioritised heroin use in disadvantaged areas and among socially excluded groups, as is reflected in the Pobal/HRB analysis of the relationship between treatment services and geographic deprivation (18).

In line with Sláintecare (9), there is a need to ensure equitable access to high-quality services across all Health Regions and population groups. The challenge is to build upon existing provision by expanding services for underserved communities across all Health Regions. Social and demographic changes, such as poverty and migration, as well as a general diffusion of drug problems across all geographic locations, require that access to treatment services is broadened. There is also a concern with the ageing profile of Opioid Agonist Treatment (OAT) service users and their vulnerability to poly drug use.

There is evidence that the funding model for service provision has failed to keep pace with changing needs and has, over time, resulted in an uneven access to care for certain communities and regions. The Citizens' Assembly recommended that significant additional funding is provided on a multi-annual basis to address service gaps, including the provision of community-based and residential services. The additional funding should ensure geographic equity in access to services, as well as accountability, transparency and traceability of allocations. Similarly, the Joint Committee proposed meaningful, sustained, ring-fenced and multi-annual investment in drug services, to ensure equitable access and to address service gaps.

A transparent funding model, based on the community services enhancement fund and with input from stakeholders, can provide a way forward, whilst continuing to support existing service providers. Equitable access to high-quality services requires a planned approach whereby service providers work together in meeting the needs of diverse population groups. There is an opportunity for the HSE Health Regions to be responsible for the planning, funding and delivery of treatment and harm reduction services that reflect the changing demographics of people who use drugs or alcohol. People with lived and living experience and families impacted by drug use should be actively involved with the Health Regions and service providers in the planning and delivery of services, as recommended by the Citizens' Assembly and the Joint Committee.

Supporting community-based services is an important element of the planned approach. Building the capacity of services will require adequate funding and the development of staff resources. Services should be supported to be flexible and responsive to changing needs and to expand access beyond traditional geographic boundaries. An example is the integrated service delivery model established in the HSE South West region in recent years. A fragmented 'patchwork quilt' model of discrete and isolated services was replaced by a hub and spoke model, with a single service provider for the entire region. This reform has streamlined and integrated service provision and provided clear points of entry for service users, family members and referring partners. Importantly, this collaborative model was developed as a partnership between statutory, community and voluntary sector organisations, and Drug and Alcohol Task Forces.

Harm reduction is a key component of service provision. This applies to emerging trends and patterns of drug use in recreational settings, and to high-risk drug consumption among people who are homeless and other vulnerable groups. Ireland has made considerable strides in harm reduction and low threshold services, notably through the distribution of naloxone and the establishment of a supervised injecting facility. The Programme for Government commits to expand these initiatives, a view supported by the Citizens' Assembly and the Joint Committee. The Joint Committee recommends additional measures to mitigate the harms associated with inhalant substances, such as nitrous oxide, and other emerging drug trends.

[1] It also made a number of recommendations on access to low-threshold treatment and alternative treatment options for people with heroin addiction, including buprenorphine.

The Joint Committee highlighted the need for a coordinated and equitable system of family support services and proposed the development of a national family support system that would embed community-based organisations, and be supported by ring-fenced, multi-annual funding. This should include families providing kinship care for children impacted by parental drug use. Other proposals on kinship care are beyond the scope of the National Drugs Strategy and may be relevant to the national policy on the rights of children living in informal kinship care, being developed by the Department of Children, Disability and Equality. The Joint Committee highlighted the link between neurodiversity and drug use and recommended the modification of service processes and practices to ensure appropriate culturally informed communication and the embedding of specialist expertise in the development of integrated care pathways.

The importance of trauma-informed services and supports for addiction was highlighted by the Joint Committee. Furthermore, the Citizens Assembly recommended that training on trauma-informed and health-led responses to problem drug use should be provided for personnel in health, education and criminal justice sectors. The EU Drugs Strategy (17) highlights the need for easy and timely access to affordable, quality and adapted treatment, in line with the right to care set out in the European Pillar of Social Rights. Healthcare systems should provide equitable access across regions and rural areas. In addition, drug treatment should be evidence-based, meet agreed standards, incorporate care plans based on individual needs, and provide integrated services for polydrug use and concurrent mental health issues.

It is important that services meet the additional care and service provision needs of women with problem drug or alcohol use, as highlighted by the Joint Committee. Both the Council of Europe and the European Drugs Agency have provided guidance on the development of gender-sensitive drug services, which should be applied in all services, along with the expansion of women-specific services grounded in an intersectional framework. Tailored services for young people should be also developed. There is a particular challenge of providing services to new communities, marginalised groups (including migrants, Travellers and LGBTQ) and rural areas.





3 Champion recovery and social integration in drug and alcohol treatment, community services and in public policies

Recovery from drug dependence is an integral aspect of the response to problem drug and alcohol use. Addiction is not an all-or-none phenomenon and exists along a spectrum of severity that varies from substance to substance. The concept of 'recovery' involves more than just control over substance use.

Actions

No.	Action	Lead
3.1	Embed recovery-oriented and user-led interventions across all treatment services.	Department of Health, Health Service Executive
3.2	Strengthen and develop recovery in community service networks and actively incorporate family support.	Health Service Executive
3.3	Ensure access to good quality accommodation to support recovery and reduce the risk of homelessness.	Department of Health, Department of Housing Local Government and Heritage
3.4	Develop coherent, multi-faceted community services and public policies that reduce stigma, build recovery capital and promote social integration.	Department of Health, Health Service Executive
3.5	Explore the development of a national network of recovery support services.	Department of Health, Health Service Executive

Recovery requires better mental and physical health, along with opportunities for social integration through community activities, employment, education and housing. Recovery is a process that takes time to achieve and effort to maintain. The strategy recognises that recovery will mean different things for different people and is best thought of as a journey towards improved health and social functioning.

Recovery and social integration are underdeveloped elements of the policy response to problem drug and alcohol use. To address this deficit, the Citizens' Assembly recommended a systemic approach to recovery, through support for evidence-based innovation in community and residential services. Social and economic measures, that contribute to sustainable recovery, are required, including social protection, childcare, education, housing, labour market and criminal justice. The Joint Committee acknowledged that recovery is an individual experience and does not necessarily equate to abstinence. They recommended that recovery is part of the continuum-of-care for the provision of treatment services. This understanding of recovery is reflected in the description of the pillar, where recovery and treatment are intertwined.

Social integration acknowledges that substance use is a social phenomenon, that is connected with individual and family trauma, stigma, poverty and social exclusion. There should be policy recognition of the importance of social integration in addressing the social determinants of drug use and supporting people to have a better life, along with dedicated funding available for recovery-oriented care. The *EU Drugs Strategy* (17) highlights the need for member states to improve reintegration of people with problem drug use into the community and the labour market, using national and EU spending instruments.

Promoting recovery and social integration is not just a drugs policy issue; it should be incorporated in the government policies on poverty and homelessness, and in supports provided for families and parents. Similarly, labour market interventions are required to support recovery through structured participation, skills development and provision of training opportunities. The community employment drug rehabilitation programme should be complemented by other measures that support progression to employment.

Helping individuals to build their recovery is at the heart of the continuum of care model, which is centred on the individual and their needs. The creation of a 'Recovery Orientated System of Care' (ROSC) offers the best chance of helping people move out of addiction. This includes social networks, education and employment skills, personal development and community supports. The pathway to recovery may utilise various types of support and interventions or may occur without any formal external help: there is no 'one size fits all'.

Recovery requires a gradual accumulation of positive benefits. The complications caused by drug dependence mean that addiction is often associated with overwhelming negativity and stigma. People who use drugs or alcohol often come into contact with multiple agencies, including drug treatment, criminal justice, mental health, welfare, and primary health care services. Interactions with any of these services may trigger a turning point in an addiction trajectory for some individuals. This is why offering a range of peer support, medical, housing, employment, education and other services matter. Lived experience is an essential part of recovery, as are peer and family support and lived experience recovery organisations (LEROs).



4 Prioritise health supports for people in contact with the criminal justice system due to drugs

People who use drugs are at high risk of coming into contact with the criminal justice system—drugs and alcohol can be a factor in a range of anti-social and criminal behaviours. Furthermore, having a criminal record can have an impact on lifetime opportunities for people. Meanwhile, the experience of being in prison itself can create additional trauma and contribute to drug use. A history of substance use has been identified as a strong predictor for reoffending and is highlighted as one of the foremost risk factors for criminal recidivism.

Actions

No.	Action	Lead
4.1	Monitor and evaluate the Health Referral Scheme for people found in possession of drugs for personal use and review the Adult Caution Scheme to consider the inclusion of other drugs.	Department of Health, Department of Justice, Home Affairs and Migration, Health Service Executive, An Garda Síochána
4.2	Increase access to treatment services for people in contact with the Criminal Justice System, including those on remand or probation.	Department of Justice, Home Affairs and Migration, Department of Health, Health Service Executive, Irish Prison Service, The Probation Service
4.3	Increase availability of treatment and recovery options for people in prison and provide continuity of care post release.	Department of Justice, Home Affairs and Migration, Department of Health, Health Service Executive, Irish Prison Service
4.4	Strengthen the drug treatment court as a progressive multi-agency, health-led response to drug-related offending and explore access for people living outside of Dublin.	Department of Justice, Home Affairs and Migration, Department of Health, Health Service Executive, Courts Service

No.	Action	Lead
4.5	Expand assertive case management for people who use drugs in public places in contact with the criminal justice system.	Department of Health, Health Service Executive, An Garda Síochána
4.6	Disrupt child criminal exploitation in the drugs trade and expand the availability of alternative pathways for young people at risk.	Department of Justice, Home Affairs and Migration, An Garda Síochána
4.7	Expand supports for individuals and families affected by drug-related intimidation and violence.	DRIVE Oversight Committee, Department of Health, Department of Justice, Home Affairs and Migration, An Garda Síochána

The Citizens' Assembly made four recommendations on alternative, health-led options for people who use drugs in contact with the criminal justice system. These included alternatives to coercive sanctions such as the Drug Treatment Courts, enhanced prison-based treatment services and a comprehensive health-led response to possession of drugs for personal use. The Joint Committee proposed replacing short custodial sentences with alternative measures, including restorative justice approaches, where appropriate. It recommended that alternative approaches adopt a broad, person-centred definition of success, recognising a range of health, social and behavioural outcomes.⁶

A first priority is to expand policy alternatives to criminal sanctions for personal possession offences, which can divert people to a health intervention and, where necessary, refer them to treatment or other support services to reduce drug demand. The commencement of the Government Health Referral Scheme in September 2026 is a significant development. The scheme offers an alternative to prosecution for people found in possession of drugs for personal use on a first occasion, by referring them to the HSE for brief intervention using the screening and brief intervention (SAOR) model. The scheme is voluntary, with no sanction applied for non-attendance and reflects the principle of depenalisation for a first offence. The brief intervention is a person-centred and supportive conversation with a health professional. It may include advice on drug use, information on reducing harm, and help to identify if further supports would be useful.

The Joint Committee made a number of proposals on the implementation of the Health Referral Scheme. These include the application of clear, transparent safeguards and monitoring mechanisms to ensure equitable and consistent application of the scheme; and the independent evaluation of the scheme after the first year, including consistency of application, outcomes and impacts. It also flagged the provision of additional resources to meet service demand and to ensure referrals are processed in a timely manner.

6. CADU recommendations #11, #12, #13 & #19; JCDU recommendations #76, #80, #82, #145, #146, #160 & #162

It is noted that the scheme will only apply to first-time offences. On a second occasion, an adult caution may be applied. However, the use of a caution for adults is currently confined to the possession of cannabis. This restriction should be reviewed to include other types of drugs under the adult caution scheme, in line with the original Government decision on a health-led approach. Furthermore, cognisance should be taken of a person's attendance at drug treatment services, so that they are encouraged to continue their engagement with treatment and recovery services.

The Dublin Drug Treatment Court is a longstanding example of an alternative to sentencing for drug-related offences. A recent evaluation of the court (36) found that it is a valuable and innovative model with significant potential. An implementation board has been established to progress the recommendations of the evaluation to strengthen the court as a progressive multi-agency, health-led response to drug-related offending. Already, a number of operational reforms have already been introduced, including changes to the graduation framework and measures to increase awareness of the programme among members of the judiciary, which have contributed to an increase in referrals in recent months. The board will consider whether any legislative changes may be required to further support the operation and future development of the court.

Law Engagement Assisting Recovery (LEAR) is an assertive case management programme targeting vulnerable individuals with complex drug-related issues, delivered by Ana Liffey in partnership with statutory agencies. It bridges law enforcement and public health approaches, focusing on harm reduction, recovery, and social reintegration for those experiencing problematic substance use, homelessness, and related challenges. It currently operates in Dublin City, Limerick City and County and Louth. A recent review identified significant strengths within the programme and also several opportunities.

A Probation Service study examined the relationship between substance use behaviour and offending. It found that that 81 per cent of clients were reported to have a history of alcohol or drug use, with half found to have a combination of problem drug and alcohol use. In line with the recommendations of the report, collaboration between the Probation Services and addiction service providers should be strengthened to so as to address the gaps in services and engage with and support those on supervision appropriately (56). For those incarcerated, interventions to treat drug use should be greatly enhanced, given the high prevalence of drug use among the prison population. The 2023 report on health needs assessment in prisons (37) made a number of recommendations in relation to addiction and substance services. This should include upskilling of healthcare staff in the Prison Service and greater availability of treatment options, including naloxone. In-prison treatment should in turn be supported with post-release programmes, to maximise the effectiveness and benefits for those concerned. The post-release health navigator project in Dublin's North East Inner City (NEIC) should be examined as to its potential to be expanded in other prisons.

The Joint Committee recommended the expansion of the treatment and recovery programme (TARP) across the prison service, including women's prisons. The evidence base supports the inclusion of prison-based therapeutic communities as part of a healthled response to prisoners with a history of drug use. The careful adaptation of the principles of a therapeutic community would require close collaboration between the Irish Prison Service, the HSE, and community-based services, with a clear focus on continuity of care, clinical oversight, and evaluation.

There are two other criminal justice issues linked to drugs. One is drug-related intimidation and violence, where individuals and families are targeted by criminal gangs to recover drug debts. The Citizens' Assembly recommended the rollout and resourcing of the Drug Related Intimidation and Violence Engagement (DRIVE) project, which is a multi-agency initiative to respond to drug-related-intimidation and violence between Drug and Alcohol Task Forces, An Garda Síochána and community services.

The second is the recruitment and exploitation of children by drug gangs. As well as criminal sanctions on the perpetrators, alternative pathways for vulnerable young people should be expanded. Both the Citizens' Assembly and the Joint Committee recommended the strengthening of community-based youth work through increased ringfenced and multi-annual funding, ensuring that restorative justice and diversion initiatives are supported.





5 Prepare for and respond effectively to a volatile and dynamic global drugs market

The Irish and European drug markets are becoming more volatile, dynamic and digitally enabled. They are also increasingly globally connected driven by criminal networks. New substances are emerging, increasing the risks of addiction and harm. Synthetic drugs, in particular, are more common, often with greater potency and unknown health implications.

Actions

No.	Action	Lead
5.1	Expand drug monitoring and drug checking mechanisms.	Health Service Executive
5.2	Respond to emerging drug trends and communicate effectively on drug related threats to public health.	Department of Health, Health Service Executive
5.3	Implement timely and effective strategies and legislation to control the availability and use of psychoactive drugs, in particular nitrous oxide and synthetic cannabinoids.	Department of Health, Department of Justice, Home Affairs and Migration
5.4	Support interventions which reduce the supply of illicit drugs and mitigate their impact in communities.	Department of Justice, Home Affairs and Migration, An Garda Síochána
5.5	Respond to the diversion and misuse of prescribable and over-the-counter drugs.	Department of Health, Health Service Executive, Regulatory Bodies

Increasingly, substances with psychoactive properties can appear on the drug market, often mislabelled or in mixtures, leaving consumers potentially unaware of what they are using, increasing health risks and creating law-enforcement and regulatory challenges. The use of multiple substances in combination and the use of drugs and alcohol together are becoming more important causes of harm. The diversion of prescribable and over-the-counter drugs into the illicit market is also of concern. To respond to the challenges of the drugs market, health and law enforcement systems must be both agile and forward looking, an issue highlighted by the Joint Committee. The capability to identify and respond to emerging threats and challenges has become critical as is evident in relation to synthetic cannabinoids and opioids, e.g. nitazenes. The Joint Committee highlighted the risks associated with synthetic and inhalant drugs and the need for measures to restrict supply and access. The use of vapes and edible jellies are marketing ploys aimed at young people. The effectiveness of policy frameworks and legal controls for new psychoactive drugs should be reviewed in a timely manner. The Citizens' Assembly called for a significant expansion of drug checking facilities and initiatives, including permanent drug checking facilities and non-festival environments, to reduce the harms of drug use.

Similarly, the Joint Committee called for real-time data on emerging substances and Government support for wastewater analysis and other innovative monitoring tools to understand emerging drug trends. It also proposed the use of surveys and research to identify emerging drug trends among children and adolescents. Disrupting the supply of illicit drugs is an important element of the response to the drugs market. Recommendation 24 of the Citizens' Assembly states that the national drug strategy should continue to prioritise the objective of reducing illicit drugs supply and associated structures, at international, national and local level within communities. The Joint Committee, in affirming this action, recommended a cross-government response to tackle the illicit supply chain and its impact on communities. It also recommended maintaining strong criminal sanctions against organised crime, drug trafficking, coercion of children, and commercial supply networks, and that Garda priorities are oriented towards organised criminal supply networks and drug-related intimidation.

Tackling trafficking networks for illicit drugs is a major focus of the *EU Drugs Strategy*. This incorporates three priorities – law enforcement and judicial cooperation, an action plan against drug trafficking, and combatting the production of synthetic drugs. The implementation of these priorities is coordinated by the Department of Justice, Home Affairs and Migration, An Garda Síochána and the Revenue Commissioners. While large scale seizures receive public attention, the impact of drug markets is felt most keenly at the local level, especially in disadvantaged areas. The collateral impact of the drugs market is visible in the social costs for communities and the activities of criminal networks that finance and supply drugs. Greater effort is required to mitigate the impact of drugs on local communities, as part of a coordinated response between government bodies, Drug and Alcohol Task Forces and community and voluntary organisations.

Enabling measures

The strategic pillars are supported by four enabling measures, set out below. These create the conditions necessary for the effective delivery of the strategy.

- A. Provide leadership and investment to build capacity to implement the National Drugs Strategy;
- B. Support communities to participate in local and regional responses to drugs
- C. Use evidence to inform, monitor and evaluate drug policies and practices;
- D. Develop collaborative and integrated partnerships to address the impacts of the global drugs challenge.

A. Provide leadership and investment to implement the National Drugs Strategy

Measures

No.	Measure
A.1	Ensure strong political leadership and cross-departmental support for the implementation of the National Drugs Strategy.
A.2	Ensure that community and voluntary organisations, Drug and Alcohol Task Forces and people with lived and living experience are represented on the governance and oversight structures for the National Drugs Strategy
A.3	Increase public funding for the implementation of the National Drugs Strategy in a planned and sustainable way, including funding from novel sources.
A.4	Develop and resource a strategic workforce plan for drug and related services; including peer support and intervention networks.
A.5	Provide training and support for continuous career and professional development, including trauma-informed and problem-solving responses, and gender sensitive interventions.
A.6	Implement robust national monitoring and implementation of the National Drugs Strategy.

The implementation of the National Drugs Strategy will only be effective if the relevant statutory and community stakeholders are involved, with adequate resources and supported by appropriate structures and processes. Sustained investment in the drug and alcohol services workforce, including the community and voluntary sector, is a key requirement to ensure capacity is available to deliver high-quality services.

The Citizens' Assembly made a number of recommendations on the governance and funding of the National Drugs Strategy. It recommended that Government make drug use a policy priority, with accountability at the highest level for the Government response. It called for policy coherence, operational cohesion and effective leadership in delivering a whole of government response to drugs-related issues. The Citizens' Assembly also highlighted the need for an effective whole-of-society response to drug-related issues. In particular, key stakeholders from the statutory, community and voluntary sectors, including Drug and Alcohol Task Forces, should continue to engage with the Minister responsible for the National Drugs Strategy and relevant government officials. There should be a plan to engage the general public, civic society and other stakeholders in the national response to drugs, and in particular to reduce stigmatisation of people who use drugs, including a series of regional and national forums and a public awareness campaign.

The Citizens' Assembly made a specific recommendation that drugs policy design and implementation should be informed by service users and people who use drugs as well as family members of people affected by drugs, with provision of appropriate supports to enable this involvement. This view was supported by the Joint Committee.

The Joint Committee proposed the establishment of a standing Joint Oireachtas Committee on Drug Use and Related Issues, to ensure that drugs policy is under continual consideration, review and scrutiny by the Oireachtas. It called for the re-establishment of the national oversight committee, with representation from civil society and community and voluntary organisations. It also said that Drug and Alcohol Task Forces should be at the centre of decision making and be represented on appropriate governance and oversight structures, and that people who use drugs would have meaningful participation in policy making, implementation and oversight structures.

The Citizens' Assembly recommended a strategic workforce development plan for drug services. This would include measures to enhance the capacity, quality and skills of the workforce in the community, voluntary and statutory sectors. It should include measures to support recruitment and retention of qualified personnel in the community and voluntary sectors. It should also include measures to recruit, train and otherwise support the enhanced involvement of professionals who can add additional capacity to prevention, harm reduction, treatment and recovery services, including family GPs, nurses, addiction nurses, pharmacists, teachers, peer support workers, peer mentors, Prison Officers, Probation Officers, Gardaí and others.

B. Support communities to participate in local and regional responses to drugs

Measures

No.	Measure
B.1	Continue to recognise and support the role of Drug and Alcohol Task Forces in developing community-led responses to drugs.
B.2	Involve community and voluntary groups, including those representing individuals and families with lived and living experience, in local and regional structures.
B.3	Build capacity and resilience in communities most impacted by drugs through community development and local development programmes.

Building the resilience and capacity of communities affected by drugs is a longstanding feature of government policy on drugs. Communities should be enabled to participate and engage in local decision-making through the variety of government programmes that support community development and local development. It is important to utilise the knowledge and experience of local communities, especially those with lived and living experience, in developing local and regional responses to drugs.

An important vehicle for coordination of community responses to drugs is the Drug and Alcohol Task Forces, with their multi-agency composition. The Citizens' Assembly emphasised that Drug and Alcohol Task Forces, together with community and voluntary sector organisations, have a crucial role in responding to drugs-related policy challenges, and in supporting the implementation of the National Drugs Strategy. It noted that many of the most innovative and responsive examples of service delivery involve strategic and operational partnerships between statutory, community and voluntary sector organisations.

The Joint Committee recognised the fundamental role of Drug and Alcohol Task Forces in addressing drug use and related social factors in local communities and called for the role of community development to be embedded and protected in the National Drugs Strategy. To ensure locally identified priorities are adequately funded and effectively delivered, Drug and Alcohol Task Forces should be co-decision makers in relevant budgetary decisions. In addition, community and voluntary organisations have a particular knowledge of the drug-related concerns and issues facing local communities. They have a valuable role working in partnership with the HSE Health Regions, local authorities, An Garda Síochána, Local Community Safety Partnerships and other statutory agencies.

Both the Citizens' Assembly and the Joint Committee highlighted that the negative impacts of drugs use are experienced disproportionately by communities experiencing high levels of poverty and social exclusion, and by marginalised and vulnerable groups such as Travellers and people experiencing homelessness. Holistic policy responses to drugs issues, including health, education, housing, social protection and social inclusion, community development and criminal justice policy, should be designed, with targeted interventions and resources directed at communities with greatest need. The National Drugs Strategy should focus on building resilient, sustainable communities through local partnerships in both urban and rural settings, and stronger community policing. This work should be informed by the analysis on the link between treatment demand and deprivation.

C. Use evidence to inform, monitor and evaluate drug policies and practices

Measures

No.	Measure
C.1	Ensure a robust system of monitoring and data collection on the drugs situation, including indicators of prevalence, ethnicity, harms and responses, and community-level data.
C.2	Support research on drug policies and services, including making use of existing data sources.
C.3	Promote best practice in evidence and knowledge exchange on drugs policy and services.
C.4	Support standards and public patient involvement in drugs research.
C.5	Undertake research on early warning systems.
C.6	Advance recovery research and practice to bring greater precision to how recovery is conceptualised, measured, explained and sustained.

Drug policies and practices should be informed by a robust evidence base. Evidence gathering should be objective, systematic and consistent, and should incorporate participatory methods. An ongoing review of service provision is needed to ensure that services are effective and remain in line with the evolving needs of people who use drugs. A dedicated research programme can support comparative understanding of problems, share evidence of effective interventions and assist with early identification of new threats and challenges. It can also assess patterns of use and inform policy responses.

The Citizens' Assembly recommended that the National Drugs Strategy should incentivise and promote evidence-based innovations in service design and delivery, prioritise the evaluation of pilot projects and emphasise the timely mainstreaming of good practice. The strategy also called for a plan to strengthen the national research and data system. This includes the adoption of technology to improve data quality and reliability, stronger coordination and joint planning across organisations, and enhanced research partnerships between national and international statutory authorities, academic researchers and key stakeholders, including service users. Additional investment will also be required to improve the timeliness of research surveys. The plan should support and incentivise public and patient involvement (PPI) and specify targets for stakeholders and service providers to provide timely and accurate data on how drugs use impacts on the services they provide.

The Joint Committee supported ongoing monitoring, research and evaluation of drug reforms, drawing evidence from other jurisdictions. It recommended the expansion of data collection and evidence on family impacts in national data systems. It further noted that data collection should include marginalised groups, such as members of the Traveller community and people experiencing homelessness.

D. Develop collaborative and integrated partnerships to address the impacts of the global drugs challenge

Measures

No.	Measure
D.1	Provide a leadership role on drugs policy during the Irish Presidency of the Council of the European Union in conjunction with Member States and EU institutions.
D.2	Strengthen links with early warning and emerging trends on an All-Island basis and in conjunction with BIC administrations.
D.3	Contribute to and implement the EU Drugs Strategy and Implementation Framework on health-led response to drugs.
D.4	Strengthen cooperation with the EUDA and jointly undertake a foresight exercise on drugs in Irish society.

Drugs are an all-island, a European and a global issue. Cooperation and shared learning with governments and international institutions are essential. Ireland is well placed to be an active contributor to collaborative partnerships on an all-island basis, and with multilateral bodies such as the British Irish Council (BIC), the European Union (including the Horizontal Working Party on Drugs and the EU Drugs Agency) and the Council of Europe (Pompidou Group on Drugs), and international organisations such as the UN Commission on Narcotic Drugs (UNCND) and the World Health Organisation (WHO).

BIC is committed to reducing the harms associated with drug and alcohol use by supporting collaboration between its eight member administrations, sharing evidence and best practice, and developing effective, evidence-based policies. Under the auspices of the drugs and alcohol work sector, BIC administrations cooperate on the involvement of people with lived experience in service development, address drug use in prisons, support community action on alcohol, and facilitate peer learning on emerging issues. The Department of Health chairs the work sector on behalf of the Irish Government and hosts periodic meetings of ministers, chaired by the Minister of State for the National Drugs Strategy, to review progress and agree work priorities.

The *EU Drugs Strategy* provides the overarching framework for cooperation between member states to address the drugs situation. The EU is committed to a balanced and multidisciplinary approach, grounded in scientific evidence and underpinned by comprehensive stakeholder collaboration and engagement with civil society. Ireland should play an active role in implementing the EU strategy and associated implementation framework, especially during its presidency of the Council of the EU. Ireland will host specific conference initiatives on evidence-based drug prevention and responses to drug use for people experiencing homelessness during the Presidency.

Ireland works closely with the EUDA to garner evidence and analysis on drug-related harms, through membership of the management board and participation in the Reitox network of national focal point on drugs (via the HRB). To strengthen Ireland's preparedness to address drug-related threats, a foresight exercise should be undertaken to anticipate future trends arising from a global drugs market, which would encompass new supply routes and substances, the increased use of technology and the changing consumption patterns and demographic trends.⁷ The EUDA has agreed to work with Ireland to undertake such a study.

7. Foresight is a strategic approach that helps organisations explore and prepare for possible futures. It involves using structured methods such as horizon scanning, scenario planning and trend analysis to identify emerging issues, anticipate change and inform better decision-making today. Rather than predicting the future, foresight encourages thinking in terms of multiple possible futures, helping organisations become more resilient, innovative and proactive. See EUDA Foresight | The European Union Drugs Agency (EUDA)

Governance and implementation of the Strategy

Governance

The successful implementation of the National Drugs Strategy depends on effective collaboration, governance and coordination. There is a direct link between governance, leadership and culture, and how well the strategy is implemented and achieves its objectives. As noted by the Chairperson of the Citizens' Assembly on Drug Use, implementation will require a 'major step-change in how the state responds to drug use'.

To achieve this step-change, it is proposed to strengthen the governance of the National Drugs Strategy across three tiers of government – Government oversight and coordination; national implementation and monitoring; and regional service planning and delivery.

At the first tier, the **Cabinet Committee on Health** will be responsible for overseeing the implementation of the National Drugs Strategy.^{8,9} The remit of the Cabinet Committee on Health is to oversee implementation of Programme for Government commitments in relation to health, receive detailed on reports on identified policy areas and consider health reforms including Sláintecare, the reform of Public Health and health system preparedness for future health threats. It will also receive reports in relation to Programme for Government commitments in drugs policy.

Ministerial leadership of the National Drugs Strategy is provided by the dedicated post of **Minister of State for the National Drugs Strategy**. The Minister of State is accountable for the delivery of the National Drugs Strategy. While based in the Department of Health, the role encompasses work across Government to ensure that there is ministerial support for the strategy. An example of this engagement is the agreement between the Minister of State and the Minister for Justice, Home Affairs & Migration to implement the Health Referral Scheme with the support of An Garda Síochána, the Office of the Director of Public Prosecutions and the HSE. The Minister of State would provide updates on the national drugs strategy via the Senior Officials Group and the Cabinet Committee as required.

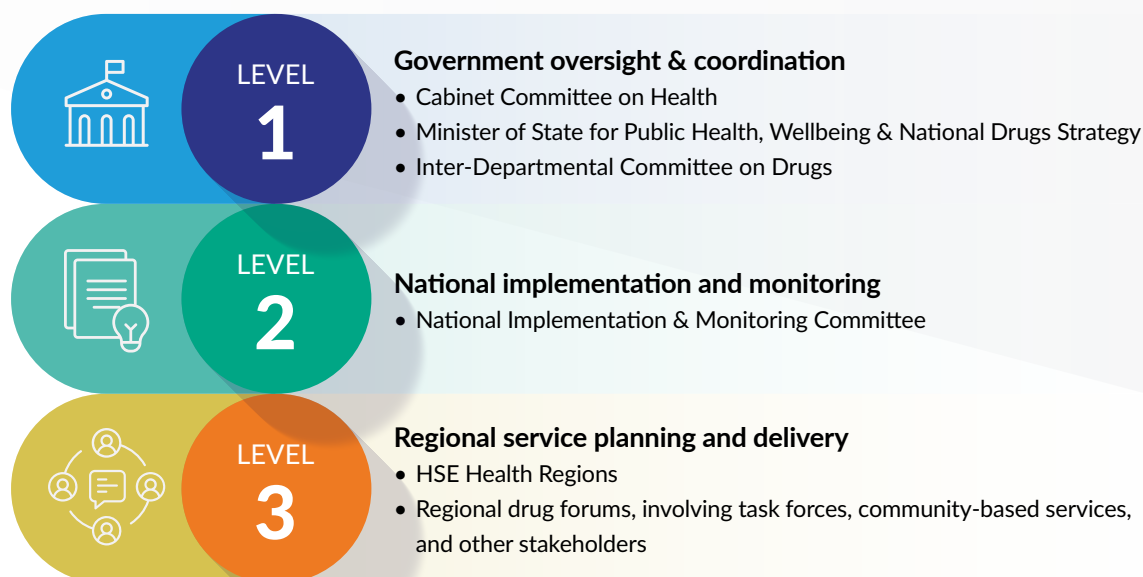
Also at the Government tier, it is proposed to establish an **Inter-Departmental Committee**, comprised of senior officials from Government Departments involved in implementing the strategy – Health, Education & Youth, Children, Disability and Equality, Social Protection, Rural and Community Development and the Gaeltacht, Justice, Home Affairs and Migration. The Health Service Executive, An Garda Síochána and other State agencies would be invited to attend the committee, as required.

8. The Cabinet Committee on Health is chaired by the Taoiseach and is attended by the Tánaiste and Minister for Finance, the Minister for Health and the Minister for Public Expenditure and Reform. The committee is supported by a senior officials' group.

9. See recommendation #3 of the Citizens' Assembly on Drug Use

The remit of the committee would be to promote interdepartmental collaboration on cross-sectoral issues impacting on drugs policy, such as housing, criminal justice or social protection. The committee would be chaired by the Minister of State for the National Drugs Strategy and would meet on a periodic basis.¹⁰

Figure 3: Tiers of governance, coordination and implementation for the strategy



The second tier of governance is the monitoring and implementation of the National Drugs Strategy. A **National Implementation and Monitoring Committee (NIMC)** would be established with responsibility to ensure the effective and timely implementation of the two-year action plan.¹¹ The NIMC will give leadership and direction to drive the implementation of the action plan. The membership should consist of government departments, Drug and Alcohol Task Forces, and community and voluntary organisations, including individuals and families with lived experience, the HSE (national lead and Health Regions), An Garda Síochána, and clinical and academic experts (covering drugs and alcohol). The committee will have an independent chairperson appointed by the Minister for a four-year term. This is to ensure continuity over the period of the strategy, to be a bridge with the diverse membership of the committee and a point of contact with the Minister of State.

The remit of the NIMC will include the publication of an annual report detailing progress in the implementation of the action plan, identifying emerging issues or risks and progress on individual departmental actions. An annual report would be submitted to the senior officials' group for the Cabinet Committee on Health, prior to its publication.¹² The committee should meet on a quarterly basis.

10. See recommendations #4 & #5 of the Citizens' Assembly on Drug Use and #5 of independent evaluation report.

11. The NIMC would replace the national oversight committee which was stood down following the completion of the previous National Drugs Strategy. It would be similar to the [National Implementation and Monitoring Committee for Sharing the Vision: A Mental Health Policy for Everyone](#) (38)

12. See recommendation #8 of the Citizens' Assembly on Drug Use

An enhanced **early warning and emerging trends committee** should be established under the auspices of the NIMC and led by the Department of Health. Other subgroups can be established to address specific issues relating to the strategy. The NIMC will have a role in the annual national drugs forum, convened by the Health Research Board (HRB), and in supporting coordination between the HRB national focal point and the European Drugs Agency (EUDA). The Department of Health will provide the secretariat support to the NIMC (NIMC Secretariat) and will prepare draft reports for approval by the committee.

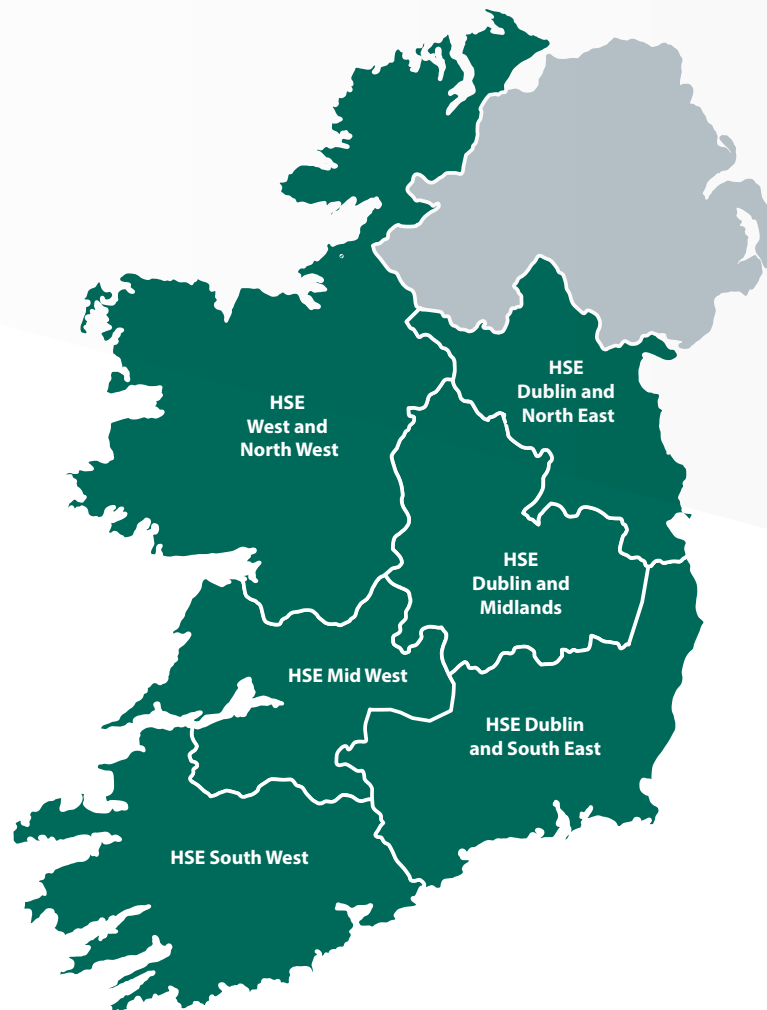
The third tier of governance will be **the HSE Health Regions**. The Government has approved the establishment of six Health Regions within the HSE to enable the equitable delivery of health and social care, in line with Sláintecare. The HSE Health Regions support a population-based approach to service planning and delivery that addresses health inequalities and have delegated budgets, and local autonomy and decision-making (39).

In line with the Sláintecare reforms, the Department of Health has mandated the HSE Health Regions to coordinate the planning, funding and delivery of drug services – HSE and community-based – in order to address disparities in treatment prevalence and to support the implementation of the National Drugs Strategy. The HSE Health Regions should ensure that the planning of drug services is aligned with population need and that population need informs the allocation of resources where additional services are required.

A core requirement is to embed an equity lens into service planning, to address geographic or social barriers to accessing services and to support peer-led and community-based services that reflect the lived experience and cultural context of local communities. Leadership of the provision of drug services in the Health Regions should be provided by a senior HSE manager and a clinical lead. The responsibilities of the HSE Health Regions for the planning, funding and delivery of drug services should include:

- Oversee existing and new funding for drug services, including community-based services;
- Engage with Drug and Alcohol Task Forces and identify opportunities for synergy and cooperation;
- Ensure clinical governance for all services and quality standards;
- Formulate strategic plans for the development of services;
- Implement a strategic workforce plan for all staff employed in drug services;
- Embed an equity lens into service planning and respond to the needs of underserved and disadvantaged communities;
- Encourage service redesign and digital transformation;
- Commission new services based on an assessment of population needs and available resources;
- Incorporate the voice of people and families with lived and living experience;
- Develop regional dashboards to monitor trends in service uptake and outcomes.

Figure 4 Map of HSE Health Regions



Following publication of the draft strategy, the Department of Health facilitated an engagement with stakeholders, including community-based services and Drug and Alcohol Task Forces, to consider the structures for the National Drugs Strategy within the HSE Health Regions. An independently facilitated three-day workshop was attended by c. 80 stakeholders. The workshop achieved consensus on principles and common ground for the design of the new regional structures to support the governance of the National Drugs Strategy in the HSE Health Regions. The workshop considered existing local and regional structures with a view to strengthening stakeholder input into health services planning, enhance the integration of community-based services within primary care and involve people with lived and living experience (7).^{13,14}

13. See recommendation #2 of the independent evaluation

14. The workshop was entitled 'A health-led response to drug and alcohol use: building a regional system that delivers for communities'. A report of the workshop deliberations will be published as a supporting document to the National Drugs Strategy. The workshop was co-produced by a planning group of stakeholders. Participants were drawn from nine stakeholder categories: Lived and Living Experience; Drug and Alcohol Task Forces; Community Service Providers; Medical Service Providers; Government Departments; HSE Medical; Justice; Education and Prevention; and Marginalised Groups and Thought Partners.

Arising from this engagement it is recommended that the Department and the HSE should now proceed to establish new regional structures (provisionally called 'regional drugs forums') based on the consensus reached on principles and common ground during the workshop. They would be independently chaired, representative of all stakeholders and underpinned by a memorandum of understanding. There would be representation from the regional structures on the NIMC (tier 2 above). The NIMC would monitor the establishment of the regional structures and conduct a formal review after two years of operation, with a view to identifying any changes in their mandate or operating procedures. Resources should be allocated to support the functioning of the regional drugs forums and the participation of stakeholders.

Action Plan

An action plan has been developed to guide and ensure delivery of the strategy for the period 2026-2028. A second plan will be developed in 2028 reflecting progress made during the initial period of the new strategy and responding to emerging trends and challenges in an agile manner.

The action plan developed using the RE-AIM Framework for 2026-2028 is available at gov.ie.

Monitoring and Evaluation

The Department of Health is committed to best practice structures, processes and systems that support the successful operation of its duties in an ethical, accountable, transparent and effective manner (40).

A review of implementation of the initial action plan for 2026-2028 will be undertaken in 2028, following which a second two-year Action Plan will be developed. The RE-AIM Framework used to develop the Action Plan for the strategy will support this review.

Core functions have been identified at each tier of the governance structure to monitor implementation of the strategy, and regular reporting of progress is envisaged to ensure timely advancement of the action plan and mitigation of emerging risks to implementation. It is anticipated that the Terms of Reference for each governance tier will include provisions for regular progress and annual reports with support from its Secretariat.

In addition, monitoring of EU and national indicators based on national trend data will be undertaken on an annual basis. See the proposed list of indicators below.

An evaluation of implementation of this four-year strategy using the RE-AIM Framework will be undertaken in 2030 with a view to informing development of a successor strategy.

EU indicators

The European Drugs Agency has chosen five epidemiological indicators to achieve its goal of providing factual, objective, reliable and comparable information on drugs and drug addiction at European level (19). These indicators underpin their reporting on trends and developments in the EU drug situation. They are also a necessary component of any analysis of the coverage of responses or the assessment of the impact of policies and actions. The five indicators are:

- Prevalence and patterns of drug use in the last year (various drugs);
- Problem drug use (injecting drug use or long duration or regular use of opioids);
- Drug treatment demand;
- Drug-induced deaths;
- Prevalence of drug-related infectious diseases among people who inject drugs.

National Indicators

A complementary set of national indicators are drawn from existing health reporting and have the capacity to be analysed at a regional level. The proposed indicators are:

- Prevalence of cannabis and cocaine use among young people aged 16-25;
- Prevalence of heavy episodic drinking (6 or more standard drinks in a single drinking occasion);
- Prevalence rate for treatment of problem drug and/or problem alcohol use (per 100,000 population);
- Individuals who have experienced drug-related violence or intimidation;
- Annual number of poisoning deaths due to the toxic effect of a drug, or combination of drugs (including prescribable drugs and alcohol);
- Annual number of people in possession of drugs for personal use who have been diverted to a health intervention;
- Annual number of people who are in or have completed treatment and are in recovery housing.

Resourcing the strategy

Currently, the Government provides in the region of €340m per annum for drug-related activities, including €174m from the Department of Health. In Budget 2025 and Budget 2026, additional resources were allocated to implement the National Drugs Strategy. It is important that existing resources are used to the maximum effect. In addition, further resources will be required to implement the National Drugs Strategy and associated action plans for the period 2026-2030. Within the health system, the HSE Health Regions are responsible for the planning, funding and delivery of treatment and harm reduction services. In the context of this strategy, each health region together with key stakeholders shall conduct a baseline assessment of needs to identify gaps and inform business case proposals for resourcing the strategy within their area.

The priorities should be threefold – first, to provide equity of access to drug services across the Health Regions, by bringing areas with lower treatment prevalence rates up to the standard of higher performing regions, while taking into account the documented relationship between treatment demand and geographic deprivation. A second step is developing a workforce plan for each health region, and a baseline assessment of the existing drug and alcohol workforce across the HSE, community and voluntary organisations and the priorities for additional staff. Third, additional funding should be provided to enhance community-based services, informed by regional planning and benchmarked by improved outcomes for those who use services.

The implementation of the actions outlined in the strategy will require additional public resources. Detailed costings will be required for the implementation of the individual actions in the action plan. In line with the growth in expenditure under the previous strategy, it is proposed that Government expenditure on drug-related activities should increase over the period 2026-2030. The composition of this increase should reflect the strategic priorities in the strategy - prevention, treatment services, recovery & social integration, services for people in contact with the justice system, and preparedness. Individual government departments and agencies will be responsible for identifying and sourcing the additional resources required to implement actions relevant to their remit.

Given the low level of resources currently allocated to prevention, it is proposed that dedicated funding is provided for prevention initiatives under the strategy. This allocation should comprise contributions from relevant government departments.

Glossary

Throughout the strategy document terminology used is aligned with [the European Union Drug Agency, Multilingual Glossary of Drug-Related Terms](#) (46). However, in the context of this strategy's vision and intent the definitions below were used for the following specific terms:

Term	Definition
Alternatives to Coercive Sanctions	Non-custodial strategies that emphasise community-based, rehabilitative, or restorative justice approaches instead of imprisonment.
Cannabinoids	Cannabinoids are chemical compounds that interact with the cannabinoid receptors in the body's endocannabinoid system. They can be: Naturally occurring in the cannabis plant (phytocannabinoids), such as THC (tetrahydrocannabinol) and CBD (cannabidiol). Produced by the body (endocannabinoids), like anandamide and 2-AG. Synthetic cannabinoids, which are man-made and designed to mimic natural cannabinoids.
Client	Service User - Any individual or group who uses, or is affected by, health and social care services
Diversion	The alternative approach taken with an individual caught in possession of illicit drugs for personal use is for An Garda Síochána to divert the person from a criminal justice approach to a health intervention approach.
Drug checking	The testing and chemical analysis of illicit drug samples.
Dual Diagnosis	HSE Model of Care defines dual diagnosis as: 'the co-morbid disorders due to substance use and/or addictive behaviours along with the presence of mental disorder(s)'. The disorders of substance use include disorders of alcohol use.
Recovery	The process of recovery from problematic drug and alcohol use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society (47).

Term	Definition
Residential treatment	Residential treatment programmes provide residential services on the same site as treatment services. The programmes generally strive to provide an environment free of substance abuse, with an expectation for compliance in a number of activities such as detoxification, assessment, information/education, counselling, group work, vocational training, and the development or recovery of social and life skills. Two main types of residential treatment are available: shorter term residential therapy (less than six months, including detoxification) and residential therapeutic community treatment (typically six to 12 months post-detoxification). Therapeutic communities are highly structured programmes focusing on the resocialization of the patient to a drug-free lifestyle, using the programme's community as an active ingredient of treatment (48).
Semi Synthetic Cannabinoids (SSC)	Are derived from the cannabis plant but altered so that they end up being chemicals that do not occur naturally. Semi-synthetic cannabinoids are mostly produced from cannabidiol (CBD) extracted from low-THC cannabis (hemp) which is similar in chemical structure of THC. An example of a typical SSC is Hexahydrocannabinol or HHC
Therapeutic community	A specialised residential treatment approach where the community itself is the primary method of change. Through shared responsibility, peer support, purposeful social interactions, and a structured group process, it drives psychological growth and recovery from drug and related problems (47).



Acronyms

AGS	An Garda Síochána
AI	Artificial Intelligence
AUD	Alcohol Use Disorder
BIC	British-Irish Council
CE	Community Employment
CYPSC	Children and Young People's Services Committees
DATF	Drug and Alcohol Task Forces
DCDE	Department of Children, Disability and Equality
DRIVE	Drug Related Intimidation and Violence Engagement
DSP	Department of Social Protection
EU	European Union
EUDA	European Union Drugs Agency
GP	General Practitioner
HBSC	Health Behaviour in School-aged Children
HED	Heavy Episodic Drinking
HHC	Hexahydrocannabinol
HRB	Health Research Board
HSE	Health Service Executive
ICAAN	Irish Community Action on Alcohol Network
IGEES	Irish Government Economic and Evaluation Service
IHA	Integrated Health Area
LCDC	Local Community Development Committee
LDATF	Local Drug and Alcohol Task Force
LEAR	Law Engagement Assisting Recovery Project
LERO	Lived Experience Recovery Organisation
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
MDA	Misuse of Drugs Acts

MDMA	3,4-Methylenedioxyamphetamine
NDS	National Drugs Strategy
NDTRS	National Drug Treatment Reporting System
NEIC	North East Inner City
NIMC	National Implementation and Monitoring Committee
NPS	New Psychoactive Substances
OAT	Opioid Agonist Treatment
OECD	Organisation for Economic Co-operation and Development
PEI	Prevention and Early Intervention
PPI	Public and Patient Involvement
RDATF	Regional Drug and Alcohol Task Force
RE-AIM	Reach, Effectiveness, Adoption, Implementation and Maintenance
ROSC	Recovery-Oriented System of Care
SAOR	Screening and brief intervention model
SCORE	Sewage analysis CORE group Europe
SSC	Semi Synthetic Cannabinoids
TARP	Treatment and Recovery Programme
UBU	UBU Your Place Your Space
UNCND	UN Commission on Narcotic Drugs
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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Appendices

Appendix 1: Non-exhaustive list of policies that intersect and overlap with the National Drugs Strategy

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The Department of Children, Disability and Equality is committed to improving support for informal kinship carers as reflected in Ireland's 2025 Programme for Government. The Department is currently in the process of developing a national policy on the rights of children living in informal kinship care. This is expected to be finalised in 2026, and this will be accompanied by an implementation plan.

Work has also commenced on the development of a National Policy on Prevention and Early Intervention (PEI). The Department of Children, Disability and Equality with funding from the Young Ireland Research Roadmap has commissioned the UNESCO Child and Family Research Centre in University of Galway to complete a scoping review of the core components and governance features of prevention and early intervention policies for children and families associated with improved outcomes. This is the first step in a complex process and Tusla and relevant stakeholders will be engaged as the work on a national policy continues.

The Department of Social Protection (DSP) aligns with the objectives of the National Drugs Strategy through the delivery of the [Community Employment Drug Rehabilitation Framework](#), which provides structured opportunities for personal development, training and progression as part of an individual's recovery journey.

The continued success of the programme is underpinned by strong collaboration between DSP, the HSE, Drug and Alcohol Task Forces, CE sponsoring organisations and community-based services, and DSP remains committed to supporting this collaborative approach.

A new whole of government, whole of society National Strategy for Improving Community Safety – *An Enabling Framework for Community Safety* – will be published by the Department of Justice, Home Affairs and Migration in late 2026. This enabling framework recognises that communities experiencing high levels of poverty and social exclusion, and by marginalised and vulnerable groups such as Travellers and people experiencing homelessness are disproportionately effected by the negative impact of issues such as drug use on community safety. A draft document was published for consultation in July 2026. Further information is available from [National Strategy for the Improving of Community Safety](#).

Appendix 2: Steering Group and Reference Group

Steering Group Membership:

- Dr Sarah Morton (Independent Chair), University College Dublin
- Cliodhna Power, Civil Society
- Pauline McKeown, Civil Society, CEO, Coolmine Therapeutic Services
- Prof. Eamon Keenan, HSE
- Brian Kirwan, HSE
- Brian Galvin, Health Research Board
- Prof. Paul Griffiths, National Drug Research Institute, Curtin University, Perth.
- Prof. Edward Day, University of Birmingham & National Recovery Champion UK
- Máire Flanagan, Department of An Taoiseach
- Mary O'Regan, Department of Justice, Home Affairs and Migration
- Jim Walsh, Department of Health

Terms of Reference

Develop a draft National Drugs Strategy for the approval of the Minister for State for Public Health, Wellbeing and National Drugs Strategy which will set out the vision and implementation of a cross sectoral plan to address issues pertaining to the prevalence and use of drugs, which also includes problematic alcohol use.

- Having regard to the Programme for Government Securing Ireland's Future 2025, the Interim Report of the Oireachtas Committee on Drug Use, the report of the Citizen's Assembly, Sláintecare, and The Path to Universal Healthcare Sláintecare 2025+, prepare a finalised draft National Drugs Strategy that will ensure people with illicit drug and problematic alcohol use, receive the right healthcare at the right time in the right place.
- Develop a suite of Strategic Pillars to provide a framework for the National Drugs Strategy.
- Develop a timebound, task orientated action plan of key priorities, milestones, associated costs, and owners.
- Agree and detail structures to ensure implementation of the new strategy including arrangements for review and evaluation.
- Develop appropriate outcome measures and key performance indicators to assess the future effectiveness of the new strategy.
- Reflect best available evidence and incorporate the relevant learnings from:

- The Independent Evaluation of Reducing Harm, Supporting Recovery, National Drugs Strategy 2017;
- Independent Stakeholder Consultations conducted on behalf of the Department of Health on the effectiveness of the current strategy and considerations for the new National Drugs Strategy;
- HRB reports on drug and alcohol use, data analysis and learnings from other jurisdictions, including on early warning systems for emergent drug challenges.
- The Citizen's Assembly on Drug Use; and
- Developments in the EU Drugs Strategy and Action Plan.

Reference Group

A Reference Group will be established to support the work of Steering Group, established by Minister of State Jennifer Murnane O'Connor, to develop the new National Drugs Strategy, to make sure decisions are informed by real-world knowledge and lived experience.

Membership of the Reference Group is as follows:

- Pauline McKeown (Chair) National Voluntary, Drug and Alcohol Sector and CEO Coolmine Therapeutic Community
- Catriona Kirwan, Carlow Family Support Group and Lá Nua
- Julie McKenna, NOVAS
- Anne Marie Sweeney, New Communities and Traveller Outreach Service, Coolmine Therapeutic Community
- Joe O'Neill, Western Region Drug and Alcohol Task Force
- Antoinette Kinsella, DRIVE Project
- Gordon Kinsley, Irish Community Action on Alcohol (ICAAN Network)
- Riona Greene, South East Region Family Support Network
- Paul Delaney, Cornmarket Community Drug Project
- Prof. Samantha Dockray eSHIELD, University College Cork,
- Laura O'Reilly, Ballyfermot Star
- Richard Healy, Service User Rights in Action (SURIA)
- Damien Quinn, Spéire Nua
- Barbara Ozga, CKU Centre for Counselling and Therapy
- Aisling Egan, Focus Ireland

Appendix 3: Key inputs which informed the Strategy

Extensive stakeholder engagement and collation of evidence have been undertaken to inform the development of the successor National Drugs Strategy. In particular the strategy has drawn on the following sources:

Evaluation of Reducting Harm, Supporting Recovery, the National Drugs Strategy 2017-2025

An [independent Evaluation of the National Drugs Strategy Reducing Harm; Supporting Recovery \(2\)](#) was commissioned. Over the course of this evaluation process, **68 stakeholders participated** in consultation sessions with Grant Thornton, with an additional five formal written submissions received. This inclusive process aimed to capture a broad spectrum of perspectives, including those of **service providers, statutory bodies, civil society organisations, and individuals with lived experience**.

The evaluation assessed the National Drugs Strategy (NDS) on four domains: *Impact, Governance, Performance and Coherence with international policies*. The publication, which shows positive results across all areas, delivers on a commitment in the Programme for Government.

- On *impact*, the evaluation finds the NDS has made notable progress in advancing a health-led approach, particularly through the expansion of harm reduction initiatives such as naloxone distribution, needle exchange programmes, and drug-checking services.
- On *governance*, the evaluation reports the introduction of strategic implementation groups and strengthened interagency collaboration at the local level as key achievements. These developments facilitate more responsive and context-sensitive service delivery.
- On *performance*, the evaluation states that the NDS has contributed to improved data collection and monitoring. Cocaine was the most common main problem drug reported for drug treatment cases in 2024, indicating the changing profile of drug users and how prevalent cocaine use has become in Irish society.
- On *international cooperation*, the evaluation concludes that the NDS is well-aligned with international frameworks, particularly the EU Drugs Strategy and Action Plan on Drugs 2021–2025 (29-30) and demonstrates strong engagement in multilateral drug forums. Ireland's contributions to early warning systems and international research initiatives are commended.

The review contains **10 strategic recommendations** with the aim of guiding the next phase of strategic development, ensuring a coordinated, equitable, and outcomes-focused response to drug use in Ireland:

1. Improve the *right to health* for people who use drugs, providing culturally sensitive and appropriate services for all groups.
2. *Increase community engagement and involvement from people who use these services*, ensuring that they are central to policymaking and service design.
3. *Align service delivery with regional priorities*, working with Health Regions to ensure that the implementation of a future drugs strategy and allocation of resources are appropriate to the local population needs.
4. *Maintain and strengthen coordination and communication* between the oversight structures of the National Drugs Strategy.
5. *Establish mechanisms for interdepartmental collaboration*, reflecting the need for systemic alignment across housing, justice and health sectors.
6. Continue to strengthen alternatives to coercive sanctions for those found in possession of drugs for personal use, such as the Health Diversion Scheme and community liaison roles.
7. *Ensure equitable access to peer-led recovery services* and develop national standards for recovery pathways.
8. *Strengthen prevention and early intervention initiatives* across sectors.
9. *Strengthen the integration of alcohol within the National Drugs Strategy*, rolling out integrated treatment services to enhance service delivery.
10. *Invest in monitoring, evaluation and research systems* to support evidence-based policy and accountability.

Independently Facilitated Stakeholder Consultations 2025

To inform the new strategy the Department undertook a consultation process with key stakeholders. A report on the consultations was published in October 2025 and is available at [Independently Facilitated Stakeholder Consultations 2025](#) (15). The consultations involved the organisation of seven workshops and interviews. Unsolicited materials received were also reviewed and included as part of the consultation process.

The series of in-person and online consultations involved 241 people including; members of the National Drugs Strategy's National Oversight Committee, Drug and Alcohol Task Forces, Health Service Executive (HSE) Addiction Managers, Individuals and families with lived and living experience, Civil society representatives and service providers, along with prevention and education stakeholders. The report from the consultation process was carefully considered by the Steering Group and the Reference Group.

These consultations were designed to identify learnings from the current National Drugs Strategy and to collect insights to help shape the successor strategy, ensuring that it is reflective of and responsive to the needs of those with direct and indirect experience of problematic drug and alcohol use.

The consultations covered a range of themes including the strategic priorities for the new strategy, the planning and delivery of drug services in the HSE Health Regions, the lived and living experience of people who use drugs and their families, the development of the drugs workforce, and drug prevention.

Several areas of progress under the current strategy were highlighted, including the increase in bed numbers in residential addiction centres and the positive role of the addiction services workforce, who are viewed as client-focused, experienced and skilled, with strong HSE clinical governance. The operationalisation of Ireland's first medically supervised injecting facility was also praised, along with the work on emerging drug trends.

Participants were also positive about increased levels of engagement with people who use drug treatment services, and those with lived experience, as part of the current strategy, but highlighted the need for stronger engagement with community-based service providers in order to build local knowledge about new and emerging drug use trends.

Areas of concern included a perceived insufficient focus on prevention and a lack of appropriately skilled prevention workers in each Task Force to deliver prevention initiatives. Participants also highlighted gaps in services in certain areas, financial barriers to accessing some treatment centres and clinics, long waiting lists, as well as gaps in services for children and young people.

In considering the requirements under the successor strategy, participants highlighted the need for those with lived and living experience to be involved in both its development and its implementation and called for a national framework to support this involvement. The report also includes recommendations for an increased focus on prevention, enhanced services and supports for young people and their parents, increased digitalisation of services and an increased focus on alcohol.

Public Consultation

The main findings of the public consultation on the National Drugs Strategy are:

- 87% of respondents strongly agreed or agreed with a health-led approach to drug use
- Between 72% and 79% strongly agreed or agreed with the vision and principles in the National Drugs Strategy
- 71% strongly agreed or agreed that the strategic pillars were a comprehensive response to drug and harmful alcohol use, with between 69% and 78% strongly agreeing or agreeing with the five individual pillars
- 68% strongly agreed or agreed that the enabling measures help to create the conditions for the effective delivery of the National Drugs Strategy

- There is strong support for the involvement of those with lived and living experience in the design and implementation of the strategy
- The health system, families and communities, and society are all considered to be best placed to support the implementation of the strategy
- Other issues highlighted were the delivery of the National Drugs Strategy, the legal framework on drugs, and the role of community-based services and drug task forces.

Overall, the findings point to a high level of support for the strategy and the strategic priorities therein. In addition, there is an expectation that the strategy should be effectively delivered, locally responsive, and grounded in lived and living experience.

Citizens' Assembly on Drug Use

The Report of the Citizens' Assembly on Drugs Use (3) was published in January 2024. It made 36 recommendations across the themes of Government prioritising response to harmful impacts of drug use, a health-led approach, development of the successor National Drugs Strategy, stakeholder involvement in decision making, family support, attention to marginalised and disadvantaged groups, security and justice responses, focus on prevention, wellbeing and recovery, harm reduction, along with development of research and evidence, and funding. The full report and recommendations are available at [Citizens' Assembly on Drug Use](#)

Ireland pledged a commitment "to carefully consider and respond with urgency to the assembly's recommendations for reform of the legislative, policy and operational approach to drug use, and to indicate the timeframe for implementing the recommendations which it accepts" at the 67th Session of the Commission on Narcotic Drugs.

The Department of Health has engaged with seven Government Departments and the HSE to formulate the government response to the 36 Citizens' Assembly on Drug Use recommendations. The Government response to the recommendations is incorporated in this National Drugs Strategy. A Memo to Government has been prepared to approve the government response.

Joint Committee on Drug Use

- The Joint Committee on Drug Use was established by the Oireachtas to consider the recommendations set out in the Report of the Citizens' Assembly on Drug Use and to provide a reasoned response to each recommendation. It produced two reports – an interim report in October 2024 (16) and a final report in June 2026 (5). The Joint Committee agreed with 33 of the 36 recommendations of the Citizens' Assembly and made observations on the remaining three. The Joint Committee made a further 161 recommendations in its final report, building on the Citizens' Assembly recommendations and the recommendations of its Interim Report.

- The recommendations of the Joint Committee cover a wide range of topics, including family & community supports, kinship care, sports & wellbeing, neurodiversity, emerging trends, legal & policy issues, and services for young people and women. The recommendations have been carefully considered in finalising the National Drugs Strategy. Most have been incorporated into the two-year action plan. These include family and community supports; drug prevention; development of drug services for women, minority groups and people with disability and neurodiversity; stigma; the Health Referral Scheme; control over the sale and marketing of nitrous oxide and other illicit products.
- Other recommendations require further consideration by government departments, especially where they relate to policies that are currently outside the scope of the National Drugs Strategy. The full report is available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/34/joint_committee_on_drugs_use/reports/2026/2026-06-24_final-report_en.pdf

An Exploration of the Relationship Between Addiction Treatment and Geographic Deprivation

This report on the relationship between addiction treatment and geographic deprivation (18) has demonstrated the strong relationship between area-based disadvantage and addiction treatment episodes: living in a deprived area is strongly associated with use of drug and alcohol treatment services. The relationship becomes more pronounced as area-based deprivation increases, with the highest rate of treatment episodes seen in the most deprived areas.

The rate of addiction treatments in the most disadvantaged areas is 13 times higher than in the most affluent areas.

For certain drug types the relationship is more pronounced. Heroin treatment is 41 times more prevalent in disadvantaged areas compared with the most affluent areas. The pattern of higher treatment rates in more disadvantaged communities holds across every deprivation band and across every drug type.

The relationship between deprivation and treatment is weakest for alcohol, although rates are still 7.5 times higher in the most deprived areas compared with the most affluent ones.

The relationship between deprivation and addiction treatment was most apparent in urban settlements, particularly cities, and much less pronounced in rural ones. The full report is available at [Addiction Treatment and Geographic Deprivation Report 2025](#)

Public consultation

A public consultation was undertaken on the draft National Drugs Strategy. Over 320 individuals and organisations engaged with the online consultation. The findings from the public consultation highlight strong support for the health-led approach to drug use and the vision and priorities set out in the strategy:

- 87% of respondents strongly agreed or agreed with a health-led approach to drug use.
- Between 72% and 79% of respondents strongly agreed or agreed with the strategy's vision and principles.

- 71% strongly agreed or agreed that the strategic pillars provide a comprehensive response to drug and harmful alcohol use, with support for the five individual pillars ranging from 69% to 78%.
- 68% strongly agreed or agreed that the enabling measures help create the conditions for effective delivery of the National Drugs Strategy.

Other issues highlighted were the delivery of the National Drugs Strategy, the legal framework on drugs, and the role of community-based services and Drug and Alcohol Task Forces. Overall, the findings point to a high level of support for the strategy and the strategic priorities therein. In addition, there is an expectation that the strategy should be effectively delivered, locally responsive, and grounded in lived and living experience. The full report is available at [Report of the public consultation on the National Drugs Strategy 2026-2029](#) (6).

Engagement process on stakeholder engagement in the National Drugs Strategy in the new HSE Health Regions

With a view to strengthening stakeholder input to the National Drugs Strategy within the HSE Health Regions in matters including health service planning, integrating community-based services within primary care and involving people with lived and living experience, an independently facilitated engagement process was undertaken with stakeholders, including community-based services and Drug and Alcohol Task Forces. Participants agreed on the values and principles that should underpin the new structures: a genuinely whole-system, health-led (not “health only”) approach; prevention treated as a resourced, upstream priority rather than an afterthought; equity of access through a “no wrong door” model; a recovery-oriented system with clearly communicated pathways; and foundational values of dignity, respect, human rights and stigma eradication, with explicit commitment to paid, non-tokenistic roles for people with lived and living experience.

Participants translated these principles into practical designs for the new regional structures, incorporating the following features:

- an independently and transparently appointed chair;
- a broad regional forum bringing together statutory bodies, task forces, community and voluntary providers and lived-experience representatives;
- clear accountability from the regional executive officer up to national mandate and the Minister;
- sub-groups covering prevention, treatment and recovery;

- and deliberate integration with, rather than duplication of, existing local structures such as Task Forces, Local Community Development Committees (LCDCs)¹⁵ and Children and Young People's Services Committees¹⁶ (CYPSC).

The strength of this convergence is itself one of the most significant outcomes: it indicates a genuine, durable consensus on how diverse stakeholders want to work together to address the harms of drug and alcohol use in a collective manner. A report on the engagement will shortly be published (7).

EU Drugs Strategy

The EU Drugs Strategy 2026-2030 and associated implementation framework (12, 13) sets out a coordinated EU response to current and future drug-related challenges which was approved by the Council (Justice and Home Affairs) on 5 March 2026. Subsequently, the implementation framework for the strategy was approved in Council (Justice and Home Affairs) conclusions on jointly operationalising the EU Drug Strategy on 4 June 2026. The EU Drugs Framework is based on a multi-dimensional and whole-of-society approach across five pillars (12, 13).

The development of the National Drugs Strategy has sought to align with the EU strategy, in particular to incorporate the following actions:

- Developing national preparedness and response measures;
- Stepping up universal and environmental health prevention;
- Strengthening the availability of evidence-based treatment options integrated in a continuum of care;
- Promoting the integration of people who use drugs and the availability of alternatives to coercive sanctions;
- Increasing the availability of harm reduction interventions;
- Enhancing EU coordination and engagement with civil society.

The EU Strategy also contains measures to tackle drug trafficking and to combat the production of synthetic drugs, which are the responsibility of the Department of Justice, Home Affairs & Migration.

Under the Presidency of the Council of the European Union, Ireland has a leadership role in the delivery of the implementation framework for the EU drugs strategy.

15. Local Community Development Committees (LCDCs) are groups established in each local authority area. An LCDC is made up of members of the local authority; local authority staff; people from public bodies who provide funding to the area; people from the local community interests; people from the local community (nominated through Public Participation Networks); people from publicly funded/supported local development groups. LCDCs draw on the expertise and experience of public and private people and organisations in each local authority area.

16. Children and Young People's Services Committees (CYPSC) are a key structure identified by Government to plan and co-ordinate services for children and young people in every county in Ireland.

Appendix 4 Psychoactive Substances, cannabis, cocaine, and other emerging trends

New Psychoactive Substances (NPS)

An NPS is a new narcotic drug its pure form or in a preparation, many of which mimic the most common illegal drugs, namely cocaine, ecstasy, amphetamine, and cannabis. Ireland monitors these drugs through the Early Warning and Emerging Trends network, which has reported 30 new NPS to EUDA since 2025. In 2025, 34 NPS were identified in Europe, 12 of which were semi-synthetic cannabinoids. These drugs are often found with plant-based drugs in seizures and there is no clear separation between them in the market. From the mid-2000s, the quantity, type, and availability of novel substances increased dramatically in Europe. Synthetic opioids, such as nitazenes, are often sold as falsified medicines or mixed with heroin and represent a particularly dangerous threat to public health, such as occurred during the overdose clusters in Dublin in 2023 and 2024. These drugs can be manufactured relatively easily and are easier to transport than heroin because of their high potency. They are likely to become a prominent feature in the drugs market as poppy cultivation in Afghanistan continues to decline and heroin becomes scarcer. Restrictions on nitazene production in China, agreed in 2024, have been a factor in the emergence of new opioid families, such as 'orphines', which have been detected in five European countries.

Cannabis

Stability of cannabis, in prevalence, but increase in hospital admissions / mental health issues

Cannabis is Europe's most commonly consumed illicit drug. The potency of both its herb and resin forms have increased substantially over the past number of years, and the drug is widely available in high-potency extracts and edibles, presenting particular response challenges. Findings from the 2023 Health Ireland survey (42) revealed that 24.1% of the population (aged 15–64 years) had used cannabis at some point in their lives; 7.4% reported use in the year prior to the survey and 3.4% in the preceding month. Treatment demand figures show that cannabis was the third most common main problem drug (reported by 17%) in 2024. Among cases aged 19 years or under, cannabis was the main drug consumed (43).

Semi-synthetic cannabinoids

The rate of increase in new synthetic cannabinoids detected in Europe began to decrease following controls in production in China in 2021. However, new semi-synthetic cannabinoids, such as hexahydrocannabinol (HHC), have emerged since then. HHC was formally identified in Ireland in 2023. In 2024, one-third of drug users aged 18 and older had used HHC in the last year, and 169 treatments were reported to the NDTRS where HHC was recorded as main or additional problem drug. In July 2025, HHC was formally controlled with an amendment to the MDA (43).

Cocaine

Cocaine is Europe's most commonly consumed illicit stimulant drug, used by around 1.6% (4.6 million) of European adults in the last year (19). Between 2023 and 2024, cocaine residues in municipal wastewater increased in over half of European cities participating in the Europe-wide network SCORE (19). Cocaine is the most frequently reported substance by those presenting to hospital emergency departments.

Prevalence of cocaine use in Ireland increased from 2010 to 2020 but appears to have stabilised. However, Ireland has the second highest prevalence of cocaine use among 15-34-year-olds in Europe (44). Analysis of data from the Growing up in Ireland showed that 4% of 17-year-olds and 23% of 20-year-olds used cocaine in the last year (45). In 2024, cocaine was the most common drug reported by treatment entrants accounting for 40% of all cases (23). Cocaine-related hospitalisations, deaths and treatment entrants have increased significantly in Ireland since 2013. (44). Ireland's wastewater data from 2025 showed that cocaine was the most commonly detected substance.

Crack cocaine: rise in prevalence

Between 2023 and 2024, the treatment demand for crack cocaine in Ireland increased by 11%. Treatment demand trends also indicate that crack use among people who use opioids is increasing. Crack cocaine use among opioid users can contribute to persistent opioid use and worsen the health and social consequences of opioid addiction. Both cocaine injection and the use of crack cocaine are reported in a growing number of countries. In 2023, there were an estimated 9,800 crack-related treatment entries (8,100 in 2022).

Opioids

In 2022, there was an estimated 19,460 problematic opioid users in Ireland, and this has remained stable since 2014 (53). There was a significant decrease between 2014 and 2022 in the estimated number of problematic opioid users aged 15-24 years and aged 25-34 years while the number of those aged 35 years and over has increased. The majority of problematic opioid users live in County Dublin, are male, and are aged 35-64 years. The proportion of treatment demand attributable to opioids has decreased year-on-year since 2017 (from 45% in 2017 to 25% in 2024).

Appendix 5 Drug markets and seizures

In 2023, the United Nations Office on Drugs and Crime (UNODC) reported that the global cocaine supply was at a record high, cultivation of cocaine doubled between 2013 and 2017, peaked in 2018, and rose sharply again in 2021 (22). In 2023, 419 tonnes of cocaine were seized in the European Union (EU); the seventh consecutive year that seizures exceeded previous records (49).

In 2024, cannabis herb was the most prominent drug analysed by Forensic Science Ireland (n=6118), followed by cocaine (n=3085), alprazolam (n=799) and diamorphine (n=719)(50). Cannabis-type seizures (n=6807) accounted for over 48% of all drug seizures in 2024.

The number of heroin seizures analysed decreased annually between 2022 and 2023 (47%) and a smaller decrease between 2023 and 2024 (17%). Similarly, the number of cocaine seizures analysed decreased annually between 2022 and 2023 (22%) and a very small decrease is evident between 2023 and 2024 (1.6%). There has been a 620% increase in the number of cocaine seizures between 2003 and 2022 (from 566 to 4,020) (51).

The most important stimulant analysed other than cocaine was MDMA (n=543), followed by amphetamine (n=161) and methylamphetamines (n=56). Ketamine was the most prominent hallucinogen accounting for approximately 73% of seizures analysed in this category.

NPS seizures have been decreasing since 2022 (n=636). In 2024, the number of NPS substances analysed was 62% lower than 2022 figures. The most prominent NPS figure in 2024 was Bromazolam (n=57), accounting for nearly 24% of seizures analysed in this category. Drug use among children and adolescence

Alcohol and cannabis are the substances most commonly used by children in Ireland (under 18s). The 2022 Health Behaviour in Schoolchildren (HBSC)(52) survey of 9,071 children aged 10-17 years found that 13% of 15-17-year-olds had used cannabis in the last year while 42% of 15-year-olds had started to drink alcohol and 24% had ever been drunk. Other drug use does not typically commence until adulthood. Data from the Growing up in Ireland cohort shows that among 17/18-year-olds, 30% have used cannabis, while just 4% have used cocaine and 4% have used ecstasy.

In Ireland, age at first alcohol is an important predictor of substance use in early adulthood. Early alcohol use in Ireland is common, with 27% reporting use aged 14 or younger. Of those who started drinking by the age of 14, 35% were using cannabis at age 20 and 50% were using other drugs. In comparison, among those who didn't commence drinking until age 17 or who did not drink alcohol at all, just 10% used cannabis at age 20 and 8% used other drugs. By age 20, 14% reported high-risk alcohol, 38% tobacco, 24% cannabis and 28% other drug use.

Appendix 6 Drug-related public expenditure

Labelled and unlabelled drug-related expenditure

Labelled drug-related expenditure is ‘the ex-ante planned public expenditure made by general government in the budget that reflects the public and voluntary commitment of a country in the field of drugs. In addition, it is any expenditure identified as drug-related in public accountancy documents’ (57). Unlabelled drug-related expenditure is the ‘non-planned or non-publicly announced ex-post public expenditure incurred by the general government in tackling drugs that is not identified as drug-related in the budget’. This would include, for example, the cost incurred for the imprisonment of people for drug-related offences (57).

Table 1 provides a summary of Ireland’s labelled drug-related expenditure since 2014. Labelled expenditure is reported by each Government Department or agency to the Drugs Policy and Social Inclusion Unit, Department of Health and supplied to the Health Research Board for inclusion in its national report on the drugs situation to EUDA.

The total labelled expenditure in for 2024 was €338,056,069. In 2021, Irish Government Economic and Evaluation Service staff based in the Department of Health, completed a focused policy assessment which attempted to estimate unlabelled drug expenditure (41). The report used a special technique to identify the proportion of prison and acute hospital costs that are attributable to drugs, as well as social costs from premature drug-related deaths. The authors described the work as an effort to characterise, rather than precisely estimate unlabelled expenditure and productivity costs.

There are limitations in the reporting of expenditure data which prevent it from being a more definitive account of changes in labelled expenditure over the period. For example, changes in the parameters of what is reported year on year by some sources makes it difficult to make comparisons across the period. Since 2018, An Garda Síochána has only reported on the cost of expenditure at the Garda National Drugs and Organised Crime Bureau, rather than all the organisation’s drug enforcement activity. Drugs may account for just part of certain activities, such as Department of Education and Youth’s UBU Your Place Your Space youth programme, which are included in drug-related labelled expenditure.

The complexity of the data can be illustrated by the context provided by the HSE for its figure for 2024. The 2024 full year spend is based on consolidated financial information available through the HSE general ledgers for Social Inclusion. Where the funding covered more than one target group (for example addiction, homelessness, migrant health, etc.), ‘best fit’ was applied and expenditure aligned to one specific area. It includes treatment and rehabilitation services provided to drug users recommended through RDATA/LDATA. Not included is expenditure in the other areas of the HSE that provide services in relation to addiction including acute hospital services and emergency departments, health and wellbeing, mental health, primary care services, and GPs providing frontline services. Attributed budgets are not available for addiction within these areas.

Table 1 Public Expenditure directly attributable to drug programmes (labelled), (2017-2024)

Government Department/ Agency ¹	2017 € million	2018 € million	2019 € million	2020 € million	2021 € million	2022 € million	2023 € million	2024 € million
HRB	0.756	0.786	0.786	0.883	1.058	1.087	1.515	1.852
HSE Addiction Services	97.87	99.828	103.419	105.653	116.833	141.427	154.788	166.561
HSE DATF	22.140	22.630	22.920	22.436	23.092	-	-	-
An Garda Síochána ²	47.000	14.250	13.170	13.218	12.557	12.262	13.598	14.742
Department of Children, Disability, and Equality	20.040	20.460	20.460	39.400	39.609	42.997	46.194	47.591
Department of Justice, Home Affairs and Migration	7.300	6.950	-	7.688	-	9.775	10.312	13.329
Revenue Customs Service	17.36	19.600	-	16.554	19.103	20.668	51.5	62.777
Department of Social Protection (former FÁS area)	17.980	17.220	20.070	20.789	20.261	19.526	20.718	23.292
Department of Health	5.540	6.015	5.955	5.974	4.746	4.989	5.434	5.370
Irish Prison Service	4.200	-	-	-	-	1.507	1.504	1.986
Department of Education and Youth	0.760	0.760	0.720	0.319	0.187	0.193	0.154	0.145
Department of Further and Higher Education, Research, Innovation and Science	-	-	-	0.289	0.250	0.269	0.338	0.411
Total ³	240.95	208.499	187.500	233.203	237.696	254.700	306.055	338.056

1. The Government Department or agency's name in September 2025 is listed here.

2. After 2017, An Garda Síochána moved from reporting on 'policing/investigation costs' to 'policing/investigation costs of Garda National Drugs and Organised Crime Bureau' only.

3. Changes in year totals may be attributed to changes in reporting methods of expenditure data by some agencies/departments, rather than changes in expenditure per se. Figures are rounded up to three decimals.







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