

**Alcohol  
Treatment  
Services:  
A snapshot  
survey  
2021**



**AlcoholAction**  
Ireland

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## Foreword

Alcohol Action Ireland, the national independent advocate for reducing alcohol harm, is pleased to present this report, Alcohol Treatment Services – a snapshot survey. This report is based on a survey of mainly residential alcohol treatment service providers. Residential services are just one element of the continuum of alcohol treatment services which ranges from the provision of information and brief interventions, outpatient treatment provision in the community, detoxification services to residential facilities. People receiving treatment in residential services account for over a third of treatment cases annually. Around half of all residential providers took part in the survey as well as a small number of community providers. The report explores some issues around the provision of treatment services for harmful and dependent drinkers in Ireland.

This report is the start of a programme of work from Alcohol Action Ireland around its strategic goal to advocate for services for those affected by alcohol harm as outlined in its strategic plan, *Leading Change: A Society Free from Alcohol Harm Strategic Plan 2020—2024*.<sup>1</sup>

It is well documented that there is a high level of alcohol consumption in Ireland and a significant level of harmful and dependent drinking. Almost half of all drinkers do so in a hazardous and harmful way and there are an estimated 250,000 people with alcohol dependency problems.<sup>2</sup> With such numbers it is important to examine the provision of alcohol treatment services particularly in the light of a changing landscape around treatment and the increased understanding of the nature of childhood trauma and its lifelong impact.

From our early exploration of these matters we believe a public discussion on these proposals could advance a better understanding of how Ireland could enhance the provision of treatment services.

The work was informed by a consultation with stakeholders from the National Voluntary Drug and Alcohol Sector (NVDAS) and a sub-committee made up of experts from the Alcohol Action Ireland Board of Directors.

We would like to thank all the survey participants for their valuable contributions. While just a small number of community alcohol services took part in the survey, their insight is very much appreciated.

The authors of this report regret that the voices of service users have not been heard as part of this project, but it was beyond the scope of this exercise to facilitate this process, not least due to the impact of COVID-19.

AAI hopes to build on this work in the future and hear from others in the alcohol treatment sector in order that all voices can contribute to the improvement of services.

1 Available at: [https://alcoholireland.ie/download/publications/21155\\_AAI\\_Strategic\\_Plan\\_v6\\_web%25E2%2580%25A2.pdf](https://alcoholireland.ie/download/publications/21155_AAI_Strategic_Plan_v6_web%25E2%2580%25A2.pdf)

2 Mongan D, Millar SR, O'Dwyer C, et al. Drinking in denial: a cross-sectional analysis of national survey data in Ireland to measure drinkers' awareness of their alcohol use *BMJ Open* 2020;10:e034520. doi: 10.1136/bmjopen-2019-034520

## Executive summary

Alcohol Action Ireland carried out a survey of mainly residential alcohol treatment services and with the analysis of this data and the findings of a brief desktop research programme, a series of recommendations around alcohol treatment are proposed.

The survey consisted of one-to-one interviews with representatives from 11 treatment providers – 8 residential services from across the country (about half of all residential treatment services) and three community-based services. The treatment providers surveyed for this report worked with approximately 2000 people in 2019.

This is a self-reported figure based on the survey question: how many people did you treat in 2019. For 2019, HRB data recorded 7,546 treatment episodes for alcohol treatment, over half (54.2%) of cases were treated in outpatient facilities, while more than one-third of cases (37.2%) were treated in residential settings - classified as any service where the patient stays overnight - i.e. includes inpatient detoxification, therapeutic communities, respite and step-down facilities.

Based on the qualitative data collected, this report highlights a number of issues in relation to the challenges facing alcohol treatment providers.

The themes of this report, set out in section 3.0, are:

- Mental health & trauma
- Reducing the impact on children and families
- Gaps in services
- Barriers to treatment

What was notable from the results was the similarity of issues that emerged among the service providers. This is even more illuminating given the breadth of the populations that service providers support, from homeless people to 'high functioning' working people with alcohol problems.

Each of the service providers surveyed spoke about the unmet mental health needs they see in people coming to their services, including anxiety, depression and other serious mental health problems. All of the services also recognised trauma in the client population though there were differing views on how best to address this. A number of service providers noted the intergenerational patterns that are all too often a feature of people with substance misuse problems. Gaps in service provision were also highlighted and there was a consistent view among providers for more detoxification facilities, better access to alcohol treatment and more aftercare once treatment ends.

There was also unanimity for greater recognition at government level that alcohol is the most prevalent drug of choice causing the most harm in Ireland, yet the funding, services and policy interventions required are inadequate to deal with the scale of the problems presenting.

Based on the insight provided by service providers and looking to national policy and international best practice, the central recommendations from this report are:

## Executive summary

### KEY RECOMMENDATIONS:

- A national strategy setting revised national standards and promoting best practice should be developed and implemented for residential services. Services should be person-centred and trauma-informed and should be monitored by the Health Information and Quality Authority – HIQA like other residential health care services in Ireland.
- Addiction services must have the skills and resources to respond to the mental health needs of clients with responses tailored to the needs of each individual. This could include undertaking a national training needs assessment, providing information on training already available through the HSE, and giving staff time to take up training as required.
- Recognising the known impact of the adverse childhood experience of problem parental alcohol use, treatment interventions should seek to reduce the impact of alcohol harm on children & families. This would involve a greater emphasis on working with family members as clients in their own right rather than as adjuncts to the client presenting with the addiction.
- Access to residential services for women with children must be improved. A mapping exercise could be undertaken to quantify the need for residential placements for pregnant and postnatal women who need in-patient treatment for addiction across the country.
- Greater investment is required to ensure that services are adequately staffed and access to alcohol services across the country should be improved, including detoxification and aftercare services.
- A comprehensive third level course should be developed to train people to work in specialist substance use services. Modules in substance misuse should be provided in counselling training courses to enable trainees to develop a speciality in addiction counselling.
- Government must recognise that alcohol as a drug is the most significant vector of harm to people, and others, in Ireland. Recognition of this reality could see commensurate funding and attention applied to alleviate a largely avoidable problem.

## 1.0 Introduction

In Ireland, alcohol remains the main problem drug for which people seek treatment, with approximately 7,500 cases of treatment reported to the HRB in 2019. These cases were made up of people seeking various different types of therapeutic interventions, based on individual needs, from a comprehensive assessment to aftercare with counselling as a core skill in all interventions. In 2019, over half of cases were treated in outpatient facilities, while more than one-third were treated in residential settings (2,806 cases).<sup>3</sup>

Current national policy, Reducing Harm, Supporting Recovery, emphasises a health-led response to drug and alcohol use in Ireland, based on providing person-centred services that promote rehabilitation and recovery.<sup>4</sup> Addiction services as provided in Ireland are referred to in terms of tier one, tier two, tier three and tier four (see figure 2). The Four-Tier Model of Care states that clients should be offered the least intensive intervention appropriate to need.<sup>5</sup> Where lower tier levels of care have not been successful, more intensive interventions should be offered. A key element of the services user's rehabilitation (including treatment and aftercare) is that an integrated pathway approach is taken in the provision of services across HSE and all other statutory and voluntary sectors. Cohesive pathways and care planning should essentially ensure that people can access the supports they require and move seamlessly from one service to another.

Residential treatment is delivered in a range of public, private and community settings including hospital-based programmes to residential centres that are privately-run through charitable and religious based treatment services. The services are provided by approximately 20 organisations, and are located in facilities throughout Ireland. (See Appendix 1 for the full list of residential services that receive public funding, some are for illicit drugs only, and are located in facilities throughout Ireland.)

According to HSE data,<sup>6</sup> current provision of all addiction residential treatment beds stands at 793 residential beds, comprising 19 inpatient unit detoxification beds, 127 community-based residential detoxification beds, 4 adolescent residential detoxification beds, 625 residential rehabilitation beds and 18 adolescent residential beds. These figures serve all addictions – alcohol, drugs and gambling. It is not known how many beds within each facility are allocated for alcohol treatment.

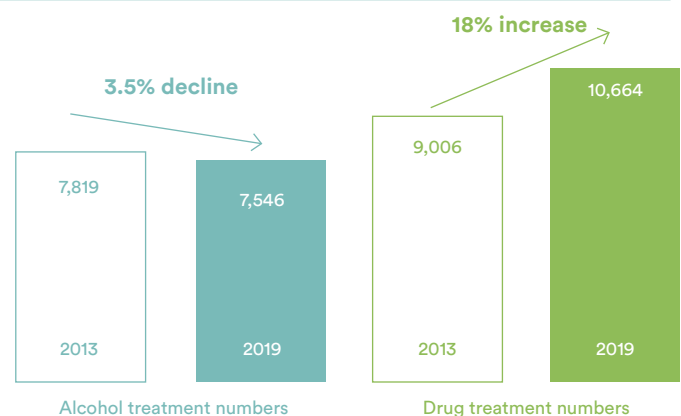
Despite the HRB's assessment that around 250,000 people in Ireland are dependent drinkers - a figure that is on the rise, treatment numbers for alcohol are actually going down (see figure 1).<sup>7</sup>

There is a growing body of international literature regarding the size of the gap between met and unmet demand for alcohol treatment.<sup>8</sup>

International data suggests that at any one time, 10% of such a cohort of may be seeking treatment – i.e. in Ireland 25,000. This means that a significant number of people who are drinking harmfully in Ireland are likely not getting the support they require.<sup>9</sup>

Figure 1

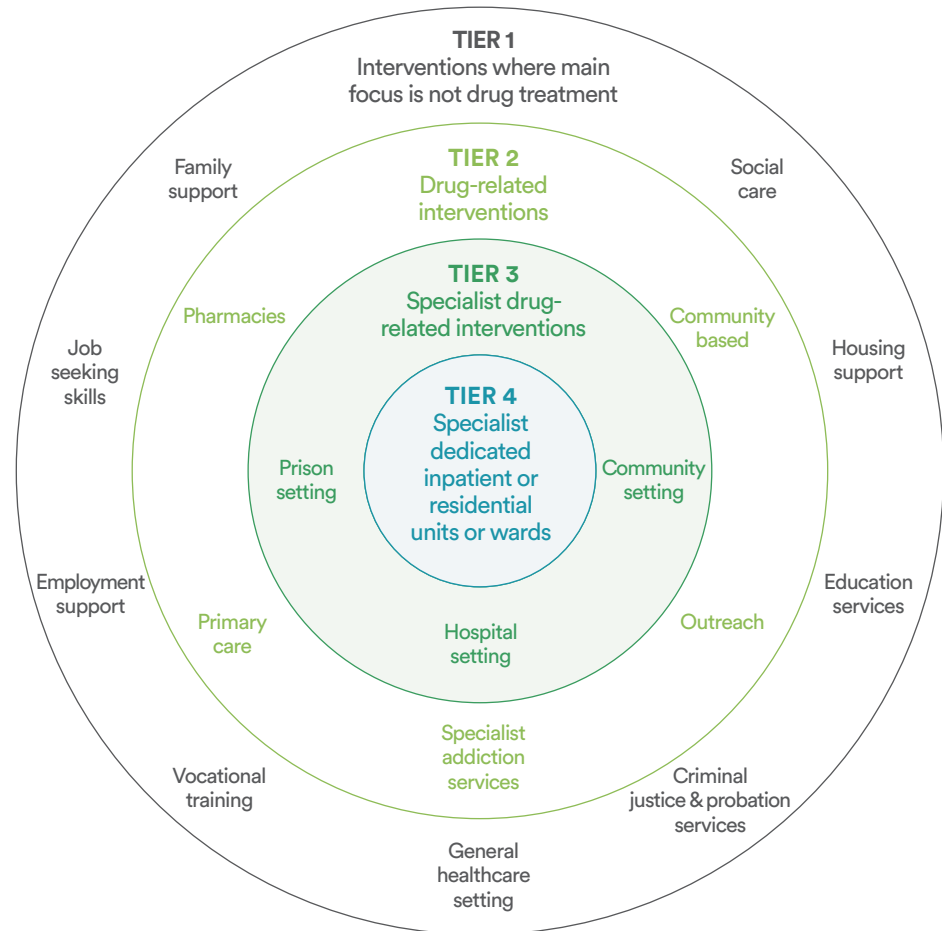
HRB NTRS figures show that in 2013 drug treatment numbers were 9,006 and alcohol treatment numbers were 7,819. The 2019 corresponding figures were: Drug treatment numbers 10,664 – an increase of 18% and Alcohol treatment numbers 7,546 – a decline of 3.5%.



- 3 HRB Bulletin. Alcohol Treatment 2019. National Drug Treatment Reporting System 2013—2019 Alcohol Data
- 4 Reducing Harm, Supporting Recovery, A health-led response to drug and alcohol use in Ireland 2017—2025.
- 5 Doyle J, Ivanovic J (2010) National Drugs Rehabilitation Framework Document. National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive.
- 6 As per a 2018 PQ, available at: <https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/pqs/pq-s-2018/pq-52694-18-residential-treatment-beds-final-jd.pdf>
- 7 Health Research Board, National Drug Treatment Reporting System 2013 to 2019, available from HRB.ie.
- 8 Busch et al., 2013; McCollister & French, 2002; Mojtabai & Crum, 2013; Sareen et al., 2013; Spence, 2003; Sung et al., 2011).
- 9 See also IMO position paper: [http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2015/Addiction\\_and\\_Dependency\\_IMO\\_Position\\_Paper.pdf](http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2015/Addiction_and_Dependency_IMO_Position_Paper.pdf)

## 1.0 Introduction

Figure 2



**Tier 1** interventions include the provision of drug-related information and advice, screening and referral to specialised drug treatment services. They are delivered in general healthcare settings (A&E, liver units, antenatal clinics, pharmacies, or in social care, education or criminal justice settings, i.e. probation, courts, prison.)

**Tier 2** interventions are delivered through outreach, primary care, pharmacies, and criminal justice settings as well as by specialist drug treatment services, which are community- or hospital-based. The interventions include information and advice, triage, referral to structured drug treatment, brief interventions and harm reduction e.g. needle exchange programmes

**Tier 3** interventions include community addiction services, but can also be situated in primary care settings such as GPs, pharmacies, prisons, and the probation service. Typically, the interventions consist of community-based specialised drug assessment and coordinated, care-planned treatment which includes psychotherapeutic interventions, methadone maintenance, detoxification and day care.

**Tier 4** interventions are residential specialist treatment using a care-planned approach by a multidisciplinary team and more extended rehabilitative care. Other interventions in inpatient settings are assessment detoxification and psychosocial interventions.

## 2.0 Methodology & demographics of services surveyed

In this survey, Alcohol Action Ireland (AAI) sought the views of services providing treatment interventions for harmful<sup>10</sup> and dependent<sup>11</sup> drinkers.

Residential rehabilitation services (known as Tier 4 services) are not the largest cohort of treatment services in Ireland. However, they provide a key element in the continuum of services. AAI believes it was appropriate to focus on them as interviewees. There were a number of reasons for this: their specialist knowledge, their willingness to participate and the fact that they are offering comparable services to a known cohort of people.

AAI contacted all Tier 4 providers<sup>12</sup> and a range of Tier 3 providers<sup>13</sup> based on the profile and work of the provider. A geographical spread was sought and a variety of locations are represented. (The comments made by services are set out under each theme according to tier.)

AAI also consulted with the National Voluntary Drug and Alcohol Sector Forum who provided advice on the survey content. This is an umbrella organisation for agencies in the voluntary sector that provide Tier 1–4 drug and alcohol addiction services in Ireland. AAI carried out one-to-one interviews with 11 treatment providers, 8 residential services from across the country (half of all residential treatment services), and 3 community-based services, one of which is a low threshold service.

Each treatment provider was asked the same survey questions, but respondents were given an opportunity to provide detail and context for their answers.<sup>14</sup>

The questionnaire is outlined in Appendix 2 along with a sample permission form.

The interviews were carried out by phone, recorded and transcribed. Interviews were typically about 25 minutes long and took place in the period Jan 2020—April 2020. Written permission for interview and recording was obtained. Code names (TS01–TS11) were given to the services to preserve anonymity.

Analysis of the interviews was carried out by examining the emergent themes and grouping the answers accordingly. All participants were contacted individually after the analysis to ensure participants were in agreement with the quotes attributed to them and with the overall recommendations.

Based on our analysis of the qualitative data this report highlights a number of themes in relation to the challenges facing alcohol treatment providers. Using our analysis, and the findings of our desktop research of published research and national policy documents, AAI proposes recommendations within each theme of Section 3.0.

<sup>10</sup> Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol.

<sup>11</sup> Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol, and continued drinking in spite of harmful consequences.

<sup>12</sup> Tier Four interventions are residential specialist treatment using a care-planned approach by a multidisciplinary team and more extended rehabilitative care. Other interventions in inpatient settings are assessment detoxification, psychosocial interventions.

<sup>13</sup> Tier Three interventions include community addiction services, but can also be situated in primary care settings such as GPs, pharmacies, prisons, and the probation service. Typically, the interventions consist of community-based specialised drug assessment and coordinated, care-planned treatment which includes psychotherapeutic interventions, methadone maintenance, detoxification and day care.

<sup>14</sup> See questions in Appendix 1.



## 2.0 Methodology & demographics of services surveyed

### 2.1 Overview of surveyed service providers

As highlighted in a comprehensive UK report on residential treatment from the NHS National Treatment Agency for Substance Misuse: “Residential rehabilitation services are based on a number of different philosophies describing aspects of their ethos, theoretical underpinning, belief systems and method of working. Increasingly, services combine different treatment strategies to meet individual client needs.”<sup>15</sup>

Similarly, the providers surveyed here encompassed a range of models of treatment and no two providers out of all of those surveyed provide the same model of care, rather what is in operation is a mixture of models and ways of working. Some providers focus on the Minnesota model<sup>16</sup>, sometimes mixed with other ways of working such as using the recovery model and/or psychotherapeutic interventions. Additionally, a number of providers said they were trauma-informed or working towards being trauma-informed.<sup>17</sup>

According to their own figures (Table 1), treatment providers surveyed for this report worked with approximately 2,000 people in 2019.

**Table 1. Survey Participants**

Provider	Number treated in 2019	Demographic	Funding
TS01	200-210	74%/26% male/female	Private w/publicly funded beds.
TS02	130	n/a	HSE/public
TS03	235	n/a	HSE/public
TS04	70-80	Mixed population	HSE/public
TS05	173	Mainly male	HSE/public
TS06	300-400 annually	n/a	HSE/public
TS07	135	65%/35% male/female	Private w/publicly funded beds.
TS08	n/a	n/a	HSE/public
TS09	144	65%/35% male/female	Private w/publicly funded beds.
TS10	170	n/a	Private w/publicly funded beds.
TS11	330	50/50 approximately	Private

15 Models of residential rehabilitation for drug and alcohol misusers. 2006 NHS National Treatment Agency for Substance Misuse, available at: [https://www.drugsandalcohol.ie/17843/1/nta\\_models\\_of\\_residential\\_rehab\\_drg\\_and\\_alc.pdf](https://www.drugsandalcohol.ie/17843/1/nta_models_of_residential_rehab_drg_and_alc.pdf)

16 The Minnesota Model is an abstinence orientated, comprehensive, multi-professional approach to the treatment of the addictions. It espouses a disease concept of drug and alcohol dependency with the promise of recovery, but not cure, for those who adhere to it. See: McElrath (1997) The Minnesota Model, *Journal of Psychoactive Drugs*, 29:2, 141–144, DOI: 10.1080/02791072.1997.10400180  
See also: Thomasina Borkman PhD, Lee Ann Kaskutas DrPH & Patricia Owen PhD (2007) Contrasting and Converging Philosophies of Three Models of Alcohol/Other Drugs Treatment, *Alcoholism Treatment Quarterly*, 25:3, 21–38, DOI: 10.1300/J020v25n03\_03; Effectiveness of a national ‘Minnesota Model’ based residential treatment programme for alcohol dependence in Ireland: outcomes and predictors of outcome, available at: <https://www.cambridge.org/core/journals/irish-journal-of-psychological-medicine/article/effectiveness-of-a-national-minnesota-model-based-residential-treatment-programme-for-alcohol-dependence-in-ireland-outcomes-and-predictors-of-outcome>

17 Addressing trauma in substance abuse treatment involves both “trauma-informed” and “trauma specific” approaches. Trauma-informed systems and services take into account knowledge about trauma – its impact, interpersonal dynamics, and paths to recovery – and incorporate this knowledge thoroughly in all aspects of service delivery. The primary goals of trauma-specific services address directly the impact of trauma on people’s lives to facilitate trauma recovery and healing. See: Substance Abuse and Mental Health Services Administration, <https://www.samhsa.gov/sites/default/files/wcdvs-article.pdf>

## 2.0 Methodology & demographics of services surveyed

### 2.2 Demographics

55% of the service providers surveyed were funded through the HSE and free to the public.

The remainder were private fee-paying services, but all but one held 'beds' funded through the HSE. In one of these, in 2019, 50% of beds were HSE funded, and 48% paid privately or had private health insurance coverage. In another, 65% were HSE funded, 25% were privately paying patients and 10% came through insurance. Another private provider said that it accepted about 10-20 HSE clients annually, approximately 10% - 15% of its population.

Many service providers have noted a change in demographics in recent years, principally the increasing number of young people coming into treatment and an increase in cocaine use in recent times. Two providers noted that there was an increase in people coming to treatment via their workplaces, or while continuing to work.

#### Respondents' commentary

##### *(Tier 3 - community)*

TS02: *"There is a steady increase in the number of women attending the project and these women are reporting an increase in their children's drug using behaviour. This increase in women attending the project is not in itself creating any difficulty. A major difficulty is encouraging members of new communities to form a therapeutic relationship."*

TS06: *"We have noticed there's a lot younger people coming in for help around drinking, could be a mixture of cocaine also – late 20s, 24 or 25... There's a cultural dimension too, language barrier, but also different understanding of drinking alcohol in different cultures. Training for staff is required...cultural diversity training, training for how to deal with LGBTQI+ ...trying to find appropriate onwards service is very difficult."*

##### *(Tier 4 - residential)*

TS01: *"The client is becoming younger – half of clients aged between 18-35 – and have multiple addictions, women are presenting more, cocaine is on the rise and with that comes drug debts and intimidation, but in this alcohol remains a constant in the drug using profile."*

TS07: *"Over the past number of years a younger cohort – 21-35 – have been coming into treatment. It can be explained perhaps by there being earlier interventions and people are becoming more aware, but also reflects that younger people are getting into difficulty with substances at early age. It may have started with cannabis and other drugs from early-mid teens, poly substance from 14 or 15 which creates dependency that can exacerbate mental health difficulties."*

TS09: *"Men and cocaine is a big trend, we are seeing the 25-35 age highly addicted to cocaine, and sometimes on its own. They want it on a Monday, Tuesday going to work...We also see a high income bracket coming through work, that is a change, they are telling their employers because they need the time off, or actually coming through work. Companies are more aware, or perhaps have better EAP. We see people from some state employers and big multinational companies too. Employers are giving people the time off and this is an improvement."*

TS10: *"Across much of the sector, services have noted the increase in presentation of young people (under 25) to services. This would be the case (here) too this does change the dynamic in group process and client's in this cohort often times present with more ambivalence which needs to be managed both in primary treatment and in aftercare. In addition the family presentation of this cohort is different and needs to be further managed/considered."*

From our analysis of the qualitative data, a number of themes emerged:

- Mental health & trauma
- Reducing the impact on children and families
- Gaps in services
- Barriers to treatment

## 3.0 Thematic breakdown of survey results

### 3.1 Mental health & trauma

#### 3.1.2 Mental health

The mental health of clients seeking treatment was a significant and serious concern for all of the service providers surveyed. It is widely accepted that people who have a diagnosed mental health problem and an addiction are considered to be more the norm than the exception.<sup>18</sup> Yet this cohort very often experience problems getting treated for both issues in parallel. This issue of ‘dual diagnosis’ – where both alcohol misuse and a mental health problem occur together, is generally thought to mean people with a serious and chronic mental health problem. However, it is clear that there is a significant cohort of people attending services with complex needs and who are struggling with anxiety and/or depression, linked to their life circumstances and alcohol use, and who may also need a mental health professional as part of their treatment.

Service providers advocated that a shared approach to client’s mental health was the best approach but said additional funding for staff and/or training was required.

#### Respondents’ commentary

##### *(Tier 3 - community)*

*TS02: “A large proportion of the clients would have co-occurring mental health issues such as anxiety, depression, social anxiety. No one is ever excluded from the service due to mental health or learning disability.”*

*TS06: We have a psychiatrist who attends once a week and we can refer to her. Underlying mental health needs are behind a lot of alcohol problems. People can get caught between the gaps. One service won’t deal with the other until other issue is sorted, we really need a parallel service – mental health and addiction working together. There was a space previously where people could talk about their mental health and addiction, we had a clinical nurse specialist, and medication was prescribed. There does need to be a multi-disciplinary approach.*

*TS08: “We work with people who have mental health issues, a huge proportion of our clients have mental health needs. Many are refused access to mental health services due to dual diagnosis.”*

<sup>18</sup> Sacks et al. 1997; Condren et al, 2001; Kamali et al 2000. In 2011, the Mental Health Commission identified that dual diagnosis (co-occurring conditions) rates among people in Ireland are reported between 30% and 80%. See also: No Wrong Door, A Mid-West Integrated, Community, Recovery and Evidence Based Treatment Resource For Those Struggling With Co-Occurring Conditions July 2015 <https://www.dualdiagnosis.ie/wp-content/uploads/2011/05/No-wrong-Door-Proposal-Tippeary.pdf>

### 3.0 Thematic breakdown of survey results

#### **(Tier 4 - residential)**

TS03: *90% of clients would have a diagnosed mental health issue. We have a clinic once a week onsite, talk therapy groups, and we accept clients on medications... they are coming from quite traumatic backgrounds for example women coming from domestic violence situations might be on meds, we would liaise with their clinicians on admission and continue to monitor and review. Largely we make every effort possible to treat.*

TS04: *“We want to help people understand the ‘why’, to understand what happened to them. We want to ensure that people’s ability to regulate their emotion is changed. Anxiety and depression are our two biggest presentations. The ideal scenario is that people can become very well and perhaps reduce (reliance on) medications; mental health issues are alleviated and they are more resilient.”*

TS09: *“For those with more serious mental health issues, it can be difficult to stay with treatment. We can administer the meds and have a psychiatrist who comes in once a week too and is on call. With dual diagnosis, people can bounce around. If they can stop with drink/drugs first, then they could get a proper diagnosis. GPs do need training in this... there is no training in addiction in their training. That is madness as most people with addiction will go to GP first. Sometimes GPs will just give an anti-depressant. More than half of our clients are on anti-depressant. If they stopped drinking, they might not need the medication.”*

TS10: *“We treat an increasing number of clients with mental health needs. We endeavour to ensure that if we are the right service for a person at a given time for them, that they have access to our program. Our team are experienced and capable of dealing with dual diagnosis but we are clear that we treat the addiction....The increased presentation of client’s with complex psychiatric/ psychological needs is another change to be noted. This also impacts service delivery as clients in this cohort often need more time prior to admission in terms of medication sourcing, psychiatric assessment, etc., and more support whilst in treatment, specifically in terms of support with emotional regulation.”*

Different areas also had unique experiences when it came to liaising with HSE mental health services:

TS07: *“It is quite common for people to present with dual diagnosis. We work with other services to ensure they get the right help. Addiction comes under the mental health services (locally) so we work in quite an integrated way. We have a protocol with the local unit so we have a pathway into treatment if someone with us needs attention. About 25% of people we see would have DD.”*

TS08: *“A huge proportion of our clients have mental health needs. Many are refused access to mental health services due to dual diagnosis....there is no buy in from mental health services.”*

While all service providers said they have no issue admitting someone to treatment who has a mental health problem, there were caveats; if the person was not willing or able to engage; if a psychiatric issue escalated; or if the person was deemed too unwell to enter treatment following a risk assessment.

TS01: *We do sometimes have to turn people away because of mental health problems, if they are not engaging with services. I think there is great scope for developing shared care around mental health, if resources were adequate, we would have mental health professionals on our staff.*

### 3.0 Thematic breakdown of survey results

#### 3.1.3 Trauma

Trauma has been recognised as a widespread, harmful and costly public health problem. It occurs as a result of traumatic experiences such as abuse, neglect, loss and other emotionally harmful experiences in childhood.<sup>19</sup> According to the US organisation SAMSHA, trauma is an almost universal experience of people with mental and substance use disorders.<sup>20</sup> Early traumatic experience may increase risk of substance use disorders because of attempts to self-medicate or to dampen mood symptoms associated with a dysregulated biological stress response.<sup>21</sup>

A growing body of evidence now makes clear that it is critical to address trauma as part of substance abuse treatment and that “misidentified or misdiagnosed trauma-related symptoms interfere with help seeking, hamper engagement in treatment, leads to early dropout, and make relapse more likely.”<sup>22</sup>

In an Irish context, a study carried out in 2019<sup>23</sup> found that the prevalence of mental health diagnosis and exposure to adverse childhood experiences (ACEs) was higher in those seeking residential treatment, primarily for alcohol, than in the general population. The research concluded that addiction and mental health services should acknowledge the role of childhood trauma in the onset of clients’ disorders and adapt services to support these needs.

All those surveyed recognised trauma in the client population. Some were more cautious on how to tackle this than others. There were some differing views among providers about the wisdom of directly asking clients about adverse childhood experiences. Some felt that it was vital in order to get a grasp of what the person’s trauma was, but others felt that unless there was a robust mechanism for dealing with that trauma, then it was best not to specifically ask about ACEs but to let the person’s issues surface naturally through their work in the programme. For example, some providers questioned what they could do in 6 weeks to tackle childhood trauma, and the wisdom of asking about ACEs, when they might not have the resources to deal with what they learned.

#### Respondents’ commentary

##### *(Tier 3 - community)*

TS06: *“It’s such a painful area that we allow it come out through therapeutic work. In early stage recovery it’s about stability. We are trauma informed and very aware that there is trauma in the background and we are sensitive to that. What’s the pain about? What is the drinking trying to mask? We try to get them to identify that and then find alternative ways (than drinking) to deal with it.”*

19 SAMSHA, Concept of Trauma and Guidance for a Trauma-Informed Approach: [https://ncsacw.samhsa.gov/userfiles/files/SAMHSA\\_Trauma.pdf](https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf)

20 SAMSHA, Concept of Trauma and Guidance for a Trauma-Informed Approach: [https://ncsacw.samhsa.gov/userfiles/files/SAMHSA\\_Trauma.pdf](https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf)

21 Khoury, Lamy et al. “Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population.” *Depression and anxiety* vol. 27,12 (2010): 1077-86. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3051362/#:~:text=Early%20traumatic%20experience%20may%20increase,a%20dysregulated%20biological%20stress%20response.>

22 Brown, 2000; Brown, Huba, & Melchior, 1995; Janikowski & Glover, 1994.

23 Lambert, Sharon and Murphy, Raegan (2019) The role of trauma in dual diagnosis. *Forum* , 36 , (10) , pp. 51–52.

### 3.0 Thematic breakdown of survey results

#### **(Tier 4 - residential)**

TS07: *“We do (ask about ACEs) without perhaps calling it that. We look at social history and family background and areas of trauma and that forms part of information/assessment that is used in individual counselling but we do not collect the data.”*

TS05: *“We don’t ask and I think we would be opening a can of worms. We do have a counselling service and we find that the emotional regulation groups works in that people don’t have to talk about themselves and it’s dealt with like that. We don’t have the staff equipped to deal with it. But we know that they (ACEs) are there and sometimes people tell us, but we are not prying in that way.”*

TS10: *“ACE’s inevitably becomes part of the conversation when people present with addiction issues. A large part of the group process work entails exploration of underlying contributors to present day presentation. Counsellors aim to help people identify past traumas and encourage them to understand links between these and current maladaptive behaviour. We do not use ACEs in a formalised way (there are other psychological measures we use as standard) but it informs much of what we do.”*

A provider working with the homeless population said:

TS05: *“There is a lot of trauma and stress and sometimes that can be mixed up with mental illness. Everybody that comes through the door has trauma – childhood trauma... what are they going to do without this substance, they will have to face their demons. One of the biggest barriers to treatment is the trauma that is going to emerge when the substance is removed.”*

A number of providers noted that intergenerational factors were a significant factor for their clients.

### Respondents’ commentary

#### **(Tier 3 - community)**

TS02: *“A considerable focus of the work done in the project relates to ACEs and we offer a programme for adults of dysfunctional families. There is also a programme to strengthen partners of problem drinkers to enable them to offer a more stable environment for their children. Statistically, we could offer an approximate figure; but we have no actual record of the exact number. Out of an Aftercare Group of eight clients, six would report ACEs.”*

#### **(Tier 4 - residential)**

TS01: *“Alcohol abuse in the home is a big factor that we see in clients – there is a group of people who grew up in that environment and that has a detrimental impact on their ability to cope with their circumstances and their own uncomfortable internal state, that they don’t know how to regulate is a very important factor.”*

A dual diagnosis service provider, (a public service that has 6 beds for alcohol treatment) was certain that a trauma-informed approach to treatment must be provided in order to get the bottom of the addicted person’s issue:

TS04: *“People are taking drink/drugs because of past complex trauma. A big part of our programme is to help people to understand that link . We were set up in 2001 as research programme, primarily for opiates; a group of HSE Addiction Staff visited different substance misuse treatment programmes in the US looking at models of treatment and the most evidenced based at that time was ones based on teaching life skills to people. So you would think that now, with research clearly showing links between attachment issues complex PTSD and substance misuse , that all services would be trauma-informed; the idea that you can work with addiction and not tackle those issues doesn’t make sense.”*

### 3.0 Thematic breakdown of survey results

#### Discussion:

Our findings signal a deep concern about the mental health needs of people with alcohol dependency and the provision of service to those people. Given the prevalence of co-occurring disorders in mental health and drug treatment settings – they are the ‘expectation not the exception’<sup>24</sup> mental health and addiction must be treated in parallel using shared concepts of recovery and trauma to bridge the divide between the two domains.<sup>25</sup> Public policy (Department of Health) should recognise the substantive links between trauma<sup>26</sup>, substance misuse and addiction and ensure that all publicly funded services offer a trauma-informed service. What this means in practice should be clarified in national policy and consistent practice should apply to all publicly funded treatment services, both residential and non-residential. There is a need for the issues around residential alcohol treatment services highlighted here to be comprehensively addressed in a new national strategy, as outlined in this report's key recommendations.

#### KEY RECOMMENDATIONS:

- A national strategy setting revised national standards<sup>27</sup> and promoting best practice should be developed and implemented for residential services. Services should be person-centred and trauma-informed and should be monitored by the Health Information and Quality Authority – HIQA like other residential health care services in Ireland.<sup>28 29</sup>
- Addiction services must have the skills and resources to respond to the mental health needs of clients with responses tailored to the needs of each individual. This could include undertaking a national training needs assessment, providing information on training already available through the HSE, and giving staff time to take up training as required.

- 24 Minkoff K, Cline CA. (2004). Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of care for Individuals with co-occurring disorders. *Psychiatric Clinics of North America*, 27 (4): 727–43.
- 25 <https://www.dualdiagnosis.ie/wp-content/uploads/2011/05/No-wrong-Door-Proposal-Tippeary.pdf>
- 26 A trauma-informed approach to addiction treatment is crucial to overcoming the mental, behavioural, physical, and social effects of addiction. SAMHSA, the Substance Abuse and Mental Health Services Administration recommends that addressing trauma in substance abuse treatment involves both “trauma-informed” and “trauma-specific” approaches. Trauma-informed systems and services take into account knowledge about trauma – its impact, interpersonal dynamics, and paths to recovery – and incorporate this knowledge thoroughly in all aspects of service delivery. The primary goals of trauma-specific services address directly the impact of trauma on people's lives to facilitate trauma recovery and healing.  
See: Substance Abuse and Mental Health Services Administration, <https://www.samhsa.gov/sites/default/files/wcdvs-article.pdf>; [https://journals.lww.com/jan/Citation/2018/10000/A\\_Trauma\\_Informed\\_Approach\\_to\\_Substance\\_Abuse.7.asp](https://journals.lww.com/jan/Citation/2018/10000/A_Trauma_Informed_Approach_to_Substance_Abuse.7.asp)
- 27 Safer Better Healthcare themes have been adapted for HSE and HSE funded addiction services. [https://www.drugs.ie/resources/national\\_standards\\_for\\_safer\\_better\\_healthcare2/sbhc\\_workbooks/](https://www.drugs.ie/resources/national_standards_for_safer_better_healthcare2/sbhc_workbooks/)
- 28 Currently Irish residential treatment centres receive accreditation from CHKS, an international healthcare accrediting body. Additionally, the Quality in Alcohol and Drug Services (QuADS) Organisational Standards manual is a set of quality standards for drug and alcohol services. The National Drugs Rehabilitation Implementation Committee (NDRIC) recommends that all rehabilitation services implement a quality framework, such as QuADS, or equivalent, in their service. See here for more information: [https://www.drugsandalcohol.ie/20964/1/QuADS\\_Organisational\\_Standards\\_manual.pdf](https://www.drugsandalcohol.ie/20964/1/QuADS_Organisational_Standards_manual.pdf)
- 29 This was first mooted in 2007 in the Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse). “The group recommends that there must be standards for the quality of the residential facilities themselves and believe that the HSE should enter into discussions with the Health Information and Quality Authority (HIQA) about the inclusion of residential services for drug and alcohol users within the range of services to be regulated by HIQA's social services inspectorate.” <http://www.drugs.ie/resourcesfiles/reports/3966-42381118.pdf>

### 3.0 Thematic breakdown of survey results

## 3.2 Breaking the cycle – reducing impact on children and families

People in treatment are very often fathers and mothers, with sons and daughters going through their own journey alongside the person who is in treatment.

Although the issue of parental alcohol misuse and its effects remains largely hidden in Irish society, in recent years a range of Irish studies, reports and initiatives have begun to recognise hidden harm.<sup>30</sup>

Public policy commitments to early intervention in families with substances misuse problems are set out in Department of Children, Equality, Disability, Integration and Youth, policy documents Better Outcomes Brighter Futures<sup>31</sup> and First 5.<sup>32</sup>

The current national drug and alcohol strategy<sup>33</sup> also highlights the need for developing and adopting evidence-based family and parenting programmes for high risk families impacted by problematic substance use. The strategy states that “awareness of the hidden harm of parental substance misuse with the aim of increasing responsiveness to affected children should be built, and that protocols between addiction services, maternity services and children’s health and social care services to facilitate a coordinated response to the needs of children affected by parental substance misuse, should be developed.”

Growing up in a home with parental alcohol misuse has been recognised internationally as an adverse childhood experience for over 20 years,<sup>34</sup> and the physical and mental consequences are comprehensively understood.<sup>35</sup>

Problem parental alcohol use damages and disrupts the lives of children and families in all areas of society, spanning all social classes and harming the development of children trapped by the effects of their parents’ problematic drinking. Yet still this issue remains a hidden one, as demonstrated by national policy, Hidden Harm, a strategy document seeking to alert professionals working with such children and families to the problem.<sup>36</sup>

Treatment services can have an important role in identifying parents in their services, and providing interventions, or pathways to reduce the harmful impact of addiction on children. This can be an essential component to break the cycle of intergenerational substance abuse that is so often a feature of addiction.

- 30 Hidden Realities: Children’s Exposure to Risks from Parental Drinking, [http://www.drugs.ie/resourcesfiles/research/2011/NWAF\\_Realities\\_Report.pdf](http://www.drugs.ie/resourcesfiles/research/2011/NWAF_Realities_Report.pdf)  
Hope, A (2011).Hidden Realities: Children’s Exposure to Risks from Parental drinking in Ireland. Letterkenny, Ireland: North West Alcohol  
Forum Ltd; HSE, The untold story: Harms experienced in the Irish population due to others’ drinking; Tusla, Hidden Harm strategic plan, <https://www.tusla.ie/uploads/content/StrategicGuide.pdf>
- 31 Better Outcomes Brighter Futures. The national policy framework for children and young people, 2014-2020
- 32 First 5: A Whole of government strategy for babies, young children and their families, 2019-2028
- 33 Reducing Harm Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017- 2025
- 34 Felitti, V.J., Anda, R.F., Nordenberg, D, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACEs) study. American Journal Preventative Medicine. 1998; 14: 245-258; Ashton, K., Bellis, M. & Hughes, (2016) Adverse childhood experiences and their association with health harming behaviours and mental wellbeing in the Welsh adult population: a national cross-sectional survey.
- 35 Gance-Cleveland, B., Mays, M.Z., Steffen, A. (2008). Association of adolescent physical and emotional health with perceived severity of parental substance abuse. Journal for Specialists in Pediatric Nursing;13(1): 15-25. Winqvist, S., Jokelainen, J., Luukinen, H., Hillbom, M. (2007). Parental alcohol misuse is a powerful predictor for the risk of traumatic brain injury in childhood. Brain Inj.;21(10):1079-85.
- 36 HSE and Tusla, The Hidden Harm Practice Guide available at: <https://www.hse.ie/eng/about/who/primarycare/socialinclusion/homelessness-and-addiction/national-hidden-harm-project/hiddenharmpracticeguide-2019.pdf>



### 3.0 Thematic breakdown of survey results

#### Respondents' commentary

##### *(Tier 4 - residential)*

TS02: *“There is nothing out there for children and families who experience long term psychological and emotional abuse and can become incredibly damaged. Much more family support is needed and it needs to be separate from the addicted person’s treatment. We see the intergenerational impact, children of people with problems, and then they have an issue and their children do too. How do you break that cycle? You need an intervention that empowers people to do what is right for them and focuses on their needs. For children the concept of one good adult is very important.”*

TS03: *“Four out of five of our clients grew up in households where either one or both parents had acute addiction problems. This cycle of addiction can increase the likelihood of traumatic childhood experiences.”*

Combined with other issues, such as socioeconomic disadvantage, family breakdown or mental health problems, the trauma risk to children is heightened.

This can become even more acute when the person trying to access treatment is a mother, raising other concerns for both the client and children.

#### Respondents' commentary

##### *(Tier 4 - residential)*

TS01: *“For women trying to get into treatment, residential treatment can be challenging, we have a lot of women who do come, social services can be involved and families step in, but it is an issue -we do not have facilities for children.”*

TS03: *“We take women from pregnancy and with children up to 5 years old. Older children come at weekends. We have an early years and preschool onsite and crèche, medical nurse team, drug liaison midwife. We have a parents under pressure (PUP) programme, a specific intervention, a strengths-based programme focusing on attachment. We see a lot of poly drug use...we are still seeing prevalence of heroin and alcohol and benzos for women - alcohol is always there.*

*There is a huge need for more services for women and children. In 2018 there were 24 beds for mother and child programme in Ireland. We operate a waiting list of 30-35 waiting list. This is a national service, 60% from regions, 33% from Midwest and 80% are mothers. In 2019, our waiting list doubled to 63, 80% were mothers and a significant number were pregnant.”<sup>37</sup>*

It should be noted that during 2020, there was investment in women's services including midwives and funding for a second mother and child service in the mid-west region. Approximately half of providers surveyed cited that there was an increase in women accessing services, while more than half of those surveyed said there is a real need for more services for family members of people in treatment. Some services offered counselling for family members, but for adults only.

### 3.0 Thematic breakdown of survey results

#### Respondents' commentary

##### *(Tier 3 - community)*

TS02: *"Clients often bring family members to the project for education/support. Family members can have individual therapy but there is a concerned person's group which operates every week and is focused on the needs, and support of the partner/parent in living both with the problem drinker while they are still drinking or when they go into recovery.... As an 18 years and adult only service, it would be nice to offer play therapy to younger teens and children, for the adults, art and drama therapy would be beneficial in recovery when there's issues of self-confidence and anxiety."*

TS06: *"We have services for family members of people who are in treatment and we can see family members of people who are not here (in treatment). For younger children there needs to be something especially for teenagers, but there is nothing at the moment. This is a neglected area. They need counselling and therapy, there needs to be child-friendly and focused services. In terms of policy-making, this is a hugely neglected area that needs much more funding."*

##### *(Tier 4 - residential)*

TS07: *"We have a counselling service for family members but not for children. In terms of family support for children we can refer to other agencies but there probably us not enough support particularly for teenage children... they need support to deal with issues in their lives while parents are caught up with addiction."*

#### Discussion:

It is clear that the children of those in treatment are largely missing from this picture. Given what is known about ACEs<sup>38</sup>, these hidden young people may be in danger of developing problems that, if not adequately dealt with, can impact across their lifetimes. Research identifies the need to provide support to families who are affected by substance misuse. In order to build 'recovery capital' and to prevent an intergenerational cycle of addiction, children and families must be considered as part of treatment interventions.<sup>39</sup>

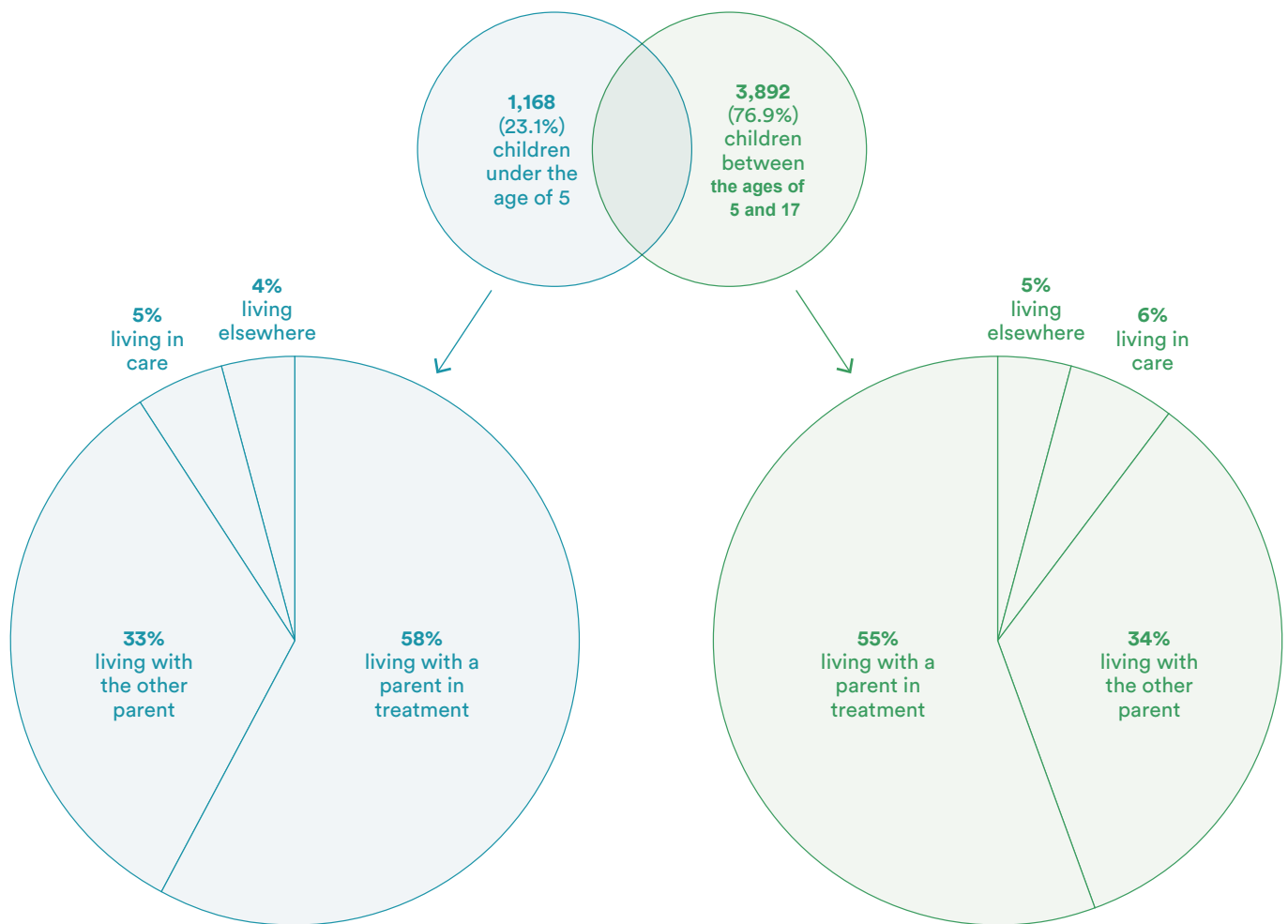
- 38 Felitti, V.J., Anda, R.F., Nordenberg, D, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACEs) study. *American Journal Preventative Medicine*. 1998; 14: 245-258; Ashton, K., Bellis, M. & Hughes, (2016) Adverse childhood experiences and their association with health-harming behaviours and mental wellbeing in the Welsh adult population: a national cross-sectional survey; Bellis, M. A., Hughes, K., Leckenby, N., Jones, L., Baban, A., Kachaeva, M., Terzic, N. (2014). Adverse childhood experiences and associations with health-harming behaviours in young adults: surveys in eight eastern European countries. *Bulletin of the World Health Organization*, 92(9), 641–655. doi:10.2471/BLT.13.129247 2
- Gance-Cleveland, B., Mays, M.Z., Steffen, A. (2008). Association of adolescent physical and emotional health with perceived severity of parental substance abuse. *Journal for Specialists in Pediatric Nursing*;13(1): 15-25. Winqvist, S., Jokelainen, J., Luukinen, H., Hillbom, M. (2007). Parental alcohol misuse is a powerful predictor for the risk of traumatic brain injury in childhood. *Brain Inj.*;21(10):1079–85. 3 Barnard, M and Barlow, J (2003) 'Discovering parental drug dependence: Silence and disclosure' *Children and Society*, Volume 17, Issue 1, p45-56; Cleaver, H; Unell, I and Aldgate, J (2011) Children's needs, parenting capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use and domestic violence on children's safety and development (2nd edition) Department for Education. 4 Nacoa, Professor Martin Callingham, Survey of children of alcohol-dependent parents (Barnard and McKeganey, 2004) Including families and social networks of substance misusers in treatment programmes can positively influence the direction substance use problems take, improve outcomes and reduce negative effects for families (Copello et al., 2006) (Zimic & Jakic, 2012).
- 39 The utilization of evidence-based family approaches has demonstrated superiority over individual or group-based treatments (Baldwin, Christian, Berkeljon, & Shandish, 2012). Treating the individual without family involvement may limit the effectiveness of treatment for two main reasons: it ignores the devastating impact on the family system leaving family members untreated, and it does not recognize the family as a potential system of support for change.

All treatment providers should identify where clients have children (including unborn children) and provide, or have access to interventions for them. Unpublished data from NDTRS indicates that 50% of people in treatment have children. (see figure 3)<sup>40</sup> Where treatment providers do not have the resources to provide their own services to young people, government funding should adequately fund resource supports. Investment is required in primary care psychology services, school psychology infrastructure and trauma-informed training for all professionals working with young people.

Figure 3

**There were 5,060 children under the age of 18 who had parents in treatment for problem alcohol use in 2019**

**3.0  
Thematic  
breakdown of  
survey results**



Source: NDTRS, 2019 unpublished

40 Requesting information on the number of children and living arrangements of people in treatment was added to data which began being collected by the NDTRS in 2016. [https://www.drugsandalcohol.ie/26858/1/Master\\_NDTRS\\_2019\\_protocol\\_hard-copy\\_V5.pdf](https://www.drugsandalcohol.ie/26858/1/Master_NDTRS_2019_protocol_hard-copy_V5.pdf)

Regarding access to treatment for women with children, as national policy notes: “The absence of childcare can be a barrier for women attending treatment and after-care services... There is a need to increase the range of wrap-around services and supports to facilitate more women with children or who are pregnant taking up treatment.”<sup>41</sup> This would inform national planning and policy in this regard.<sup>42</sup>

### 3.0 Thematic breakdown of survey results

#### KEY RECOMMENDATIONS:

- Recognising the known impact of the adverse childhood experience of parental problem alcohol use<sup>43</sup>, treatment interventions should seek to reduce the impact of alcohol harm on children & families. This would involve a greater emphasis on working with family members as clients in their own right rather than as adjuncts to the client presenting with the addiction.
- Access to residential services for women with children must be improved. A mapping exercise could be undertaken to quantify the need for residential placements for pregnant and postnatal women who need in-patient treatment for addiction across the country.

### 3.3 Gaps in services

Service providers cited what they viewed as gaps in how treatment services are delivered with a number of consistent themes emerging, namely the lack of access to detox supports, aftercare support, staffing and resources.

Some providers said that unless people can access treatment very shortly after making the decision to do so, they may not attend. Some also noted that diminished staffing and resources meant bed capacity had reduced in recent years, and that if the resources were there, many more people would be in treatment. Each of these themes are expanded below.

#### 3.3.1 Detoxification

Most of the service providers outlined that access to adequate alcohol detoxification services is inadequate and needs to be improved. This is acknowledged in national policy, (Reducing Harm, Supporting Recovery, p 39). Service providers were critical of the lack of appropriate detoxification services and the impact it has regarding access to treatment.

41 See Reducing Harm, Supporting Recovery, p 42.

42 This reflects work already underway as part of Reducing Harm, Supporting Recovery, see progress report, p 15–17. <https://www.drugsandalcohol.ie/30660/1/RHSR-2018-Progress-Plan-2018-and-Planned-Activity-2019.pdf>

43 Turning Point (2006). Bottling it up – The Effects of Alcohol Misuse on Children, Parents and Families. 8 See <https://alcoholireland.ie/campaigns/silent-voices/> for an overview of the research data. 9 See <https://alcoholireland.ie/campaigns/silent-voices/> for an overview of the research data. 10 Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., & Marks, J.S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245–258. Baumeister R.F., Schmeichel B.J., Vohs K.D. (2013) Self-Regulation and the Executive Function: The Self as Controlling Agent. In Kruglanski A., Higgins E.T. *Social Psychology: Handbook of Basic Principles* (2nd ed.) New York: Guilford, pp. 516–539.

### 3.0 Thematic breakdown of survey results

## Respondents' commentary

### (Tier 3 - community)

TS02: "GPs need more support and training, particularly as to the most appropriate time for an individual to be detoxified and what supports would be helpful to have in place to ensure that the detoxification would be successful."

TS06: "There are no HSE detox beds in reality. This is a huge missing link and there are people who will never make it in to programmes because of it. People need to be streamlined straight from detox into residential treatment and that's not understood. A continuum of care is missing. One of biggest detox services in Dublin will only detox people from opiates only - why?"

TS08: "For poly drug use – benzos, crack, heroin, detox is not available. I believe there is a need for poly drug use detox beds in the Midwest."

### (Tier 4 - residential)

TS04: "Detox is a barrier for people to treatment, I think clearly more beds for detox are required. For alcohol in particular, GP/community detox is used, but there are people who need residential detox....The policy regarding detox needs to take into account that there are many substances that people need to detox from – people are being prevented from accessing services because they can't detox. There are no specific HSE Residential alcohol detox beds. It has to be acknowledged that more residential places for alcohol are needed and within that cohort there are people who will need to detox from multiple substances and that can be a barrier to their admission."

TS07: "Detox is arranged in community prior to referral. This is not adequate and a lack of specific detox units is a gap in service provision in this region. It can mean going to general hospital, or a psychiatric unit, which is far from ideal. A detox unit that would provide transition into treatment would be preferable."

TS09: "We use a lot of home detox and this is a big gap. Community detox is OK with good family support but there is very low supervision. It can get us by, but in a detox unit we are 100% safe that they (clients) have detoxed ...we have had seizures in the past...people can get aggressive and if someone is in a bad way it can be rough. Ideally there should be regional detox units/beds."

One service that deals with the homeless maintained that people are getting stuck in their service because there are no onward placements for them and this becomes a barrier for new cases trying to gain access to the service.

TS05: "Unless there is a pathway for people there is no point in having more detox beds. We have 73 recovery beds and they are full all the time, (onward) movement is a difficulty for us, but there is nowhere (for people) to go...is it ethical to detox someone and then put them back into the same situation as before?"

The same service provider also outlined that they regularly receive phone calls from professionals and the public seeking to obtain a detoxification bed. The service is for homeless people only.

"Cases are now more complex... we are always at capacity and don't leave a bed empty but can only take homeless people. We have the general public begging us to take them in for detox because there are no detox beds (elsewhere)...hospitals ring us... people say they will make a family member homeless just to get in."<sup>44</sup>

44 The treatment provider clarified that it is made clear to the public this is not a viable option.

### 3.0 Thematic breakdown of survey results

#### 3.3.2 Aftercare

As per the tier 4 framework, a key element of recovery including treatment and aftercare is the assurance that an integrated approach will be taken and that people can move from one service to another as required. Each service provider offered their own aftercare services ranging from counselling to support groups and peer support networks, with many lasting up to two years after treatment. Providers highlighted how crucial linkages to supports in the community are for recovery, and while some service providers contended there is adequate support in the community, others signalled the need for much better aftercare supports and services for people who are vulnerable after leaving residential treatment. Some questioned the ethics of sending people back to the environment they had come from after putting them through a recovery programme and highlighted how difficult it can be to return to employment following treatment. This commentary highlights gaps in the pathways approach that states people should be able to move between services and access different kinds of interventions along their recovery journey seamlessly.

#### Respondents' commentary

##### *(Tier 4 - residential)*

TS01: *"I don't think the need is for more (residential) beds, but for more resources to manage the addiction going forward. Pre and after services are not well developed enough to meet needs. ...As people move from one service to another, from treatment to continuing care, there are vulnerable times... if people have trauma history or mental health challenges, it is very difficult and there is a risk of relapse. (Residential) Services can't provide the full wrap around care that some people need."*

TS03: *"We need to increase the complex needs detox beds, increase stepdown accommodation and (stepdown) treatment programme beds. I don't think we need more treatment beds. It's the before and after – way in and way out. We need a much more integrated continuum of care....Community supports are vital – Tier 4 can be far from workplace, very important to bridge that gap back into the workplace with recovery supports for people...training for skills/ jobs built on a social enterprise model (is needed). We need a national driving force behind this."*

TS09: *"Residential step down programmes are badly needed for people to transition to. There are some great secondary care units...we know that the longer you are in, the better the outcomes. You are doubling your chance of success after the step down programme...Lot of times I work with someone who is going back to the same deprived environment and there is no chance for them. Sending people back to same situation is very difficult, they don't have a chance if that's where they are going."*

TS07: *"The biggest challenge would be the after care – being able to support people adequately as they move back into own environments, back into same environments.... People might feel they are doing OK and disengage (from supports)....services are quite good at making effort to keep in touch."*

TS11: *"We advise people to link with AA, Life Ring, Smart Recovery, any support system that is out there. There is a lot of support in the community and the area we are based in is great regarding supports... we give people the information and hope they will go."*

### 3.0 Thematic breakdown of survey results

#### 3.3.3 Staff & training

Most providers noted an issue around staffing whether it was that they did not have enough staff or funding to provide the service they would like. They also highlighted difficulty in finding adequately qualified staff. One provider noted that the service was not understaffed, but if it was adequately funded to provide a level of service to match the level of need, it might be – i.e. if it had more funding, it could offer more services to a wider cohort of people.

#### Respondents' commentary

##### *(Tier 3 - community)*

TS06: *"We need training and resources and investment in staff. We need managers that are trained or know about the clinical side of things as this creates issues in terms of how services develop. We need to have a Minister who knows the sector, knows how big the issue of alcohol is and has a seat at the table and is advocating for the services that are needed. People on the ground know what needs to be done....When we had more resources and staff the waiting list was at 100. In reality we should have waiting list of 400-500 given the nature of the problem. Calls come in a crisis and we need to be able to respond as people can change their minds, or go elsewhere or don't want to do it anymore."*

TS08: *"We would like to have capacity to run more groups or target specific areas for outreach but do not have the staff capacity."*

##### *(Tier 4 - residential)*

TS05: *"We have 70 people waiting about on average 70-80 days. You need to capture someone the day they say they want to come in. We used to be able to do that but now it's so long. Meth is big issue – for nurses to be able to deal with it, manage it etc, is very difficult. I don't know of many people that come off it. Its hugely over relied on, there is money in methadone, GPs have people on their list, we have these people addicted and their lives are tied up with it."*

TS04: *"We have 16 – 20 beds, but they are not all open due to staffing issues. Staff leave and are not replaced. My team was more than twice this size ten years ago."*

TS05: *"Have had trouble recruiting nurses, huge issue for years, they would stay for short time and be gone again, We decided to recruit from overseas, have had stability for three years, enough nurse, train them up ourselves, takes quite a while, homeless, addiction. So they are coming without the experience and skills so we have to train them. Inhouse induction and training and upskill them on the job."*

#### Discussion:

As highlighted in these findings above and also acknowledged in the national drug and alcohol strategy: Reducing Harm, Supporting Recovery,<sup>45</sup> there is a need to provide wider geographic access to addiction services and to continue to diversify the range of treatment options available to meet current and emerging needs. Improvements are required in the provision of detoxification, to better respond to the range of need across the spectrum of alcohol dependence. This may include coordination of access to detoxification in residential and medically supervised settings for those who require such treatment. A national protocol on alcohol detoxification should be established,<sup>46</sup> and streamlining people straight from detoxification into residential treatment should be a seamless process.<sup>47</sup>

<sup>45</sup> <https://www.drugsandalcohol.ie/27603/1/Reducing-Harm-Supporting-Recovery-2017-2025.pdf> p 8.

<sup>46</sup> This recommendation was made by the Steering Group Report On a National Substance Misuse Strategy February 2012. In 2015, the IMO also urgently called for the establishment of acute alcohol and illicit drugs detoxification centres for those who wish to choose detoxification as part of their recovery. [http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2015/Addiction\\_and\\_Dependency\\_IMO\\_Position\\_Paper.pdf](http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2015/Addiction_and_Dependency_IMO_Position_Paper.pdf)

<sup>47</sup> This mirrors the recommendation made by the Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse) in 2007: "The group recommends that where inpatient detoxification is required, it should be, as a rule, provided in dedicated units." <http://www.drugs.ie/resourcesfiles/reports/3966-4238118.pdf>

### 3.0 Thematic breakdown of survey results

Service providers highlighted that the appointment of staff with adequate skill sets is difficult and that on-going training and upskilling is required. Treatment services should be fully and adequately staffed and staff who leave or retire must be replaced. Appropriate training of all physicians in treatment of addiction and dual-diagnosis should form part of core curricula for GPs, social workers and counsellors, while continuing professional development should continue to upskill all staff working in addiction treatment services. A comprehensive third level course to train people to work in specialist substance misuse services should be developed as well as modules in substance misuse counselling to enable trainee counsellors to develop a speciality in addiction counselling.

As committed to in the national drug and alcohol strategy,<sup>48</sup> aftercare services need improvement. Step down services linked in with education and employment opportunities should be invested in and made available for complex cases that require support to prevent relapse.<sup>49</sup> Research has found that groups like AA, Smart Recovery and Life Ring provide a valuable source of social capital for recovery.<sup>50</sup> As the Health Research Board (HRB) report on the role of social and human capital in recovery from drug and alcohol addiction highlighted, while the value of self-help groups is widely recognised, the mechanisms by which they support abstinence are not well understood. It is recommended that research be carried out to hear the voices of people who use such groups in order to better understand how they work.<sup>51</sup>

#### KEY RECOMMENDATIONS:

- Greater investment is required to ensure that services are adequately staffed and access to alcohol services across the country should be improved, including detoxification and aftercare services.
- A comprehensive third level course should be developed to train people to work in specialist substance misuse services. Modules in substance misuse should be provided in counselling training courses to enable trainees to develop a speciality in addiction counselling.

48 Reducing harm, supporting recovery: <https://www.gov.ie/pdf/?file=https://assets.gov.ie/14571/c22d1dd1756440f8946717a80ad2ffc3.pdf#page=1>

49 Building the capacity of communities to respond to the drugs situation is a key goal of Reducing Harm, Supporting Recovery.

50 HRB: [https://www.hrb.ie/fileadmin/publications\\_files/The\\_role\\_of\\_social\\_and\\_human\\_capital\\_in\\_recovery\\_from\\_drug\\_and\\_alcohol\\_addiction.pdf](https://www.hrb.ie/fileadmin/publications_files/The_role_of_social_and_human_capital_in_recovery_from_drug_and_alcohol_addiction.pdf). <https://www.cochrane.org/news/new-cochrane-review-finds-alcoholics-anonymous-and-12-step-facilitation-programs-help-people>

51 This reflects the HRB recommendation, see p 34: [https://www.hrb.ie/fileadmin/publications\\_files/The\\_role\\_of\\_social\\_and\\_human\\_capital\\_in\\_recovery\\_from\\_drug\\_and\\_alcohol\\_addiction.pdf](https://www.hrb.ie/fileadmin/publications_files/The_role_of_social_and_human_capital_in_recovery_from_drug_and_alcohol_addiction.pdf)



### 3.0 Thematic breakdown of survey results

#### 3.4 Barriers to treatment

In discussion of barriers to people accessing treatment, detoxification was often cited and is covered in the previous section. Other significant barriers that were cited were the onerous criteria to being admitted to residential care and the perceived stigma of going into treatment, as well as finances, which can hamper choice.

##### Respondents' commentary

###### *(Tier 3 - community)*

TS01: *"As a society we are very ambiguous about tackling alcohol with proper national policies, resourcing, treatment structures... alcohol is the centre of this problem, cocaine and heroin makes the headlines, but with alcohol we feel it has such a prized place in society... as long as that remains we will not tackle the problem sufficiently."*

###### *(Tier 4 - residential)*

TS02: *"Resources for alcohol treatment which grasps the breadth of issues that arise from alcohol mis-use are rare and mostly the approach is formulaic and judgemental which precludes trust and a strong therapeutic alliance forming. Residential treatment is very difficult to access and can be very stressful for the population of people we serve. The model (of treatment) can be very old school and it takes people away from normal life stressors and puts them back into it with little support."*

Regarding stigma, finance and other barriers to treatment:

##### Respondents' commentary

###### *(Tier 3 - community)*

TS02: *"Finance is a major barrier as it denies individuals any choice in treatment. A lack of adequate daytime facilities for those who have not got health insurance is also a major barrier. Individuals in that position are forced into charitable religious residential treatment which means putting their accommodation at risk."*

TS06: *"There is a stigma around coming into treatment. In general most of our clients are highly functioning with high incomes. People who are working come to counselling and groups, but they are still working. Sometimes they are referred through work and seeking help that way, while others do not want their work to know and are trying to juggle....There should be queues of people waiting to get in here. There is a lack of publicity about what's available -there is a free service here, where are the people? But if you do that (advertise) then you'll have to provide the staffing to back it up. I think also people have a fear of being labelled 'alcoholic'.The term 'functioning' alcoholic is problematic because it excludes people from treatment. Because they are perhaps not causing nuisance on streets etc, that is more apparent with others, the focus is on other substances. Drinking is a much bigger issue (than drugs) but because it's hidden doesn't get the same focus."*

### 3.0 Thematic breakdown of survey results

#### **(Tier 4 - residential)**

TS01: *“People will often opt for less intensive treatment that may or may not be adequate... there is a stigma attached to going into rehab – more perceived perhaps than real, a fear that everybody knows their business.”*

TS07: *“For those who don’t have a medical card, finance is a barrier to treatment and another is people being able to negotiate their way through the jungle of various services. When you explain the steps that they need to take to get to us, sometimes that can seem too onerous when you are caught up in the throes of addiction.”*

*There is a greater emphasis on health led approach now, addiction is a health issue and it is good that approach is being taken. People need to be made aware that (alcohol problems) are not just for those at sharp end ...I see small signs that we are becoming more aware of the impact of alcohol.”*

TS10: *“Their own readiness to change is the number one reason why people who come to us for assessment do not progress into treatment. Stigma is also a significant barrier. Financial circumstances certainly present a barrier for some. Detox services also present a barrier- often times by the time someone has sourced detox they no longer meet the necessary criteria or their attitude towards entering into recovery has changed.”*

#### **Discussion:**

A lack of real commitment to alcohol treatment by government was highlighted as a barrier to accessing treatment. Broadly, service providers did not seek more residential beds, but more so they called for resources such as additional staff and training, and a recognition at government level that alcohol is the most prevalent drug of choice that causes the most harm in Ireland. There is a perception that somehow alcohol is protected from criticism because of its perceived status in Irish society. HRB data on alcohol use in Ireland suggests that there are as many as 250,000 dependent drinkers in Ireland.<sup>52</sup>

However, although the numbers of dependent drinkers are increasing, treatment options are not. An Alcohol Action Ireland analysis of HRB data from 2013 to 2019 shows that although there has been an 8% increase in the number of people accessing inpatient substance misuse treatment, all of it has been in relation to illicit drugs.<sup>53</sup>

HRB data from 2013 to 2019 shows that the number of cases treated for problem alcohol use actually decreased by 3.5% from 7,819 in 2013 to 7,546 in 2019. However, the level of alcohol consumption per capita over the age of 15 actually increased over that time from 10.53 litres to 10.78 litres. Such a level of consumption is approximately 40% higher than the HSE low risk guidelines and suggests there is a high level of harmful drinking in Ireland and in turn a significant level of unmet alcohol treatment needs.

52 A 2019 paper puts Ireland’s dependency rate at 10.5%. See: Mongan D, Millar SR, O’Dwyer C, et al. Drinking in denial: a cross-sectional analysis of national survey data in Ireland to measure drinkers’ awareness of their alcohol use. *BMJ Open* 2020.

53 See HRB annual alcohol treatment reports: <https://www.hrb.ie/publications/publication/alcohol-treatment-in-ireland-2013-to-2019/returnPage/1/>

### 3.0 Thematic breakdown of survey results

The prevalence of faith-based service providers was highlighted by a number of service providers. Service providers with a religious ethos make up about half of all treatment beds provided in Ireland. One provider alone has 300 beds for alcohol, drugs and gambling in various locations around the country. A recent UK report on the issue of faith-based alcohol treatment services highlights the concerns of key stakeholders and some faith-based alcohol treatment providers about: *“moral and judgemental views on alcohol; lack of expert knowledge and experience; lack of registration with regulatory bodies; clarity over ethics, theology and practice; and lack of safeguarding and equality and diversity knowledge and training.”*<sup>54</sup> The UK report also states that: “Service users accounts of faith-based recovery are diverse with significant positive and negative experience.”

No faith-based provider participated in the AAI survey but reflecting on recent research, further exploration of these issues are desirable and highlight a wider need for an oversight body for all treatment service providers. HIQA oversight of all services, with comprehensive standards, regulation and inspection, as recommended in this report, would ensure that faith-based services met the requirements of a modern human-rights based service.

#### KEY RECOMMENDATION:

That Government must recognise that alcohol as a drug is the most significant vector of harm to people, and others, in Ireland. Recognition of this reality could see commensurate funding and attention applied to alleviate a largely avoidable problem.

<sup>54</sup> See: Alcohol Change, Faith in recovery? Service user evaluation of faith-based alcohol treatment, available at: <https://alcoholchange.org.uk/publication/faith-in-recovery-service-user-evaluation-of-faith-based-alcohol-treatment>

## 4.0 Concluding remarks

It is estimated that the socio-economic cost of alcohol harm in Ireland runs to €2.35 billion annually; this includes costs to the health care system, criminal justice system, lost work, loss of life through road deaths and suicide. A HSE/TCD study found that the estimated cost of the 'Harm to Others' could be evaluated at €863 million.<sup>55</sup>

According to the World Health Organisation, health services should provide prevention and treatment interventions to individuals and families at risk of, or affected by, alcohol-use disorders and associated conditions. The WHO stipulates that services “*should be sufficiently strengthened and funded in a way that is commensurate with the magnitude of the public health problems caused by harmful use of alcohol.*”

Understanding the costs of alcohol-related treatment services is an important aspect of public health policy yet there is so much that we do not know about publicly funded alcohol treatment services. For example, as noted previously, we do not know how many are used for alcohol at any one time, or what level of dedicated funding is directed specifically towards alcohol treatment.

The HSE annual service plan allocates in the region of €155M annually for drug and alcohol treatment services across the country. However, as well as funding a wide range of drug and alcohol treatment services, this figure includes funding for access to health services for a range of vulnerable groups including Travellers and Roma, asylum seekers, LGBTQI+ and the homeless. Without robust and transparent data, on how many people are accessing, or seeking, alcohol treatment services, it is very difficult, to have a clear view of what is required to ensure modern, effective service provision.

The current drug and alcohol strategy has adopted a health-led approach to addiction; thus alcohol services should be regarded as part of the health system. Why, then, do they not fall under HIQA's national guidance like all health services? Residential treatment services are one of the last group setting environments not inspected by HIQA. It is also difficult to find information about what kind of service some providers offer, and very little data or insight available on outcomes and the efficacy of services funded through the public finances. A national strategy for residential services and a HIQA inspection regime would ensure that Ireland's treatment services are equipped to provide the best possible care to people in need. In the words of the WHO, we must ensure that the solution is proportionate with the scale of the public health problems caused by harmful use of alcohol.

## Appendices

### Appendix 1

#### Service providers of residential treatment services (publicly funded)

**Aiseiri** (4 locations), Cahir, Co. Tipperary; Ballybeg, Co. Waterford; Ballyragget, Co. Kilkenny; Roxborough, Co. Wexford

**Bushy Park**, Ennis, Co. Clare

**Coolmine**, Dublin

**Cuain Mhuire** (4 locations), Athy, Co. Kildare; Coolarne, Co. Galway; Farnanes, Co. Cork; Bruree, Co. Limerick

**Cuan Dara** (drug only), Dublin

**Hope House**, Foxford, Co. Mayo

**Keltoi**, Phoenix Park, Dublin

**Merchants Quay Ireland** (2 locations, drug only), Dublin

**New Hope Residential Centre**, Dublin

**Peter McVerry Trust Residential Community Detox** (drug only), Dublin

**Rutland Centre**, Dublin

**Simon Community Rehabilitation**, Dublin

**St. Michael's Ward**, Beaumont Hospital (drug only), Dublin

**St. Patrick's Mental Health Services**, Dublin

**St. John of God Hospital**, Dublin

**Tabor Lodge** Co. Cork (3 locations)

**Tabor House**, Navan, Co. Meath

**Talbot Grove**, Ardfert, Co. Kerry

**Tiglin**, Ashford, Co. Wicklow

**White Oaks Centre**, Muff, Co. Donegal

## Appendices

### Appendix 2

#### AAI Treatment Survey

1. What kind of model of treatment is your service based on and what 'Tier' does your service fit into?
2. What are the exclusion criteria (if any) for your service?
3. Can you provide figures for the number of people in treatment over the past 3 years?
4. Does a lack of suitably qualified professionals impact your service? How do you manage that?
5. Where do your referrals come from? Do GPs require training on this issue and should they be more involved in diagnosing/referring?
6. Do you provide an alcohol detox service and do you think more detox services are required?
7. Do you see many clients who also have a mental health need? How do you deal with such cases, i.e. do you have to turn people away based on mental health issues? Figures?
8. Do you have good links with state agencies, i.e. housing, penal, social and mental health services? How could this be improved?
9. Do you ask about Adverse Childhood Experiences (ACEs) and do you think your service should ask this question? If so, can you provide any data?
10. Do you have a follow on care programme?
11. Do you ask about a client's family situation, i.e. if they have children? What kind of support do you have for families?
12. What are the changing demographics/trends you see in your service? Do you experience any challenges in relation to gender/culture when it comes to treatment delivery?
13. What would you classify as the main barrier for people to treatment, i.e. financial, familial, mental health etc.
14. Do you operate a waiting list? If so, can you give an idea of what that looks like/how it works?
15. What are the biggest causes of relapse/do you see high rates of return clients?
16. What are the challenges/gaps in your service?

**Any other comments that you'd like to make are more than welcome.**

### Appendix 3

#### Research project title: Alcohol Treatment Services in Ireland

- I agree to participate in research carried out by Jennifer Hough of Alcohol Action Ireland to aid with the research into alcohol treatment providers.
- I am fully aware that I will remain anonymous throughout data reported and that I have the right to stop or withdraw my consent and information at any time.
- I am fully aware that data collected will be stored securely, safely and in accordance with data protection laws.
- I am fully aware that I am not obliged to answer any question, but that I do so at my own free will.

Printed Name

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Participant's Signature

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Date

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