Focal Point Ireland: national report for 2023 – Treatment

Ireland

Health Research Board. Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction

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(2024) Focal Point Ireland: national report for 2023 – Drug policy

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T0. Summary

National Profile

Ireland's current national drugs strategy is structured around cross-cutting goals rather than the pillars of the previous national drugs strategy. Its main aims are to minimise the harms caused by the use and misuse of substances and to promote rehabilitation and recovery. Therefore, there is a focus on the need for a range of treatment, rehabilitation, and recovery services using the four-tier model. The strategy also recognises the need for timely access to appropriate services for clients.

The Health Service Executive (HSE) is responsible for the provision of all publicly funded drug treatment in Ireland. Drug treatment is therefore provided not only through a network of HSE services (public), but also through non-statutory/voluntary agencies, many of which are funded by the HSE. Some private organisations also provide treatment.

A range of treatment options is available for people with problem drug use, mainly in outpatient settings, but also in residential settings. Almost all opioid agonist treatment (OAT) provided is methadone; however, since November 2017, buprenorphine-based products have been available nationally for patients where clinically appropriate. In 1998, the first formal methadone treatment protocol (MTP) was introduced in order to ensure that treatment for problem opioid use could be provided wherever the demand existed. Outpatient OAT for people with problem opioid use is provided only through specialised HSE outpatient drug treatment clinics, satellite clinics, or specialised general practitioners (GPs) in the community. The first national comprehensive clinical guidelines for OAT were published in 2016.

Trends

The majority of drug treatment (more than 75%) continues to be provided through publicly funded and voluntary outpatient services. Outpatient services include low-threshold and specialised OAT GPs in the community. Inpatient treatment is mainly provided through residential centres run by voluntary agencies.

In 2022, a total of 11,488 treatment entrants were reported. This is a 10.4% increase from the number of cases reported in 2021, when 10,408 were reported. This is likely to indicate that there has been no residual impact of the public health restrictions due to the COVID-19 pandemic on addiction care.

In 2022, cocaine overtook opioids as the most common problem drug reported. The increase in the number of cases presenting for treatment for problem cocaine use continued in 2022. More than one-fifth (21.2%) of cocaine cases were reported to be due to crack cocaine.

Opioids (mainly heroin) were the second most common problem illicit drug used by treatment entrants, followed by cocaine and cannabis. The proportion of all treatment entrants reporting an opioid as their main problem drug has decreased year on year since 2004, from a peak of 65% in 2004 to 33% in 2022.

Cannabis was the third most common problem drug reported in 2022. From 2004 to 2018, cannabis was consistently reported as the second most common main problem drug. The proportion of cases reporting cannabis as their main problem drug peaked at 28.9% in 2013, with the proportion decreasing almost every year since then.

The majority of cases entering treatment have been treated previously. The proportion of new treatment entrants remained relatively unchanged in 2022, at 39%, compared with 2021. The proportion of new treatment entrants has fluctuated, from 39% in 2004 to a peak of 47% in 2009, but the proportion has stabilised at around two-fifths since 2013.

In 2022, cocaine was the most common drug reported by new treatment entrants, a continuation of the trend first seen in 2020.

On 31 December 2020, 11,667 clients were registered for OAT (including those receiving OAT in prison). In 2022, more than one-half of all OAT clients received OAT in specialist outpatient clinics, two-fifths received it from specialist GPs, and an even smaller proportion (less than 6%) received it in prison.

T1. National profile

T1.1. Policies and coordination

T1.1.1. Main treatment priorities in the national drug strategy

Treatment and rehabilitation are covered under Goal 2 of the national drugs strategy, *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* (Department of Health 2017). The main aims of the strategy are to minimise the harms caused by the use and misuse of substances and to promote rehabilitation and recovery. Goal 2 focuses on the range of treatment, rehabilitation, and recovery services available to users. It recognises that "timely access to appropriate services relevant to the needs and circumstances of the person concerned is of fundamental importance" (p. 33). There are two objectives to the goal; the first relates to treatment and rehabilitation and is described below, and the second focuses specifically on people who inject drugs and the issues of overdose and drug-related deaths – this is considered in more detail in the *Harms and harm reduction workbook*.

The first objective under Goal 2 of the national drugs strategy is "To attain better health and social outcomes for people who experience harm from substance misuse and meet their recovery and rehabilitation needs" (p. 33). It focuses on improving access to a range of services, both for users generally and for some groups in particular. The HSE follows a four-tier, person-centred model of rehabilitation which is based on the principle of 'continuum of care'. This continues to be the national framework through which treatment and rehabilitation services are delivered, with all substances of misuse being dealt with and with a focus on polydrug use.

There are a number of actions under each objective; the time frame for their delivery is from 2017 to 2025. In terms of improving access to services, actions include:

- Strengthening the implementation of the National Drugs Rehabilitation Framework (Doyle and Ivanovic 2010) by developing a competency framework on key working, care planning, and case management, and by extending the training programme on the key processes of the Framework.
- Expanding the availability and geographical spread of relevant quality drug and alcohol services and improving the range of services available, based on need. This will be done by identifying and addressing gaps in provision in the four tiers of the model, increasing the number of treatment episodes provided across the range of services, and strengthening the capacity of services to address complex needs.
- Improving the availability of OAT by examining potential mechanisms to increase access through the expansion of GP prescribing and nurse-led prescribing, and through the provision of OAT in community-based settings and homeless services.
- Enhancing the quality and safety of care in the delivery of OAT by implementing the HSE's *Clinical Guidelines for Opioid Substitution Treatment* (Health Service Executive 2016) (Health Service Executive 2020).

Also central to these objectives are a range of actions set out to promote recovery by expanding and improving access to services for specific groups of people, including women; children and young people; groups with more complex needs; and prisoners. For example, these actions aim to:

- Expand addiction services for pregnant and postnatal women
- Respond to the needs of women who are using drugs and/or alcohol in a harmful manner by improving the range of wraparound services available
- Expand the range, availability, and geographical spread of services for those aged under 18 years
- Examine the need to develop specialist services in order to meet the needs of older people with long-term substance use issues, and
- Improve outcomes for people with comorbid severe mental illness and substance misuse problems by supporting the Mental Health National Clinical Programme in order to address dual diagnosis, and by developing joint protocols between mental health services and drug and alcohol services.

For more information on the national drugs strategy, see Section T1.1.2 of the *Drug policy workbook*. In 2023, a new strategic action plan was published (Department of Health 2023). For more information, see Section T3.1 of the *Drug policy workbook*.

T1.1.2. Governance and coordination of drug treatment implementation

The HSE is identified as the lead agency with responsibility for the delivery of most of the treatment- and rehabilitation-related actions under the 2017–2025 national drugs strategy (Department of Health 2017). However, other agencies identified as having lead responsibility on specific actions include the Department of Health, Tusla – Child and Family Agency, and the Irish Prison Service (IPS).

Established by the Health Act 2004, the HSE is responsible for the provision of all publicly funded health and personal social services for everyone living in Ireland. It provides an addiction service, including both drugs and alcohol, delivered through the National Social Inclusion Office, which is part of the HSE's Primary Care Division. The National Social Inclusion Office promotes and leads on integrated approaches to healthcare at different levels across the statutory and voluntary sectors, including the development of integrated care planning and case management approaches between all relevant agencies and service providers.

The HSE supports the non-statutory sector in providing a range of health and personal social services, including the drug projects supported by the local and regional Drug and Alcohol Task Forces, which receive annual funding of more than €20 million. This funding is governed by way of service arrangements and grant aid agreements. The HSE's Primary Care Division assists the Drug and Alcohol Task Forces to participate in planning and reporting in line with the monitoring tool developed by the National Addiction Advisory Governance Group, and it seeks to ensure that funded organisations support and promote the aims and objectives of the national drugs strategy.

Introduced in 2015, the HSE's Performance Accountability Framework makes explicit the responsibilities of all HSE managers, including primary care managers, to deliver the targets set out in the HSE's service plans. Addiction services are provided by the National Social Inclusion Office, the core objective of which is to improve health outcomes for the most vulnerable in society, including those with addiction issues, the homeless, refugees, asylum seekers, and the Traveller and Roma communities.

T1.1.3. Further aspects of drug treatment governance

In order to address problem opioid use and standardise treatment, in 1998 a more formalised methadone treatment protocol was introduced in order to ensure that treatment for problem opioid use could be provided wherever the demand exists (Methadone Prescribing Implementation Committee 2005)(Methadone Treatment Services Review Group 1998). New regulations pertaining to the prescribing and dispensing of methadone were introduced. GPs who wish to prescribe methadone in the community must undergo formalised training, and the number of clients each GP can treat is capped depending on the GP's experience.

While methadone is the main OAT drug prescribed in Ireland, in November 2017 there was a phased roll-out of buprenorphine-based products nationally for appropriate clients (Fitzgerald 2011) (Expert Group on the Regulatory Framework 2011). Prior to 2017, such products were provided to a small number of clients and reported via other sources.

The Central Treatment List (CTL) was established under S.I. No. 225/1998, following the 1998 *Report of the Methadone Treatment Services Review Group* (Methadone Treatment Services Review Group 1998) (also see Section T5.1 of this workbook). The CTL is a complete register of all patients receiving OAT (for treatment of opioid misuse) in Ireland and is administered by the HSE's National Drug Treatment Centre.

The HSE has published comprehensive clinical guidelines for OAT in community and hospital settings (Health Service Executive 2016) (Health Service Executive 2020).

T1.2. Organisation and provision of drug treatment

T1.2.1. Outpatient drug treatment system – Main providers and client utilisation

Outpatient services are provided through a network of HSE services (public) and non-statutory, voluntary agencies (see also Section T1.1.2 and Section T1.4.1 of this workbook). There are an unknown number of private organisations that also provide outpatient addiction treatment, such as counselling. Very few of the private agencies contribute data to the Treatment Demand Indicator (TDI) figures. Some addiction treatment is also provided and/or funded through the HSE's Mental Health Division and is included in the TDI under the category of 'specialised drug treatment centre'. However, many outpatient mental health services do not currently provide data for the TDI.

Low-threshold services provided 11.5% of outpatient treatment reported to TDI in 2022. This is because these agencies provide many additional services that do not meet the inclusion criteria for TDI, such as needle exchange only, social support, food, etc.

Only GPs who have completed the requisite specialist training can provide OAT to clients who are stable. As such, they represent an important part of drug treatment in Ireland, particularly for stable clients on OAT. Of note, the number of GPs providing buprenorphine has increased to 61 as of January 2023 (Dáil Éireann debate. Written answer 1323 - Substance misuse [Rehabilitation

methadone] [63820/22]. 2023) For further information, see Section T1.4.10 of this workbook. Not all GPs choose to provide OAT, and some GPs may provide other drug treatments, such as benzodiazepine and alcohol detoxification, or brief interventions. These other interventions are not currently captured for the TDI, due to resource issues. While there have been concerted efforts by the National Drug Treatment Reporting System (NDTRS) team to improve GP data returns, TDI still does not accurately reflect the total number of OAT clients treated by GPs in the community (see Table I). In 2022, the coverage for GPs increased slightly to 45.9% compared with 44.8% in 2021.

T1.2.2. Further aspects of outpatient drug treatment provision

No new information.

Table I. Network of outpatient treatment facilities (total number of units and clients)

1.	2. Total number of units	3. National definition (characteristics/types of centre included within your country)	4. Total number of clients
5. Specialised drug treatment centres	6. 322	7. Treatment facilities where the clients are treated during the day (and do not stay overnight). Includes OAT clinics, any specialised addiction service (e.g. counselling), therapeutic day care, and socioeconomic training units.	8. 7,881
9. Low-threshold agencies	10. 61	11. Aim to prevent and reduce health-related harm associated with problem drug use, in particular the incidence of blood-borne viral infections and overdoses, and to encourage active drug users to contact health and social services. May provide low-dose OAT, general medical assistance, brief interventions, and needle exchange.	12. 1,161
13. General primary healthcare (e.g. GPs)	14. 392	15.	16. 385
17. General mental healthcare	18.	19.	20.
21. Prisons (in-reach or transferred)	22. 31	23. In-reach provided by voluntary services funded by the IPS and others.	24. 650
25. Other outpatient units	26. 0	27.	28.
29. Other outpatient units	30. 0	31.	32.

T1.2.3. Further aspects of outpatient drug treatment provision and utilisation

No new information.

T1.2.4. Ownership of outpatient drug treatment facilities

All OAT is publicly funded, whether provided in a clinic or by a GP. All HSE outpatient services provide free treatment to those who are entitled to such. Many non-statutory agencies, which include low-threshold agencies, are wholly or partly funded by the HSE (see also Section T1.1.2 of this workbook). The proportion of agencies that are fully funded by the HSE is not currently available and is recorded as 'Other' in Table II, indicating that this is unknown. There is an unknown number of private organisations also providing outpatient addiction treatment, such as counselling. Some of this treatment may be covered by private health insurance; however, the proportion is not known. All addiction treatment in prison is provided free of charge.

Table II. Ownership of outpatient facilities providing drug treatment in your country (percentage). Please insert % in the table below.

33.	34. Public/government	35. Non-government owned 36. (not for profit)	37. Non-government 38. (for profit – private)	39. Other	40. Total
41. Specialised drug treatment centres	42.	43.	44.	45.	46. % 100
47. Low-threshold agencies	48.	49.	50.	51.	52. % 100
53. General primary healthcare (e.g. GPs)	54. 100	55.	56.	57.	58. % 100
59. General mental healthcare	60.	61.	62.	63.	64. % 100
65. Other outpatient units (1)	66.	67.	68.	69.	70. % 100
71. Other outpatient units (2)	72.	73.	74.	75.	76. % 100

T1.2.5. Inpatient drug treatment system – Main providers and client utilisation

Inpatient addiction treatment services are provided mainly through non-statutory agencies. There are two dedicated inpatient hospital HSE detoxification units, but other non-statutory agencies also provide inpatient detoxification services (see Table III). The coverage of inpatient services in TDI is high.

As of June 2020, the HSE estimated that there were 636 residential beds (for both alcohol and other drugs), which consisted of: 12 inpatient unit detoxification beds; 86 community-based residential detoxification beds; 2 adolescent residential detoxification beds; 530 residential rehabilitation beds; and 6 adolescent residential beds. (Dail Eireann debate. Question 340 - addiction treatment services. 2020). However, in 2020, in order to comply with the associated public health measures during the COVID-19 pandemic, the number of residential beds was reduced (Dail Eireann debate. Question 340 - addiction treatment services. 2020) (Bruton et al. 2021). This is a reduction from the total number reported for 2018 (793 beds) (Dail Eireann debate. Question 340 - addiction treatment services. 2020). There is currently no update on whether or not the number of residential beds has increased since 2020, although the number of cases recorded for residential treatment in 2022 has increased compared to 2021 (see Table III, Section T1.2.6 of this workbook).

Mental health services provide inpatient addiction treatment in 66 different hospitals. Figures from these services are not included in the annual TDI figures, which show that in 2022, 813 cases with a drug disorder were admitted to psychiatric facilities (Daly and Lynn 2023). Of these cases, 318 cases were treated for the first time. These figures are lower than what was reported for 2021.

T1.2.6. Further aspects of inpatient drug treatment provision

No additional information.

Table III. Network of inpatient treatment facilities (total number of units)

77.	78. Total number of units	79. National definition (characteristics/types of centre included within your country	80. Total number of clients
81. Hospital-based residential drug treatment	82. 2	83. Wards or units in hospitals where the clients may stay overnight. This figure refers to the two hospital inpatient detoxification units. There are also 66 psychiatric hospitals for inpatients, but these do not currently report to the TDI.	84. 67
85. **86.** Residential drug treatment (non-hospital based)	87. 0	88.	89. 0
90. Therapeutic communities	91. 0	92.	93. 0
94. Prisons	95. 0	96.	97. 0
98. Other inpatient units (1 – please specify here)	99. 57	100. Centres where the clients may stay overnight. They include therapeutic communities,	101. 1,344

		detoxification units, and centres that offer residential facilities. It is not possible to differentiate between residential inpatient and therapeutic communities, so both are reported together in this section.	
102. Other inpatient units (2 – please specify here)	103. 0	104.	105. 0

T1.2.7. Ownership of inpatient drug treatment facilities

Inpatient addiction treatment services are provided mainly through non-statutory agencies. Most of these agencies are partially or wholly funded by the HSE (see also Section T1.1.2 of this workbook). The number of clients and the proportion of treatment facilities that are fully funded by the HSE are not currently available and are recorded as 'Other' in Table IV, indicating that this is unknown. Some of this treatment may be covered by private health insurance; however, the proportion is not known.

Inpatient mental health services are provided free of charge to social welfare clients with the appropriate entitlements. Some mental health services treatment can be covered by private health insurance; however, again, the proportion is not known.

Table IV. Ownership of inpatient facilities providing drug treatment in your country (percentage). Please insert percentage in the table.

106.	**107. Public/ 108. government**	**109. Non-government owned 110. (not for profit)**	**111. Non-government 112. (for profit – private)**	**113. Other**	**114. Total**
115. Hospital-based residential drug treatment	116.	117.	118.	119.	120. 100 %
121. Residential drug treatment	122.	123.	124.	125.	126. 100 %
127. (non-hospital based)	128.	129.	130.	131.	132. 100 %
133. Therapeutic communities	134.	135.	136.	137.	138. 100 %
139. Prisons	140. 100%	141.	142.	143.	144. 100 %
145. Other inpatient units (1 – please specify here)	146.	147.	148.	149.	150. 100 %
151. Other inpatient units (2 – please specify here)	152.	153.	154.	155.	156. 100 %

T1.2.8. Further aspects of inpatient drug treatment provision and utilisation

Data from September 2022 showed that average waiting times for hospital inpatient detoxification was between 6 and 12 weeks (depending on the service). Other residential detoxification waiting times ranged from 1 month to 9 months (depending on the service). Waiting times for other residential rehabilitation services ranged from zero days to approximately 4 months (depending on the service) (Dáil Éireann debate. Written answer 715 - Substance misuse [Residential] [48595/22]. 2022).

T1.3. Key data

T1.3.1. Summary table of key treatment related data and proportion of treatment demands by primary drug

The number of entries to treatment reported in 2022 showed a continuation of the increase seen in 2021, indicating no residual impact of public health restrictions due to the COVID-19 pandemic on addiction care.

In 2022, for the first time, cocaine (3,872 cases) surpassed opioids (3,808 cases) as the most common main problem drug for cases entering treatment (see Figure I).

The proportion of all cases entering treatment for problem cocaine use has increased again, from 30.2% (3,139) in 2021 to 33.7% (3,872) in 2022. This is a continuation of the upward trend observed over the past number of years (see also Section B T1.2.2 of the *Drugs workbook*).

The proportion of all cases entering treatment reporting opioids as their main problem drug dropped again in 2022 to 33.1%, compared with 33.7% in 2021. The rate of decrease in 2022 was lower than in previous years, but it is a continuation of the overall downward trend in the number and proportion of cases presenting to treatment for problem opioid use, for example, compared with 64.6% in 2004.

Heroin continues to be the main problem drug in this category, with 86.6% of all cases with problem opioid use reporting heroin as their main problem drug in 2022. The proportion of opioid cases seeking treatment for heroin has decreased slightly in the past three years (87.3% in 2021 and 89.7% in 2020) (see also Section C T1.2.2 of the *Drugs workbook*).

Cannabis remains the third most common problem drug reported (19.0%) in 2022. The proportion of cases treated for problem cannabis use peaked in 2013 at 28.9% but has shown a downward trend ever since (see also Section A T1.2.2 of the *Drugs workbook*).

Benzodiazepines remain the fourth most common problem drug reported; the proportion of cases treated for problem use of benzodiazepines in 2022 was 10.7%, similar to the proportion reported in 2021 (11.3%).

Amphetamines (0.3%) and ecstasy (0.1%) continued to make up a very small proportion of the main problem drugs reported in 2022, a similar trend to previous years (also see Section B 1.2.2 of the *Drugs workbook*).

For further information, see Section T2 of this workbook.

T1.3.2. Distribution of primary drug in the total population in treatment

No new information.

T1.3.3. Further methodological comments on the Key Treatment-related data

No new information.

T1.3.4. Characteristics of clients in treatment

Drug treatment demand in Ireland, 2022

Published in June 2023, the latest annual publication from the NDTRS reported data on treated problem drug use (excluding alcohol) for the year 2022, followed by trends for the 7-year period from 2016 to 2022 (O'Neill et al. 2023a). Note that the selection used for the cases reported in the NDTRS report is slightly different to what is reported through TDI.

This report showed that, in 2022, some 12,009 cases were treated for problem drug use. This is the highest annual number of cases recorded by the NDTRS to date. Almost 4 in 10 (37.1%) of those cases were never treated before, while almost 7 in 10 (68.9%) cases were treated in outpatient facilities.

Cocaine was the most common main problem drug reported in 2022, accounting for 1 in 3 (34.0%) treated cases. Opioids were the second most common main problem drug reported in 2022. Heroin accounted for 86.6% of these opioid cases. Cannabis was the third most common main problem drug reported in 2022, while benzodiazepines were the fourth. Among new cases, cocaine (41.3%) was the most common main problem drug reported in 2022. Among previously treated cases, opioids (45.7%) were the most commonly reported main problem drug.

Problem use of more than one drug (polydrug use) was reported in more than one-half of cases (56.8%) in 2022. Cannabis (40.3%) was the most common additional substance reported by cases with polydrug use, followed by alcohol (36.2%), cocaine (36.1%), and benzodiazepines (32.2%) (see Figure I).

Among new cases with polydrug use reported in 2022, alcohol (50.5%) was the most common additional substance, while among previously treated cases with polydrug use, cannabis (40.8%) was the most common additional substance. Among cases with polydrug use, the most common drugs used together were: (i) cocaine plus alcohol, followed by (ii) cocaine plus cannabis, followed by (iii) opioids plus cocaine.

In 2022, powder cocaine accounted for almost 8 in 10 treated cocaine cases (78.0%), while 2 in 10 (22.0%) were crack cocaine.

Powder

For cases with powder cocaine as the main problem drug, nearly 8 in 10 (78.6%) were male and 4 in 10 (41.4%) were employed.

One-half of cases entering treatment for powder cocaine were aged 30 years and under.

Crack

For cases with crack cocaine as the main problem drug, 4 in 10 (42.0%) were female, 6 in 10 (58.0%) were male, and less than 1 in 10 (5.6%) were employed.

One-half of the cases entering treatment for crack cocaine were aged 39 years and under.

Crack cocaine cases resided mostly in Dublin, Kildare, Meath, and Limerick.

Among young cases aged 19 years and under, cannabis was the main drug generating treatment demand. Among those aged 20–34 years, cocaine was the main drug generating treatment demand, while among those aged 35 years and over opioids were the main drug generating such demand.

A summary of the sociodemographic characteristics show:

The median age of cases was 33 years.

One in seven (13.9%) cases were recorded as homeless.

The proportion of cases with an Irish Traveller ethnicity was 3.0%

Almost three in five (59.1%) cases were recorded as unemployed.

One in five (22.0%) cases were in paid employment.

In 2022, rates of homelessness, ceasing education before the age of 16 years, and unemployment were higher among previously treated cases than among new cases.

In 2022, almost 3 in 10 (27.9%) cases were female, while 13 cases identified as non-binary or in another way.

A comparison by gender was reported.

Females

The median age was 34 years, while the median age for new cases was 29 years.

A total of 1 in 2 (51.5%) cases were aged under 35 years.

5.7% were aged 50 years and over.

13.6% were homeless.

For one-half of female cases, the time lag between first use of the main problem drug and seeking treatment was 7 years or longer.

Among females, the most common main problem drugs were opioids (37.0%), followed by cocaine (31.6%) and cannabis (16.1%). The same drugs were also most common among new female cases entering drug treatment for the first time. However, the order was different, with cocaine (34.8%) being the most frequent, followed by cannabis (30.5%) and then opioids (18.5%).

55.9% reported polydrug use, most commonly cannabis and cocaine.

Males

The median age was 32 years, while the median age for new cases was 27 years.

The majority (56.7%) of cases were aged under 35 years.

5.9% were aged 50 years and over.

14.0% were homeless.

For one-half of male cases, the time lag between first use of the main problem drug and seeking treatment was 8 years or longer.

Among males, the most common main problem drugs reported were cocaine (35.0%), followed by opioids (31.6%) and cannabis (19.6%). The same drugs were also most common among new male cases entering drug treatment for the first time. However, the order was different, with cocaine (43.5%) being the most frequent, followed by cannabis (33.4%) and then opioids (11.8%).

57.1% reported polydrug use, most commonly cannabis and alcohol.

In 2022, almost one-half of cases (47.3%) in drug treatment were parents who had children. Where parents were known to have children aged 17 years and under, 39.6% had at least one child residing with them at the time of treatment entry, while 59.9% had at least one child residing elsewhere . A higher proportion of females entering drug treatment reported having dependent children and living with children, while males were more likely to not be residing with their children.

Looking at trends between 2016 and 2022, a total of 71,567 cases treated for problem drug use (excluding alcohol) were reported to the NDTRS. Over the 7-year period 2016–2022, opioids (mainly heroin) were the most common drug type reported, followed by cocaine and cannabis.

Trends have changed over the time period, however, and in 2022 cocaine was the most common main problem drug reported. The proportion of cases treated for cocaine as the main problem drug increased from 12.3% in 2016 to 34.0% in 2022. Over the period 2016–2022, there was a 258.9% increase in the number of cases where cocaine was the main problem drug. As a proportion of all cases treated, opioids as the main problem drug decreased year-on-year, from 47.0% in 2016 to 33.1% in 2022. Heroin accounted for 86.6% of all opioid cases in 2022. The proportion of cases treated for cannabis as the main problem drug decreased from 26.4% in 2016 to 18.7% in 2022.

Among new cases, cocaine as the main problem drug increased annually from 16.1% in 2016 to 41.3% in 2022, a 223.8% increase in the number of cases. The proportion of opioids as the main problem drug decreased steadily from 26.9% in 2016 to 12.6% in 2021 and increased to 13.4% in 2022.

Among previously treated cases, the most common main problem drugs reported were opioids, cocaine, and benzodiazepines. Decreasing trends were observed among previously treated cases for opioids and cannabis as main problem drugs, while increasing trends were observed for cocaine and benzodiazepines as main problem drugs.

The proportion of all cases that had ever injected decreased year-on-year, from 32.1% in 2016 to 20.8% in 2022. Over the 7-year period, there was a 15.8% decrease in the number of cases reporting that they had ever injected. Among new cases, the proportion that reported ever injecting decreased over the period from 13.5% in 2016 to 4.4% in 2022. The proportion of previously treated cases that reported ever injecting decreased from 44.6% in 2016 to 31.3% in 2022. In 2022, some 42.7% of cases that had ever injected had also shared needles and syringes, an increase on 37.2% in 2019.

T1.3.5. Further top level treatment-related statistics

No new information.

Table V. Summary table – clients in treatment

157.		158.	Number of clients
159.	Total clients in treatment	160.	11,488
161.	Total OAT clients	162.	11,667
163.	Total clients entering treatment	164.	Data on OAT and TDI are from different sources, are collected using different methodologies, and have duplication between them; therefore, they cannot be combined or compared meaningfully.

Source: ST24 and the TDI

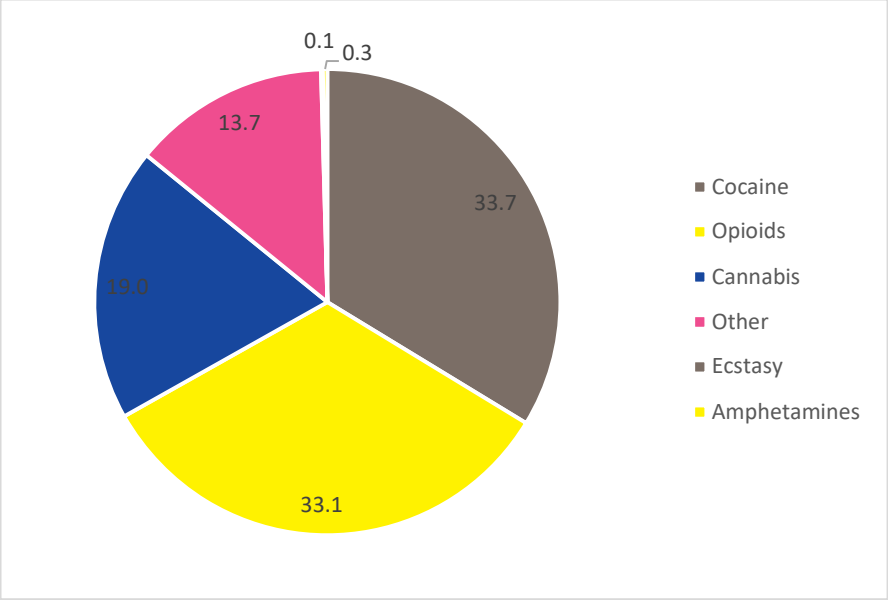

Figure I. Proportion of treatment demands by primary drug (2022)

T1.4. Treatment modalities

Outpatient and inpatient services

T1.4.1. Please comment on the types of outpatient drug treatment services available in your country and the scale of provision, as reported in table VI below.

The types of treatment and services offered vary depending on the ethos and primary purpose of individual drug treatment centres. The majority of OAT is provided by designated HSE clinics, which often also offer other specialist services, including psychiatry, counselling, social services, and general medical services such as vaccinations (see also Section T1.4.9 of this workbook).

Development of a care plan and case management are integral parts of a client's treatment programme (Doyle and Ivanovic 2010). Services that do not offer OAT may provide a wide variety of

other treatments, including counselling, group therapy, socioeconomic training, complementary therapies, relapse prevention, etc. Clients who require specialised treatments that are not available in the service they are currently attending will be referred on to a service that can provide those treatments. It is not mandatory for GPs to provide OAT (see also Section T1.4.9 of this workbook).

Addiction treatment in prison is delivered by the prison medical service or by in-reach services provided by voluntary agencies. Treatments include 21-day pharmacy-supervised detoxification (Cronin *et al*. 2014), OAT, and psychiatric treatment; counselling is mainly provided by in-reach services (Dail Eireann debate. Written answer 223 - Prison service [23629/22]. 2022)

Currently, as IPS medical units do not participate in the NDTRS, only data on counselling are provided to the TDI.

There are no data currently available for Table VI, with the exception of data on individual case management.

Table VI. Availability of core interventions in outpatient drug treatment facilities
Please select from the drop-down list the availability of these core interventions.

165.	166. Specialised drug treatment centres	167. Low-threshold agencies	168. General primary healthcare (e.g. GPs)	169. General mental healthcare
170. Psychosocial treatment/ counselling services	171. Not known	172. Not known	173. Not known	174. Not known
175. Screening and treatment of mental illnesses	176. Not known	177. Not known	178. Not known	179. Not known
180. Individual case management	181. >75%	182. >75%	183. Not known	184. Not known
185. Opioid substitution treatment	186. Not known	187. Not known	188. Not known	189. Not known
190. Other core outpatient treatment interventions (please specify in T1.4.1.)	191. Not known	192. Not known	193. Not known	194. Not known

T1.4.2. Further aspect of available outpatient treatment services

No new information.

T1.4.3. Availability of core interventions in inpatient drug treatment services

Residential drug treatment (non-hospital based), including therapeutic communities: These services are provided mainly by non-statutory voluntary services, and the ideology behind each varies according to the agency running the service. Some require clients to be drug free and, depending on the service, may also require them to be off methadone. These types of services offer a wide range of treatments, including counselling, group therapy, social/occupational activities, family therapy, complementary therapies, and aftercare. More detailed information on the services

offered by non-hospital-based residential services (mainly run by voluntary services) can be found in Section T1.5.3 in the *Harms and harm reduction workbook*).

Detoxification: There are two dedicated HSE hospital inpatient detoxification units (with a total of 12 beds as of 2020, plus 6.5 stabilisation beds that can be used interchangeably). There are 11 other residential centres, provided by voluntary/non-statutory services, that also offer detoxification as part of their suite of residential treatment (a total of 86 beds as of 2020). There is one centre that provides adolescent residential detoxification (with a total of two beds as of 2020) (Doyle 2022).

Inpatient psychiatric hospitals: Addiction treatment provided in psychiatric hospitals includes psychiatric treatment, detoxification, and any other medical treatment required by the client.

Some residential services cannot provide OAT due to staffing and governance issues but will facilitate clients to continue their OAT through an outpatient service. Detoxification-only programmes will offer a different range of services compared with longer-stay residential rehabilitation services, depending on the length of the programme.

Clients who require specialised treatments that are not available in the service they are currently attending will be referred on to a service that can provide those treatments.

The data in Table VII should be interpreted under the proviso that the interventions are available if appropriate to the service, as there is no State-mandated model of treatment for inpatient services. For therapeutic communities and prisons, this is not applicable.

Table VII. Availability of core interventions in inpatient drug treatment facilities
Please select from the drop-down list the availability of these core interventions.

195.	196. Hospital-based residential drug treatment	197. Residential drug treatment 198. (non-hospital based)	199. Therapeutic communities	200. Prisons
201. Psychosocial treatment/counselling services	202. Not known	203. >75%	204.	205.
206. Screening and treatment of mental illnesses	207. >75%	208. >75%	209.	210.
211. Individual case management	212. >75%	213. >75%	214.	215.
216. OAT	217. >75%	218. >75%	219.	220.
221. Other core inpatient treatment interventions (please specify in Section T1.4.3.)	222. Not known	223. Not known	224.	225.

T1.4.4. Further aspect of available inpatient treatment services

No new information.

T1.4.5. Targeted interventions for specific drug-using groups

Senior drug users (aged 40 years and over): There are no specific services for senior drug users; they can access treatment through the normal channels.

New psychoactive substance (NPS) users: There are no specific services for NPS users; they can access treatment through the normal channels.

Recent undocumented migrants (asylum seekers and refugees): There are no specific services for undocumented migrants. Asylum seekers and refugees who apply for a State Medical Card can access free treatment provided by public services.

Women (gender-specific): There are just two residential treatment centres that cater for women where they can attend with their children. Otherwise, women can access treatment through the normal channels.

There are drug liaison clinics in several maternity hospitals in Ireland. In 2021, 103 women were referred to the drug liaison midwife in the Rotunda Hospital, a large maternity hospital in Dublin (The Rotunda Hospital 2022). Thirty-nine of the women were on OAT (see also Section T1.3.6 of the *Harms and harm reduction workbook*).

Underaged children and adolescents: There are some specific outpatient services that cater for children aged under 18 years (see also Section T1.4.1 of the *Harms and harm reduction workbook*). There is also one residential treatment centre for children aged under 18 years for both detoxification and residential rehabilitation.

Other target groups – People receiving treatment in prison: In 2022, the IPS estimated that approximately 70% of prisoners have substance misuse problems (Dail Eireann debate. Written answer 223 - Prison service [23629/22]. 2022). On committal, every person is medically assessed. Those who report problem opioid use, when confirmed by laboratory testing and where clinically appropriate, are offered a medically assisted symptomatic detoxification as per IPS policy. If a person is on OAT, they can discuss stabilisation and continued maintenance. The IPS has protocols with the HSE in order to enable the seamless transfer of OAT clients from prison back to the community.

Counselling, motivational interviewing, cognitive behaviour therapy, and other psychological supports are provided by Merchants Quay Ireland (MQI) on behalf of the IPS. MQI anticipates restarting an 8-week programme (postponed during the COVID-19 pandemic), which enables a person to undergo OAT detoxification in conjunction with a daily structured programme provided by external voluntary organisations.

Not all interventions are available in open prisons, as a person needs to be drug free in order to secure a transfer to those facilities. Also see the *Prison workbook*.

T1.4.6. E-health interventions for people seeking drug treatment and support online

Online drug screening tool

Currently, there is no Internet-based drug treatment (IBDT), as defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), reported via the TDI. However, the Drug Use Disorders Identification Test (DUDIT) drug screening tool is available online for individuals aged over 18 years. With this tool, a person answers 11 questions and is then provided with a video containing personalised feedback based on their answers. Depending on their answers, the automated feedback

may advise them to contact a health professional (for more information, visit: http://www.drugs.ie/drugtest).

T1.4.7. Treatment outcomes and recovery from problem drug use

No new information.

T1.4.8. Social reintegration services (employment/housing/education) for people in drug treatment and other relevant populations

No new information.

T1.4.9. Main providers/organisations providing opioid substitution treatment

Outpatient OAT for people with problem opioid use is provided only through HSE drug treatment clinics, satellite clinics, or specialised GPs in the community, and is provided free of charge. Under the opioid treatment protocol (Methadone Prescribing Implementation Committee 2005) (Methadone Treatment Services Review Group 1998), GPs in the community are contracted to provide OAT at one of two levels: Level 1 or Level 2. Level 1 GPs are permitted to maintain OAT for people with problem opioid use who have already been stabilised on OAT. Each GP qualified at this level is permitted to treat up to 15 stabilised patients. Level 2 GPs are allowed to both initiate and maintain OAT. Each GP qualified at Level 2 may treat up to 35 OAT patients. Practices where 2 Level 2 GPs are practising are permitted to treat up to 50 OAT patients in total.

In 2022, according to data from the CTL, as of 31 December 2022, 56.0% of patients received OAT in specialist outpatient clinics; 38.2% received OAT from GPs; 5.7% received it in prison; and less than 1.0% received it in an inpatient setting (unpublished data, CTL, 2023; also see Figure IV in Section T2.2 of this workbook). These trends are similar to those reported for 2021.

The proportion of clients receiving OAT from GPs has increased slowly but steadily over the years, from 32% in 2001 to a peak of 41% in 2015. The change seen between 2001 and 2015 likely reflects the policy of moving stable OAT clients back to primary care, where they can receive all their care, including OAT, from their own GP.

T1.4.10. Number of clients in OST

The number of clients registered for OAT on 31 December each year is reported by the CTL, the national register of all clients on OAT (see Figure IV in Section T2 of this workbook, as well as ST24).

On 31 December 2022, 11,667 clients were registered for OAT (including those receiving OAT in prison) (personal communication, CTL, 2023).

There was a small increase in the number of people registered for OAT in 2022 when compared with the comparable figures for 2021. This is likely due to the response of addiction services to the COVID-19 pandemic, as there were concerted efforts to improve access to OAT by reducing waiting lists,

allowing some services and GPs to increase their caseload, which led to an increase in clients and a decrease in any waiting lists.

Almost all clients receive methadone maintenance treatment (MMT) as their opioid substitute, as historically this has been the primary drug of choice for treating opioid dependency in Ireland (Health Service Executive 2016)(Health Service Executive 2020). However, in November 2017, there was a phased national roll-out of buprenorphine-based products to appropriate clients, which is now also included in the official reporting of the CTL, the national OAT register (see ST24 for more information). While the number of clients receiving buprenorphine-based products has increased, in 2022, 94% of those receiving OAT were prescribed methadone.

T1.4.11 Characteristics of clients in OST

No new information.

T1.4.12. Further aspect on organisation, access and availability of OST

Pregnant women accessing OAT

A study from a busy Dublin maternity hospital looked at problem opioid use and other drug use over the 10-year period 2010–2019 in women attending their specialist clinics with dedicated drug liaison midwives (Corbett et al. 2022). In total, 525 (0.6%) women self-reported drug use, out of 82,669 deliveries. This is likely to be an underestimation.

There was a significant reduction in the proportion of women on OAT over the period, with 97% (64) in 2010 down to 64.5% (20) in 2019, which appears in line with the reduction in self-reported heroin use. In 2010, of the women on OAT, 25% had been prescribed it for the first time during that pregnancy, compared with 35% in 2019.

The study found that infants born to women in this cohort had a 52% risk of being admitted to neonatal intensive care (NICU). The rate of admission to NICU for opioid-exposed infants for neonatal abstinence syndrome fluctuated over the period from a low of 15% in 2011 to a high of 68% in 2019.

The authors stress that interventions to reduce drug-related morbidity are integral to the specialist antenatal clinic, which includes counselling and harm reduction. The need for targeted postnatal support is also highlighted in relation to drug-related crises and the high level of psychiatric comorbidity identified.

For more information, see Section T1.1.5 of the *Harms and harm reduction workbook*.

Nurse prescribers for OAT

There is no update on the expanding the role of nurse prescribing, to include nurse prescribing of OAT (Dáil Éireann debate. Written answer 782 Substance misuse. 2022). The need for nurse prescribing is an issue that has been raised for a number of years (Comiskey *et al*. 2019).

Association between increased levels of hope and slower rates of relapse following discharge from OAT

A recent study evaluated the association between levels of hope and rates of relapse following discharge from OAT and/or detoxification programmes among people with problem opioid use (Reddon and Ivers 2023).

The background to the study is in relation to the personal hope of a person on OAT as an important aspect of personal recovery capital. Hope has been shown to be pivotal in the recovery process and can be a determinant of overall recovery outcomes. The term 'hope' has been conceptualised as having a positive outlook for the future. It consists of two pathways: pathways thinking and agency thinking. Pathways thinking refers to an individual's ability to develop routes to goal achievement, whereas agency thinking refers to their level of intention, confidence, and ability in reaching the desired outcome. Both these pathways have been linked with improved impulse control among those recovering from problem opioid use. However, there has been limited evaluation of the success of interventions to improve hope in this cohort.

Participants were recruited through publicly funded residential services in Ireland. All participants had previously received a 4–6-week detoxification treatment programme which included a 10-day methadone detoxification. Following detoxification, patients followed three distinct recovery pathways, including inpatient, outpatient, and self-selected programmes. Those aged 18–65 years were included in the study. A total of 142 participants met this inclusion criteria and consented to take part.

The study was designed prospectively, with data collection points organised at initial assessment, as well as at the 3-, 6-, and 9-month mark. At each data collection point, participants completed a self-reported questionnaire that included sociodemographic factors, medical background, and previous engagement with addiction services. A validated measure, the Adult Trait Hope Scale provided a means to assess 'hope'. This scale includes 12 items, with 4 items measuring pathways thinking, 4 items measuring agency thinking, and 4 distractor items. The primary outcome objective was the first self-reported opioid relapse, which was either a single event substance use or a return to daily use.

Among the 142 study participants, the mean age was 34.5 years, 30.3% were female, and a high proportion were experiencing homelessness (85.9%). Inpatient rehabilitation, outpatient rehabilitation, and no formal care were received in 59.2%, 19.0%, and 21.8% of study participants, respectively. Average years of reported drug use was 14.3 years, and more than 50% of individuals had engaged previously with addiction services.

The study demonstrated that high levels of hope among participants had a protective effect on their rate of relapse during the 9-month window of the study period. For every increase of five units in a participant's overall hope score, there was a 23% decrease in their likelihood of relapse. The agency-hope domain was strongly associated with a slower relapse rate, while the association between the pathways aspect and lower relapse rate was not significant. This is in line with current literature which suggests that hope and the agency-hope domain are strongly associated with treatment adherence, initiation, and completion.

The task of improving hope among those with problem opioid use remains challenging due to the wider determinants of drug use, such as socioeconomic status and stigmatisation. Peer-based recovery and addiction communities are examples of interventions that could increase levels of hope. The high failure rate of standalone interventions indicates that a multifaceted approach is needed for long-term recovery adherence. This demonstrates the need for long-term

implementation of a more integrated approach to recovery, particularly peer-led addiction services and socialisation.

The limitations of this study include the self-reported nature of the assessment, the lack of information on participants' frequency of opioid use, the non-random sample, and the high occurrence of homelessness among study participants. Nonetheless, the study builds on the literature surrounding hope levels and the addiction recovery process.

Increased measures of hope are associated with slower rates of relapse among those receiving treatment for problem opioid use. Further implementation and examination of interventions that increase hope levels and personal agency will play a key role in addiction recovery.

A human rights-based exploration of service-user narratives in Irish MMT

A 2022 qualitative study looked at how to better understand the human rights perspective in relation to people accessing MMT services in Ireland. In-depth qualitative interviews about the experience of undergoing MMT were conducted with 40 current and recent service users (Healy et al. 2022). The majority of participants were from Dublin and included 17 women and 23 men. Data were collected between January and December 2019 and analysed using a narrative inquiry design.

The authors found five interrelated themes among the narratives of the participants:

1. Giving away control and the eroding of one's personal autonomy
2. Coercive, restrictive, and disrespectful practice
3. A system predicated on reward and punishment
4. Service providers disregarding best practice, and
5. Consequences of system failure.

A sample of the narratives included:

Theme 1: Giving away control and the eroding of one's personal autonomy

This is characterised by power imbalances; restriction of personal agency; and fear of perceived authority.

Many expressed living in fear, being 'controlled' or 'chained', and feeling like a 'puppet' due to the practices of some service providers. They reported that they felt doctors had powers which often impinged on their private lives, such as around childcare, and which brought unnecessary difficulty to their lives.

> I do feel under threat by the doctor. She's never come straight out and said it, but there are things she could do that would make my life more awkward. She could put me back on 'dailys' [daily supervision of consuming methadone]…and she uses this to control me (Joseph, p. 5).
>
> As for dignity and respect, me bollix. One dirty urine, the takeaway is gone, even if you have months of clean urines. Really, with the amount of urines, clean urines that I've given, I should be on weekly takeaways. If I had these, maybe then I could get a job (Jason, p. 5).

Theme 2: Coercive, restrictive, and disrespectful practice

This is characterised by unmet expectations of treatment; social opprobrium; and shame and hopelessness. Many service users spoke of becoming disillusioned with their expectations of MMT, which they had hoped would improve their lives, enabling them to rehabilitate, return to work, and repair relationships, for example. Moreover, most participants felt they had received unequal

treatment when compared with other health service users, and they sometimes felt treated like second-class citizens.

> I can't complain, anything I done was my own fault, dirty urines so I had to be punished. Anything I got punished for was my own fault. (Emma, p. 5).

Theme 3: A system predicated on reward and punishment

This is characterised by pejorative binaries and the lack of a robust complaints facility. Participant narratives often referred to being 'dirty/clean' (in relation to urines) and how this was internalised. Some participants spoke of their reluctance to make a complaint about certain service providers because of the fear of any ensuing consequences.

> I can't complain about him [doctor/service provider], even it was anonymous, he would find out it was me…I would be reluctant to make a complaint because I think he would make my life a living hell (Jason, p. 6).

Narrative 4: Service providers disregarding best practice

This is characterised by an observed lack of staff knowledge and experience and lack of choice. Narratives suggested some participants felt doctors in MMT services did not have enough experience, and this hampered participants' recovery.

> I don't feel my doctor knows enough about addiction to be running my life. They don't do much training, but we are expected to do all the work to get on methadone and stay on methadone…They don't realise there is more to it than the drug (Lisa, p. 6).

Some participants also felt that some doctors often overlooked their other medical problems, such as stress, anxiety, and pain.

Theme 5: Consequences of system failure

This is characterised by geographical restrictions; the stigma of MMT precluding social reintegration; being 'back in the circle'; and a lack of follow-up care. Many participants, especially those from more rural areas, discussed the consequences of long waiting times – ranging from 2 months to 2 years – to access MMT services.

Narratives frequently indicated that the set-up of MMT services hindered the attempts of many service users to get employment, which put some of them at risk of returning to criminal activities in order to alleviate financial pressures. The participants spoke of other external risks associated with MMT, for example, exposure to drug dealing in the environs of the clinics.

> Going back into the clinics every day makes it impossible to stay clean, especially when you're from the inner city. Zimovane, Valium, there would be everything, never mind heroin. And I'd be stable. I think that once you get stable there is no need for you to be going in there every day or even every few days…I could get lay on [drugs first, money later], the lot, I wouldn't even need money (Robbie, p. 7).

Other issues highlighted were the lack of support services when a person finishes MMT, and then the subsequent problem of re-accessing services if they need to return to treatment. These factors encouraged participants to stay in MMT rather than move on.

The authors conclude that their study presents an overarching narrative which does not support the position that Irish MMT services are "compliant with a human rights-based approach that

incorporates principles such as fairness, respect, equality, dignity and autonomy" (p. 7). As such, the study points to possible 'system failures' in Irish MMT services. The response needs to be multidimensional and include adequate resources in order to move towards a more human rights-based approach within the system.

T1.5. Quality assurance of drug treatment services

T1.5.1. Quality assurance in drug treatment

Organisational attributes and client engagement in community OAT services

A new study explored what client characteristics and staff perceptions impacted on client engagement with outpatient OAT (Kelly et al. 2022a). This was a multi-site cross-sectional study using the concept of organisational readiness to change (ORC) as a measure of the overall functioning of a service. Internationally validated and reliable data collection tools were used: the Survey of Organizational Functioning tool for staff (n=132) and the Client Evaluation of Self and Treatment tool for clients (n=262).

The study showed, in line with similar international research, that there were higher levels of engagement, rapport, and participation from clients where the service they attended had better levels of functioning, as per the ORC, and included positive measures of staff autonomy and empowerment. However, clients who had been longer in treatment (more than 73 months) reported significantly lower levels of satisfaction.

The authors state that the study shows the need to understand both the service and the client attributes in order to improve the overall quality of OAT treatment. They state that policy-makers need to take a 'whole system' approach when planning, developing, and evaluating services.

Organisational characteristics and training adoption in Irish community drug treatment services

A related study to the multi-site cross-sectional ORC study looked at the impact of staff and service characteristics on staff training uptake in OAT services (Kelly et al. 2022b). The study found a number of characteristics associated with willingness to take up training: for example, staff with lower levels of stress and more influence with peers were more likely to take up training. The authors conclude that the managers of OAT services need to take the structure of the individual service into account when undertaking any changes and any associated training required.

T2. Trends

T2.1. Long term trends in numbers of clients entering treatment and in OST

The number of new cases reported in 2022 has increased when compared with 2021 and has surpassed the number of cases reported for 2020, which indicates that there appears to be no residual impact from public health restrictions due to the COVID-19 pandemic on addiction care.

In 2022, there were 4,455 new treatment entrants recorded (see also the TDI). This represents an increase when compared with the 4,200 new entrants reported in 2021.

Proportionally, in 2022, new treatment entrants represented 38.8% of all cases, which is similar to the 2021 figure (40.5%). The proportion of new treatment entrants has fluctuated over the 14-year reporting period, peaking at 47.2% in 2009, but it has stabilised since 2014 at around 39%.

In 2011, cannabis surpassed opioids (mainly heroin) as the main problem drug reported by new treatment entrants, but in 2020, the number of new entrants reporting cocaine as the main problem drug just surpassed cannabis for the first time. This trend continues for 2022, with 41.3% of new treatment entrants reporting cocaine as the main problem drug, compared with 32.8% reporting cannabis.

In 2021, 'other drugs' (mainly benzodiazepines) was the fourth largest group of main problem drugs reported by new treatment entrants, which is similar to previous years.

Both amphetamines and ecstasy continue to be very rarely reported as main problem drugs by new treatment entrants.

All treatment entrants (Figure III)

The number of all cases reported in 2022 has increased when compared with 2021, and has surpassed the number of cases reported for 2019, which indicates that there appears to be no residual impact from public health restrictions due to the COVID-19 pandemic on addiction care (see Figure III).

In 2022, a total of 11,488 treatment entrants was recorded (see also the TDI). Of the cases recorded in 2022, the majority (55.2%) had been previously treated, the same as in 2021 (55.1%).

In 2022, cocaine (33.3%, includes powder and crack) surpassed opioids as the most common problem drug reported among all treatment entrants. There has been an increase in the number of cases presenting for treatment for problem cocaine use since 2015. Previously, the highest proportion of cases was reported in 2007 at 13.3%, dropping steadily until 2012, when it stabilised; however, the proportion of cases has increased since then to a new peak of 33.3% in 2022, compared with 30.2% in 2021. In 2022, 21.2% (820) of cocaine cases were crack cocaine.

In 2022, opioids (mainly heroin) were the second most common problem drug reported by treatment entrants, with 33.1% of all entrants, compared with 33.7% in 2021. The number of cases reporting problem opioid use peaked in 2010 at 4,929 and has shown a consistent downward trend since then.

Cannabis (19.0%) was the third most common problem drug reported in 2022. From 2004 to 2018, cannabis was consistently reported as the second most common main problem drug. The proportion

of cases reporting cannabis as their main problem drug peaked at 28.9% in 2013, and has been decreasing almost every year since then.

In 2022, 'other drugs' (mainly benzodiazepines) was the fourth most common group of main problem drugs reported, which is similar to previous years.

Both amphetamines and, to a lesser extent, ecstasy are very rarely reported as main problem drugs by treatment entrants in Ireland. In 2022, there were 34 amphetamines cases reported, compared with 25 in 2021, while there were only 16 ecstasy cases reported, compared with 12 in 2021. However, these small numbers make interpretation difficult.

Please note that the data reported via TDI are a different selection from the data reported in the regular NDTRS bulletins (O'Neill et al. 2023b) and interactive tables (see https://www.drugsandalcohol.ie/tables/). Therefore, figures reported through these sources will differ slightly.

T2.2. Additional trends in drug treatment

Changes in first-time registration for OAT in Ireland between 1999 and 2019

A recent study sought to investigate historic trends in problematic opioid use in Ireland using data from the CTL by examining rates of initiating for OAT for the years 1999–2019 (McCarron et al. 2023).

Data from 1999 onwards were included in the study, as that was the first full year that there was a legislative requirement for registration on the CTL. As there were very few first-time registrations among those aged under 15 years or over 65 years, these age groups were excluded from the analysis. As well as calculating rates of first-time OAT registration, the study carried out statistical analysis in order to test for differences in registration rates over the study period. Rates of initiation on OAT (first-time registrations) were calculated using official census data.

In total, 17,198 people were first-time registrations on OAT between 1999 and 2019. The majority were male (72.7%). Other main findings of the study were (see also Table 2.2.1):

- In 1999, the majority of first-time registrations were among people aged 15–29 years (78.8%).
- In 2019, the majority of first-time registrations were among people aged 40–64 years (26.9%).
- The highest number of first-time registrations occurred in 1999 (N=1,014), reducing over the period to 741 in 2019.
- The rate of first-time registrations reduced from 40.7 per 100,000 in 1999 to 23.0 per 100,000 in 2019.
- The biggest reduction in rates of first-time registrations occurred in the group aged 15–19 years, followed by the group aged 20–24 years.
- Conversely, there were small increases in the rate of first-time registrations for the older age groups (aged 30–65 years).
- The findings were statistically significant.

Table 2.2.1. Changes in rates of first-time registrations on OAT, CTL, 1999–2019

	1999		2019			
Age range (in years)	1999 first-time registrations (n (% of total))	1999 first-time registration rate	2019 first-time registrations (n (% of total))	2019 first-time registration rate	P value	Change in rate of first-time registrations, 1999 versus 2019
Total (both sexes)	1014 (10.0)	40.7	741 (10.0)	23	<.001	-43.5
Female						
15–19	91 (26.9)	55.3	5 (2.3)	3.2	<.001	-94.2
20–24	142 (42.0)	94.5	26 (12.1)	17.7	<.001	-81.3
25–29	51 (15.1)	36.6	46 (21.4)	32.0	0.504	-12.6
30–34	20 (5.9)	14.5	50 (23.3)	29.2	0.007	+101.4
35–39	18 (5.3)	13	39 (18.1)	19.0	0.181	+46.2
40–64	16 (4.7)	3.1	49 (22.8)	6.1	0.018	+96.8
Total (female)	338 (10.0)	27.3	215 (10.0)	13.3	<.001	-51.3
Male						
15–19	110 (16.3)	63.3	9 (1.7)	5.5	<.001	-91.3
20–24	258 (38.2)	168	53 (1.1)	35.0	<.001	-79.2
25–29	147 (21.7)	104.6	112 (21.3)	77.1	<.014	-26.3
30–34	67 (9.9)	5	109 (2.7)	68.2	0.045	+36.4
35–39	44 (6.5)	32.5	92 (17.5)	47.9	0.034	+47.4
40–64	50 (7.4)	9.7	151 (28.7)	19.3	<.001	+99
Total (male)	676 (10.0)	54.1	526 (10.0)	33.0	<.001	-39.0

* Table reproduced from McCarron *et al.* (2023).

One of the limitations of the study is that it only includes those who presented for OAT. However, the reduction in problem opioid use among younger people in Ireland is consistent with the results

shown by a number of other Irish studies. The authors note that since 1999 there has been an increase in prevention and treatment programmes for problem opioid use, with the subsequent national drugs strategies focusing on this issue. Therefore they conclude that insufficient treatment capacity is not the reason for the reduction in problem opioid use among this group. Other research suggests that timely access to suitable treatment has been shown, for example, to reduce heroin use, and by reducing the number of heroin users it also reduces the number of new heroin users. One of the hypotheses put forward by international research is that younger people who have witnessed the harm and stigma of heroin use on their older peers may be less likely to start using heroin themselves.

The authors state that it is important to note this positive trend and the success of prevention and treatment programmes which contributed to it, while acknowledging data which show increased use of other groups such as cannabis and cocaine in this age group. Equally, the upward trends observed in first-time registrations in older age groups requires continued monitoring and resources.

Impact of changes to agonist treatment during the COVID-19 pandemic

A recent study aimed to examine the impact of changes introduced to the delivery of OAT on the number of people accessing treatment and treatment dropout during the COVID-19 pandemic (Durand and et al 2023).

With the advent of the COVID-19 pandemic and the implementation of widespread public health measures, access to a variety of health services and health service delivery was affected. This led to concerns surrounding the potential implications of these COVID-19-controlling measures with regard to OAT delivery. OAT in Ireland is based on face-to-face contact. This factor, coupled with treatment interruptions, changes to drug availability, and the price and potency of illicit drugs had the potential to increase drug-related harms, including overdose. In response to these challenges, rapid access and/or low-threshold pathways were developed as part of the national contingency guidelines set by the HSE in March 2020. These pathways helped ensure rapid access and uninterrupted care to those currently on OAT as well as new service users, thus mitigating the risk of drug-related harms. E-consultations, electronic prescriptions, and home delivery of medication for those isolating during the pandemic were also some of the measures introduced to further enable continuity of OAT.

Using time series analyses (ITS), monthly CTL data from March 2019 to February 2020 were compared against data from April 2020 to March 2021 using time series analysis. This supports the collection of anonymised aggregate-level data over consistent periods of time, which in this case allowed for the primary outcomes to be assessed appropriately. The primary outcomes for the study were: calculating the total number of service users, the total number of new service users, and the number of those who dropped out.

In March 2019, a total of 10,251 service users accessed OAT in March 2019. Of this cohort, 30% were female and 70% were male; 44% were aged under 40 years; 98% were prescribed methadone; and 2% were prescribed buprenorphine.

In March 2021, a total of 11,441 services users were recorded. Of this cohort, 29% were female and 61% were male; 49% were aged under 40 years; 96% were prescribed methadone; and 4% of were prescribed buprenorphine. Analyses showed an increase in those accessing OAT on the last day of the month between April 2020 and March 2021, when compared with the period March 2019 to

February 2020. The study observed an immediate and continued increase in the number of people accessing OAT following the introduction of OAT contingency guidelines ($p<0.05$). Changes in treatment initiation or dropout during these time periods were found not to be significant. However, the rate of dropout of those on buprenorphine was found to be reduced ($p<0.05$).

This study suggests that changes to OAT under the national contingency guidelines had a positive impact on coverage in Ireland, which represents an important protective factor for reducing drug-related harm, including mortality.

The study showed that the highest number of service users commenced or recommenced treatment in April 2020. The authors postulate that one reason for this was that there was a backlog of people on the waiting list, which, once addressed, led to reduced numbers in the following months. The contingency guidelines for OAT recommended multiple changes to the delivery of OAT. Which specific changes, or combination of changes, led to these observed effects is unknown.

The rate of OAT dropout was lowest in April 2020 and January 2021, corresponding to 'hard' lockdown measures in Ireland (i.e. closure of all non-essential retail, restriction of movement, police enforcement), which is consistent with the findings of recent published literature on this period.

A number of limitations were identified. Delays in updating the CTL with exit details for service users which could have led to the number of dropouts being underestimated. Misclassification of deaths as dropouts, could have led to an overestimated of the number of dropouts. However, the study provides valuable insights into the effect the HSE contingency guidelines had on OAT service uptake and access.

The findings of the study suggest the OAT contingency guidelines developed during the pandemic increased access to OAT in Ireland. However, it is not yet known if these positive changes will be sustained following the easing of pandemic-related restriction measures.

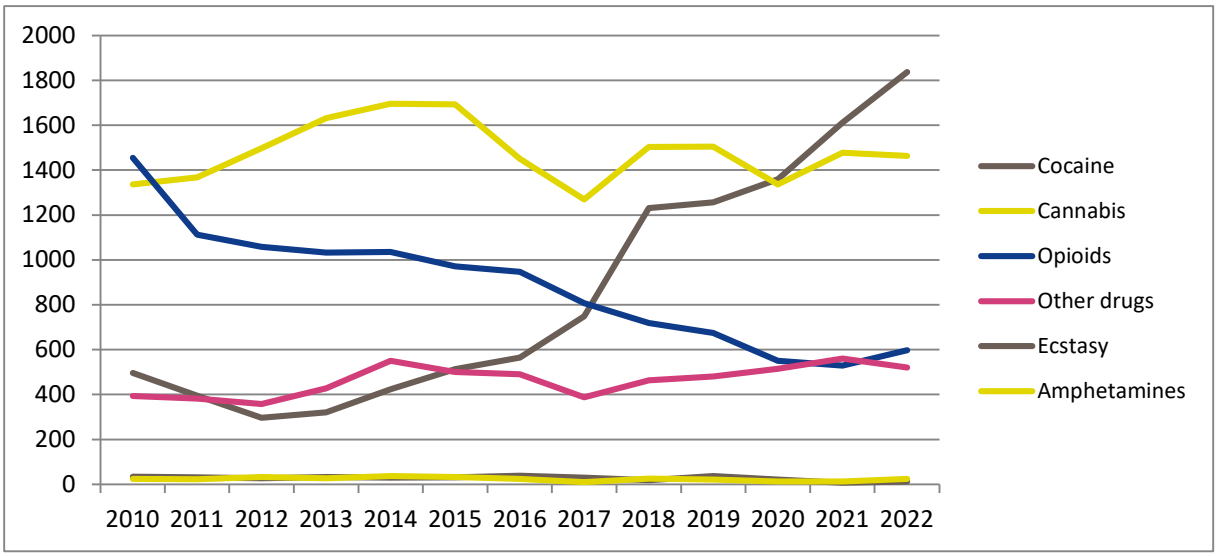

Figure II. Trends in numbers of first-time clients entering treatment, by primary drug, 2010–2022

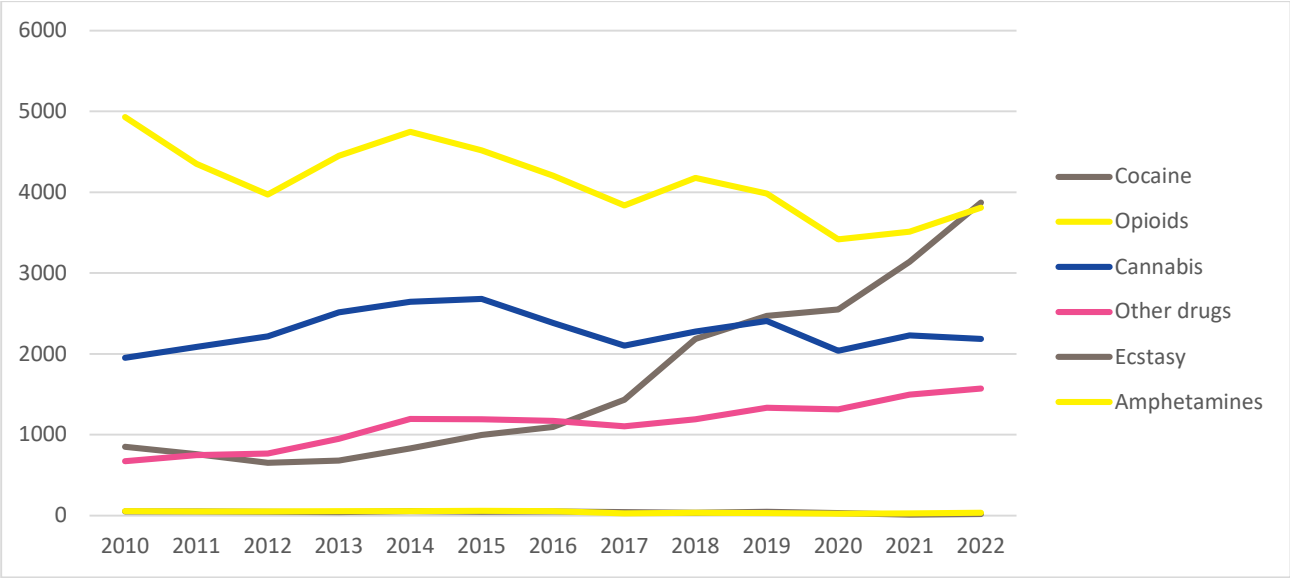

Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2010–2022

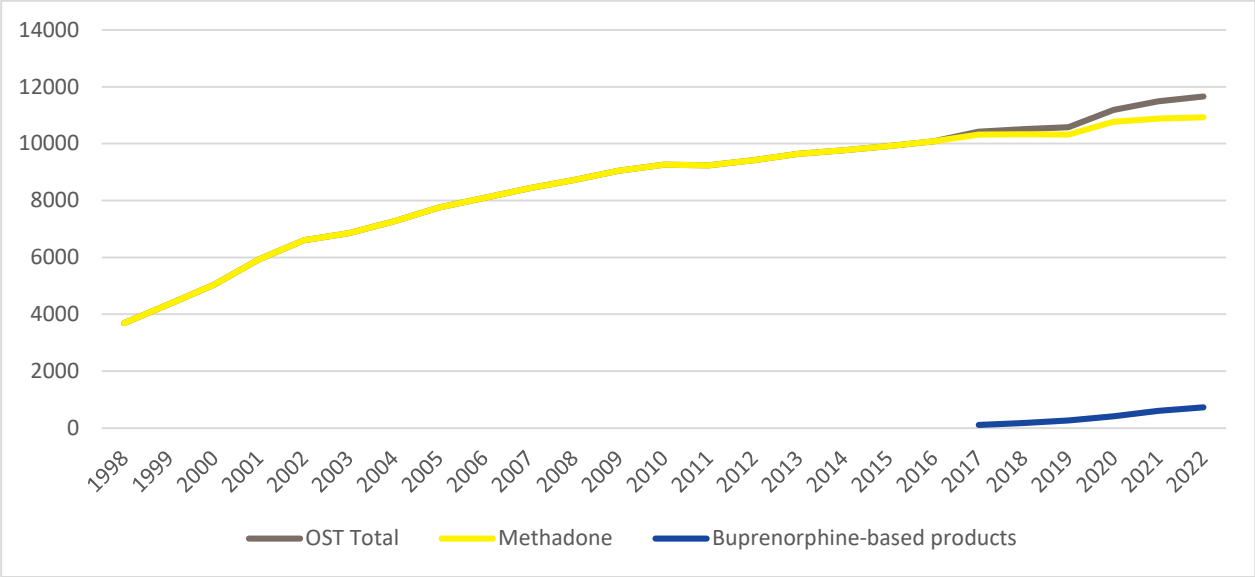

Figure IV. Trends in numbers of clients in OST, 1998–2022
Source: CTL.

T3. New developments

T3.1. New developments

No new information.

T4. Additional information

T4.1. Additional Sources of Information

No new information.

T4.2. Further Aspects of Drug Treatment

No new information.

T4.3. Psychiatric comorbidity

Model of Care for Dual Diagnosis: mental health disorder and substance use disorder

The Model of Care for Dual Diagnosis, approved by the HSE Chief Clinical Officer Forum and endorsed by the College of Psychiatrists of Ireland, was formally launched on 23 May 2023 (National Working Group for Dual Diagnosis 2023) . The term 'dual diagnosis' is used to describe a person who presents with a simultaneous mental health disorder and a substance use disorder (SUD). However, dual diagnosis can often be defined in different terms internationally. While dual diagnosis is not unusual, research suggests that up to one-half of those attending HSE Community Mental Health Teams also have a comorbid SUD.

The Model of Care for Dual Diagnosis is the culmination of the efforts of the National Working Group for the HSE Dual Diagnosis National Clinical Programme, which was established between 2016 and 2018. In 2021, Dr Narayanan Subramanian was appointed National Clinical Lead, following which a second working group was established to progress the development of the programme. Central to the process of drafting the Model of Care, the working group studied and took account of people with lived experience of dual diagnosis, including both service users and carers.

In the HSE, dual diagnosis services will be a tertiary service that provides support to Community Mental Health Teams; Community Child and Adolescent Mental Health Service Teams; acute inpatient psychiatric units; HSE Addiction Services; and community, voluntary, and HSE-funded organisations, including Section 39 agencies.

As envisioned in the recommendation for dual diagnosis in the Department of Health's mental health policy (Department of Health 2020), an integrated collaborative approach will be employed by the dual diagnosis services. This will involve: HSE Addiction Services; Community Mental Health Teams; the HSE National Office for Suicide Prevention; HSE Health and Wellbeing; HSE Mental Health Engagement and Recovery; liaison psychiatry services; maternity services; community and voluntary agencies; and regional universities.

Resources such as staff, training, and premises will be shared between the service partners, primarily under the clinical governance of HSE Mental Health and in some cases under shared clinical governance with HSE Addiction Services. The service is due to start early 2024.

T5. Sources and methodology

The purpose of this section is to collect sources and present a bibliography for the information provided above, including brief descriptions of studies and their methodology where appropriate.

T5.1. Sources

Data on drug treatment in Ireland are collected through two national data collection tools: the CTL and the NDTRS.

The CTL is an administrative database used to regulate the dispensing of methadone. Established under S.I. No. 225/1998, it is a complete register of all patients in Ireland receiving OAT for problem opioid use. When a person is considered suitable for opioid detoxification, stabilisation, or maintenance, the prescribing doctor notifies the CTL by completing an entry form. A unique number is allocated to the client, and they receive a treatment card when the methadone is dispensed in community pharmacies.

The NDTRS is a national epidemiological database that provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres, and low-threshold services. For the purposes of the NDTRS, treatment is broadly defined as any activity that aims to ameliorate the psychological, medical, or social state of individuals seeking help for their substance misuse problems. The NDTRS is a case-based, anonymised online database. It is coordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health.

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European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised European Union (EU) agency based in Lisbon. The EMCDDA provides the EU and its member states with information on the nature, extent, and consequences of, and responses to, illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the EU and member states.

There are 30 national focal points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data-collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the EMCDDA for analysis, from which it produces the annual *European Drug Report* and other outputs.

The Irish Focal Point to the EMCDDA is based in the HRB. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators, and supply indicators in the form of standard tables and structured questionnaires on response-related issues, such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment, and control of NPS.

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Drugs Policy Division, Department of Justice

Drugs Policy Unit, Department of Health

Forensic Science Ireland

Health Protection Surveillance Centre, Health Service Executive

Hospital In-Patient Enquiry scheme, Health Service Executive

Irish Prison Service

National Advisory Committee on Drugs and Alcohol, Department of Health

National Social Inclusion Office, Primary Care Division, Health Service Executive