Focal Point Ireland: national report for 2024 – Treatment

Health Research Board. Irish Focal Point to the European Union Drugs Agency (EUDA)

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(2025) Focal Point Ireland: national report for 2024 – Harms and harm reduction

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Table of Contents

T0. Summary

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 70%) 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 2023, a total of 12,597 treatment entrants were reported. This is a 9.7% increase from the number of cases reported in 2022 (11,488). Much of the increase is related to an increase in cocaine cases; there has been increased funding for cocaine-specific services over the previous five years.

In 2023, cocaine was the most common problem drug reported. The increase in the number of cases presenting for treatment for problem cocaine use continued in 2023. Almost one-quarter of cocaine cases (24.2%) were reported to be due to crack cocaine use, compared with 21.2% in 2022.

Opioids (mainly heroin) were the second most common problem illicit drug used by treatment entrants, followed by cannabis and benzodiazepines. The number of cases reporting problem opioid use peaked in 2010 at 4,929, and there was a consistent downward trend until 2020 (3,419). However, since then the number of cases has increased slightly to 3,704 in 2023.

Cannabis was the third most common problem drug reported in 2023. 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 2015, 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 2023, at 38.0%, similar to the previous 10 years.

In 2023, cocaine was the most common drug reported by new treatment entrants, a continuation of the trend first seen in 2020.

On 31 December 2023, 11,844 clients were registered for OAT (including those receiving OAT in prison). In 2023, more than one-half of all OAT clients received OAT in specialist outpatient clinics, two-fifths received it from specialist GPs, and just under one-tenth received OAT 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, which deals with all substances of misuse and has a focus on polydrug use.

There are a number of actions under each objective; the time frame for their delivery is 2017–2025. 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.
- enhancng the quality and safety of care in the delivery of OAT by implementing the Health Service Executive's (HSE) *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. 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, 2023b). 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 MTP was introduced in order to ensure that treatment for problem opioid use could be provided wherever demand existed (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 Table I in Section T1.1.2 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 8.3% of outpatient treatment reported to TDI in 2023. 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. 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 2023, the coverage for GPs decreased slightly to 43.3%, compared with 45.9% in 2022.

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)

	Total number of units	National definition (characteristics/types of centre included within your country)	Total number of clients
Specialised drug treatment centres	329	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.	8,957
Low-threshold agencies	42	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.	1,049
General primary healthcare (e.g. GPs)	416		290
General mental healthcare	0		
Prisons (in-reach or transferred)	31	In-reach provided by voluntary services funded by the IPS and others.	533
Other outpatient units	0		

Other outpatient units	0

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. 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.

	Public/government	Non-government owned (not for profit)	Non-government (for profit – private)	Other	Total
Specialised drug treatment centres	Not known	Not known	Not known		100%
Low-threshold agencies	Not known	Not known	Not known		100%
General primary healthcare (e.g. GPs)	100	~	~		100%
General mental healthcare	Not known	Not known	Not known		100%
Other outpatient units (1)	Not known	Not known	Not known		100%
Other outpatient units (2)	Not known	Not known	Not known		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 the TDI is high.

As of January 2024, the HSE estimated that there were 1,036 residential beds (for both alcohol and other drugs) across all inpatient addiction treatment services (Keenan, E 2023). The number of cases recorded attending residential treatment in 2023 (1,768) has increased when compared with 2022 (1,344) (see Table III).

Mental health services provide inpatient addiction treatment in 66 different hospitals. Figures from these services are not included in the annual TDI figures. The most recent figures available are from 2022, which show that 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)

	Total number of units	National definition (characteristics/types of centre included within your country	Total number of clients
Hospital-based residential drug treatment	2	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.	149
Residential drug treatment (non-hospital based)	0		0
Therapeutic communities	0		0
Prisons	0		0
Other inpatient units (1 – please specify here)	61	Centres where the clients may stay overnight. They include therapeutic communities, 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.	1,619
Other inpatient units (2 – please specify here)	0		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). In 2023, €1.8 million additional funding was provided for residential treatment (Department of Health, 2023a).

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.

	Public/ government	Non-government owned (not for profit)	Non-government (for profit – private)	Other	Total
Hospital-based residential drug treatment					100%
Residential drug treatment (non-hospital based)					100%
Therapeutic communities					100%
Prisons	100%	0%	0%		100%
Other inpatient units (1 – please specify here)					100%
Other inpatient units (2 – please specify here)					100%

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

Data from January 2024 showed that average waiting times for hospital inpatient detoxification was 12–16 weeks. Other residential detoxification waiting times ranged from 2 weeks to 19 weeks (depending on the service). Waiting times for other residential rehabilitation services ranged from zero days to approximately 4 months (depending on the service) (Keenan, E, 2023).

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 2023 showed a continuation of the increase seen in 2022.

In 2023, cocaine (4,708 cases) was 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 33.7% (3,872) in 2022 to 37.4% (4,708) in 2023. This is a continuation of the upward trend observed over the past 5 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 2023 to 29.4% (3,704), compared with 33.1% (3,808) in 2022. However, these proportions must be interpreted carefully, as opioids continue to represent a significant proportion of treatment demand, and the actual drop in the number of cases has been small (2.7% between 2022 and 2023).

Heroin continues to be the main problem drug in this category, with 85.8% of all cases with problem opioid use reporting heroin as their main problem drug in 2023. The proportion of opioid cases seeking treatment for heroin has decreased slightly in the past 3 years (86.6% in 2023, 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 (17.6%) in 2023. The proportion of cases treated for problem cannabis use peaked in 2015 at 28.9% but has shown a downward trend ever since (see also Section A T1.2.2 of the *Drugs workbook*). However, these proportions must be interpreted with caution, as the actual number of cases reported in 2023 (2,220) was slightly higher than in 2022 (2,184).

Benzodiazepines remain the fourth most common problem drug reported; the proportion of cases treated for problem use of benzodiazepines in 2023 was 11.3%, slightly higher than the proportion reported in 2022 (10.7%).

Amphetamines (0.1%) and ecstasy (0.1%) continue to make up a very small proportion of the main problem drugs reported in 2023, a similar trend to previous years (also see Section B T1.2.2 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, 2023

Published in June 2024, the latest annual publication from the NDTRS reported data on treated problem drug use (excluding alcohol) for the year 2023, followed by trends for the 7-year period of 2017–2023 (Lynch *et al.*, 2024). Note that the selection used for the cases reported in the NDTRS publication is slightly different to what is reported through TDI.

In 2023, 13,104 cases were treated for problem drug use. This is the highest annual number recorded by the NDTRS to date and an increase of more than 1,000 cases compared with 2022.It is important to consider the changing landscape of treatment demand when interpreting the data. While overall percentages may appear stable, the raw number of cases entering treatment may have increased or in some scenarios decreased. This highlights the need to look beyond percentages and analyse absolute figures to fully understand the trends over time.

Main problem drug

Cocaine was the most common drug reported in 2023, accounting for 37.6% of all cases and showing a 20.5% increase from 2022 (4,923 versus 4,084 cases). Cocaine remained the most common main

problem drug among *new cases* in 2023, accounting for almost one-half (46.1%) of new cases. However, for previously treated cases, cocaine accounted for 32.7% of cases, the highest number recorded to date.

Opioids (mainly heroin) were the second most common main problem drug reported. The number of cases fell by 126, from 3,971 in 2022 to 3,845 in 2023. Heroin accounted for 86.0% of all opioid cases in 2023. Cannabis was the third most common main problem drug reported.

The type of drug for which cases sought treatment varied by age and has changed over time. Among cases aged 19 years and under, cannabis was the main drug generating treatment demand. Among those aged 20–39 years, cocaine was the main drug generating treatment demand. Opioids were the main drug generating treatment demand among those aged 40 years and over.

Polydrug use

Problem use of more than one drug (polydrug use) was reported by more than one-half of cases (58.9%), similar to previous years. Cannabis (38.8%) was the most common additional drug, followed by cocaine (36.3%), alcohol (35.7%), and benzodiazepines (31.0%).

Risk factors

Risk factors recorded in the NDTRS include injecting behaviour, sharing of needles and syringes, and sharing of other drug paraphernalia (such as joints, straws, foil, pipes, spoons, filters, water to mix drugs, and water or bleach to clean equipment). In 2023, one in five cases (20.3%) reported that they had ever injected. Among these, almost 3 in 10 (28.9%) were currently injecting (i.e. in the 30 days prior to treatment).

The number of cases who reported ever injecting has increased from 2,492 in 2022 to 2,659 in 2023, and this is mainly due to an increase in previously treated cases. The number of cases who report that they are currently injecting has increased from 752 in 2022 to 769 in 2023, and this is mainly due to an increase in previously treated cases.

Among cases in 2023 who were known to be currently injecting, the majority were male (70.7%), and the median age at which they first injected (where known) was 22 years (range 15–39). The most common main problem drug was opioids (76.5%), followed by cocaine (15.0%) (but these were not necessarily the drugs that were injected). Almost four in five cases (78.8%) currently injecting reported polydrug use. Most cases had been previously treated (81.8%), and many of them were homeless or living in unstable accommodation (41.7%).

In 2023, two in five cases (39.8%) who had ever injected also reported ever sharing needles and syringes, similar to 2022. Among cases who reported currently injecting, where known, 21.8% reported having shared needles and syringes in the 30 days prior to starting treatment.

Socio-demographic characteristics

The median age of cases was 34 years, with the majority (68.8%) of cases male. One in eight (12.1%) cases were recorded as being homeless. The proportion of cases with an Irish Traveller ethnicity was 2.8%. The majority (59.7%) of cases were recorded as being unemployed, with 22.2% cases in paid employment.

In 2023, almost one-half of the cases (49.9%, 6,535 cases) in drug treatment were parents who had children. Of these, 8 in 10 (83.6%, 5,463 cases) were known to have children aged 17 years and under. Of parents known to have children aged 17 years and under, 33.7% had one child, 31.4% had two children, 18.3% had three children, while 16.6% had four or more children. One-half of these parents were aged 35 years and over. Cases entering drug treatment in 2023 with children aged 17 years and under had on average 2.3 children.

In 2023, of parents known to have children aged 17 years and under, 40.1% 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 their children. Males were less likely to be residing with their children.

Key trends over time (2017–2023)

Over the period 2017–2023, there was a 228.2% increase in the number of cases where cocaine was the main problem drug. Powder cocaine use increased by 197.1% over this time period, and crack cocaine use increased by 594.2%.

Between 2017 and 2023, there was a 388.4% increase among females who have sought drug treatment for cocaine, from 284 cases in 2017 to 1,387 cases in 2023. Between 2017 and 2023, there was a 259.0% increase in the number of previously treated cases reporting cocaine as a main problem, from 692 cases in 2017 to 2,485 cases in 2023.

The proportion of treatment demand attributable to opioids has decreased year on year (from 45.0% in 2017 to 29.3% in 2023). Opioids were the main drug generating treatment demand for cases aged 40 years and over, compared with earlier years when it was 35 years and over. Among new cases, the proportion that reported ever injecting decreased over the period, from 11.0% in 2017 to 4.0% in 2023. However, among previously treated cases, the numbers reporting ever having injected have increased since 2020.

T1.3.5. Further top level treatment-related statistics

There has been a 9.7% increase in the number of cases reported in 2023 (12,597), compared with 11,488 in 2022. Of note, there was increased investment by the Department of Health in cocaine-specific services in recent years, and cocaine cases make up the majority of the increases seen between 2022 and 2023 (Department of Health, 2023a).

Table V. Summary table – clients in treatment

	Number of clients
Total clients in treatment	12 597
Total OAT clients	11 844
Total clients entering treatment	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 TDI

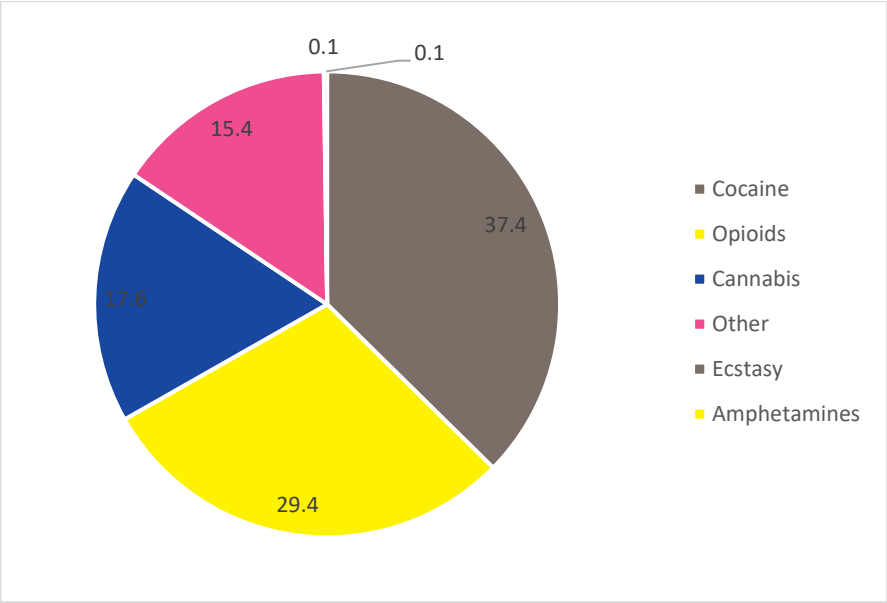

Figure I. Proportion of treatment demands by primary drug (2023)

T1.4. Treatment modalities

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, Ryan and Lyons, 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.

	Specialised drug treatment centres	Low-threshold agencies	General primary healthcare (e.g. GPs)	General mental healthcare
Psychosocial treatment/ counselling services	Not known	Not known	Not known	Not known
Screening and treatment of mental illnesses	Not known	Not known	Not known	Not known
Individual case management	>75%	>75%	Not known	Not known
Opioid substitution treatment	Not known	Not applicable	Not known	Not known
Other core outpatient treatment interventions (please specify in T1.4.1.)	Not known	Not known	Not known	Not known

T1.4.2. Further aspect of available outpatient treatment services

New interactive treatment services map

An interactive map of all treatment services is now available to enable people to search for publicly funded residential and community addiction services near to them. This new initiative, which was a collaborative project between the Department of Health, the NDTRS, and the Health Research Board (HRB) National Drugs Library, gives a complete overview of all publicly funded addiction treatment and family support services across Ireland.

The map shows the types of treatment available (e.g. counselling) and the focus of the service (alcohol, drugs, alcohol and drugs, gambling, or family support). For each service, the name, address, type of facility (community-based or residential), and the specific groups services are available for (i.e. adults, young people) are shown. The map can be accessed at: https://www.drugsandalcohol.ie/services_map.

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. There are 13 other residential centres, provided by voluntary/non-statutory services, that also offer detoxification as part of their suite of residential treatment (excluding alcohol-only detoxification). There is one centre that provides adolescent residential detoxification.

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.

	Hospital-based residential drug treatment	Residential drug treatment (non-hospital based)	Therapeutic communities	Prisons
Psychosocial treatment/counselling services	Not known	>75%		
Screening and treatment of mental illnesses	>75%	>75%		
Individual case management	>75%	>75%		
OAT	>75%	>75%		
Other core inpatient treatment interventions (please specify in Section T1.4.3.)	Not known	Not known		

T1.4.4. Further aspect of available inpatient treatment services

See Section T1.4.2 in relation to the new interactive treatment service map.

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 2022, 117 women were referred to the drug liaison midwife in the Rotunda Hospital, a large maternity hospital in Dublin (The Rotunda Hospital, 2023). Thirty-six 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 into the community.

Counselling, motivational interviewing, cognitive behaviour therapy, and other psychological supports are provided by Merchants Quay Ireland (MQI) on behalf of the IPS. 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*.

A study which looked at the prescribing trends in prison for drugs with potential for misuse for the years 2012–2020 also looked at prescribing trends among those with a history of OAT (Lynch *et al.*, 2024) (Durand *et al.*, 2023). The most common OAT prescribed was methadone, with monthly prescribing rates ranging from 364–723 per 1,000 women, and 96–163 per 1,000 men. For buprenorphine and naloxone in-combination preparations, the monthly prescribing rates ranged from 0–13 per 1,000 women, and 0–1.3 per 1,000 men. The study found that benzodiazepines were the most common drug co-prescribed for women along with OAT, while gabapentinoids were the most common drug co-prescribed for men along with OAT. The authors note that, with the exception of benzodiazepines for women on OAT, there were very low rates of co-prescribing other opioids, Z-drugs, or gabapentinoids, which is in line with recommended safe prescribing guidelines for prisons. However there was an observed increase in the rate of gabapentinoids prescribed over the study period, which is an issue of concern. Also see Standard Table 24 and Section T4.2 in 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 Union Drugs Agency (EUDA), 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

Treatment outcomes in 2023

The recent NDTRS publication on treatment demand included a section on treatment outcomes for the first time (Lynch *et al.*, 2024). These data allow for a greater understanding of the patterns, trends, and outcomes of treatment for cases receiving treatment for drugs as their main problem substance. Note that the selection used for the cases reported in the NDTRS publication is slightly different to what is reported through TDI.

The outcomes are based on the condition of the case at the point of treatment exit only. These figures show that 10,659 cases exited drug treatment in 2023, which includes cases recorded as exiting treatment between 1 January 2023 and 31 December 2023 inclusive, irrespective of when treatment commenced. These figures are comprised of 7,330 (68.8%) cases who both entered and exited treatment within 2023, as well as 3,329 (31.2%) cases who exited treatment in 2023 but had commenced treatment in previous years. A small number of cases were excluded, as the service provider was unable to provide adequate information.

Treatment duration

The length or duration of treatment referred to the length of time (in days) from the treatment start date to the treatment end date (exit). This showed that:

- One-half of cases remained in treatment for 81 days or longer.
- Treatment duration ranged from 1 to 614 days (5th–95th percentile).
- Nearly one-quarter (23.4%) of cases participated in treatment for less than a month.
- More than 1 in 10 cases (10.9%) stayed in treatment for more than a year.

Duration by intervention type

Treatment duration varied according to intervention type, summarised below by the most common interventions recorded:

- brief intervention (4,572 cases): one-half of cases attended for 2 days or fewer
- individual counselling (3,547 cases): one-half of cases attended for 65 days or fewer
- group counselling (1,028 cases): one-half of cases attended for 50 days or fewer
- individual programmes (1,030 cases): one-half of cases attended for 58 days or fewer, and
- group programmes (2,109 cases): one-half of cases attended for 42 days or fewer.

Reason for treatment exit

Reason for exiting treatment was assigned by the individual service provider based on their own criteria. The most common reason for exit in 2023 was when cases did not return for subsequent appointments ('no shows') (31.8%), followed by when cases completed their treatment (29.5%) (see Table 1.4.7.1).

Table 1.4.7.1 Reason for treatment exit (NDTRS 2023)

	n	%
All cases exiting treatment in 2023	10 659	
Client did not return for appointments ('no show')	3,387	(31.8)
Treatment completed	3,148	(29.5)
Client declined further treatment	1,496	(14.0)
Transferred/referred to treatment in another drug/alcohol service	1,305	(12.2)
Sentenced to prison	264	(2.5)
Premature exit from treatment for non-compliance	250	(2.3)
Medical or mental health reasons	115	(1.1)
No longer lives in the area	101	(0.9)
Died	97	(0.9)
Staffing issues (resignation/retirement/maternity, etc.)	85	(0.8)
Released from prison but not linked to other treatment service	76	(0.7)
Prison-to-prison transfer	73	(0.7)
Unable to attend due to work/study commitments	70	(0.7)
Other	16	(0.2)
Not known	176	(1.7)

Reproduced from Lynch *et al*. (2024)

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 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 clients. Level 2 GPs are allowed to both initiate and maintain OAT and treat a higher number of clients.

In 2023, according to data from the CTL, as of 31 December 2023, 54.4% of clients received OAT in specialist outpatient clinics; 37.1% received OAT from GPs; 8.4% received it in prison; and less than 1.0% received it in an inpatient setting (unpublished data, CTL, 2024; also see Figure IV in Section T2.2 of this workbook). These trends are similar to those reported for 2022 data.

The proportion of clients receiving OAT from GPs has remained stable from 2016 to 2023. The proportion increased slowly but steadily between the years 2001 and 2015, 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 T2.2 of this workbook, as well as ST24).

On 31 December 2023, 11,844 clients were registered for OAT (including those receiving OAT in prison) (personal communication, CTL, 2024), a small increase compared with 2022, when 11,667 clients were registered. This is partially due to an increase in the number of clients reported from prisons (663 in 2022, compared with 1,000 in 2023). The reason for this increase is not yet known.

Almost all clients receive methadone maintenance treatment (MMT) as their OAT, 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 since its introduction, 94% of those receiving OAT in 2023 were prescribed methadone.

T1.4.11 Characteristics of clients in OST

Opioid use disorder and OAT during pregnancy in Dublin city, 2010–2019

A 2023 retrospective observational cohort study was conducted at a major Irish maternity hospital in Dublin city. All women with opioid use disorder (OUD) or substance use in pregnancy delivered their baby in the hospital between 2010 and 2019 were included (Corbett *et al.*, 2022).

Of the 82,669 women delivered, 525 had OUD or substance use in pregnancy (1 in every 160 women booking into the service). Over the period 2010–2019, there was a significant reduction in the number of women who delivered with OUD or substance use in pregnancy (0.8–0.4%, RR=0.55, 95% CI: 0.36–0.85) and a significant reduction in the proportion of women on OAT (RR=0.66, 95% CI: 0.51–0.87). Also see Section T1.3.6 of the *Harms and harm reduction workbook*.

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

Waiting times to access OAT

Figures from the HSE for May 2023 (the latest data available at time of publication) show that the average waiting time from referral to assessment for OAT was 3.7 days (compared with an organisational target of 4 days). The time varied by region, ranging from 0 days to 10.6 days (Health Service Executive, 2024).

Figures from the HSE for May 2023 (the latest data available at time of publication) show that the average waiting time from OAT assessment to exit from waiting list or to commencement of

treatment was 44.5 days (compared with an organisational target of 28 days). The time varied by region, ranging from 0.4 days to 196.3 days (Health Service Executive, 2024).

Length of time in OAT treatment

A small study of people undergoing drug treatment, conducted in 2023 in inner city Dublin, an area of deprivation, reported that 137 of the 138 interviewees were on OAT (Inner City Organisations Network, Community Action Network, and Service Users Rights in Action, 2024). Of those, 79% had been on OAT for more than 10 years. Looking at it in another way, 56% had been on OAT for more than 16 years, or 1 in 10 reported being on OAT for 26 years or more. The overall study results have been summarised in depth below.

Human rights and equality issues identified by service users of drug treatment services in Dublin's North-East Inner City

A recently published study looked to 1) identify issues experienced by service users of drug treatment projects; 2) review the changes in key monitoring points arising from the HSE Action Plan; 4) empower service users; 5) promote positive actions to fulfil responsibilities; and 5) act on non-compliance (Inner City Organisations Network, Community Action Network, and Service Users Rights in Action, 2024). The study was peer led, with a peer review process, to allow the voice of the service user to be heard. The survey was implemented in early 2023, and the questionnaire covered areas such as demographics, treatment choice and plans, supervision and frequency of urine sampling, engagement and participation of service users, and complaints mechanisms. The interviewees come from a marginalised and disadvantaged community in Dublin.

In total, 138 interviews were conducted, with 36% of respondents living in the inner city and another 36% of respondents homeless. There were more males (58%) than females (41%). More than three-quarters (77%) of all those who answered were aged 36–55 years. The vast majority (94.6%) were not employed, but 11.7% were in education.

The study revealed that more than one-half (57%) of respondents did not know how to make a complaint about their addiction treatment care, while almost one-half (49%) did not know what a care plan entailed.

Men tend to access services more than women due to the additional barriers women experience to accessing treatment, due to their own trauma as well as their roles as mothers. Mothers are expected to make rapid recoveries in order to get their children out of care, further feeding into the assumption that because they are on an opioid treatment programme they are not capable of looking after their children.

Many respondents felt there was no end in sight for their treatment journey: as many as 87% reported they had never been offered an alternative to methadone treatment. The study included direct quotes from the respondents, many of whom stated that they were told by service providers they were not ready to move on from methadone, even when they requested a change. The vast majority of the respondents (88%) felt stigmatised because they suffered with an addiction, or because they were in treatment, and felt they had been treated differently to people who were not in treatment. Many reported that people's attitudes, including those of healthcare workers, changed

upon learning that the person they were dealing with was on methadone: the respondents felt as though their opinions ceased to matter and that they were treated as second-class citizens.

The respondents also reported poor quality of life as a result of addiction and the prolonged treatment: more than one-half (56%) had been in treatment for more than 16 years. Fewer than two-thirds (61%) of respondents agreed that methadone had improved their quality of life, while more than one-third (35%) said that it had not. They voiced a huge issue with their own lack of control regarding their treatment, with many participants feeling chained by 'liquid handcuffs' to the clinics they had been assigned. Looking for employment, going on a holiday, or moving house were not options for many, as frequent visits to the clinic determined their movements and controlled their daily lives. Many respondents did not expect life to get any better.

When asked, the respondents did express having life goals, although the majority of them felt they had not reached those goals. Most of the goals related to changing treatment type, entering into treatment including detoxification, becoming drug free, having children, and generally improving their quality of life. However, many respondents felt that they had been told that they had to stay on methadone, as they were not ready to detoxify from it, while some did not know they had a choice, or that they could even ask for an alternative to methadone. Those who did ask for an alternative to methadone felt that their requests had not been listened to and their voice regarding their treatment choice was not being heard.

The report recommendations include the cessation of the use of urine sampling by all drug treatment service providers and other agencies; meaningful engagement and participation for service users, including that the HSE engage with service users to review the provision of information on treatment choice; and for the HSE to engage with service users in developing and implementing a positive action plan to ensure that information on a complaints system is available in an accessible manner.

T1.5. Quality assurance of drug treatment services

T1.5.1. Quality assurance in drug treatment

An exploration of organisational climate in community-based opiate prescribing services

A study published in 2024 (Kelly, Searby and Goodwin, 2024), related to previous research (P Kelly *et al.*, 2022) (Peter Kelly *et al.*, 2022), looked to identify relationships between programme factors that influence organisational climate and to explore which mechanisms might underpin these relationships. The study's main findings were that the efficacy of the services is influenced by a range of specific factors, and some shortcomings can be addressed without investing additional resources. Overall, staff insights of organisations can provide valuable information with regard to supporting service improvement. Using a mixed-methods approach can not only identify where relationships between organisational variables exist but can also help to understand the mechanisms that underpin these relationships as well as identify and address deficits. In order to improve substance misuse services, it is necessary to employ a long-term systemic approach to programme development that incorporates some of the findings from this study.

T2. Trends

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

New treatment entrants (Figure II)

In 2023, there were 4,789 new treatment entrants recorded (see Figure II, also see TDI), an increase when compared with the 4,455 new treatment entrants reported in 2022.

In 2023, new treatment entrants represented 38.0% of all cases, which is similar to the 2022 figure (38.8%). The proportion of new treatment entrants has remained stable in the years 2013–2023.

In 2011, cannabis surpassed opioids (mainly heroin) as the main problem drug reported by new treatment entrants, but in 2020 the number of new treatment entrants reporting cocaine as the main problem drug surpassed cannabis for the first time. This trend continues for 2023, with 46.0% of new treatment entrants reporting cocaine as the main problem drug, compared with 29.1% reporting cannabis.

In 2023, '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. However, both are reported more frequently among new treatment entrants than among those who have been previously treated.

All treatment entrants (Figure III)

The number of all cases reported in 2023 has increased when compared with 2022 (see Figure III and also see Section T1.3.5).

In 2023, a total of 12,597 treatment entrants was recorded, representing an increase when compared with 11,488 treatment entrants in 2022 (see also the TDI). This is the highest number of cases reported by the NDTRS to date. Of the cases recorded in 2023, the majority (56.2%) had been previously treated, almost the same as in 2022 (55.2%). The proportion of new treatment entrants remained relatively unchanged in 2023, at 38.0%, similar to the years 2013–2023.

In 2023, cocaine (37.4%, includes powder and crack) remains the most common problem drug reported among all treatment entrants. There has been a continued 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 (13.3%), dropping steadily until 2012, when it stabilised; however, the proportion of cases has increased since then to a new peak of 37.4% in 2023, compared with 33.3%, in 2022. In 2023, 24.2% (1,138) of cocaine cases were known to be crack cocaine, compared with 21.2% (820) in 2022.

In 2023, opioids (mainly heroin) were the second most common problem drug reported by treatment entrants (29.4%), compared with 33.7% in 2022. The number of cases reporting problem opioid use peaked in 2010 at 4,929 and overall showed a consistent downward trend until 2020 when 3,419 cases were reported (but should be interpreted in the context of COVID-19 pandemic-related public health restrictions). Since then, the number of cases has increased slightly to 3,704 cases in 2023. However, although overall coverage of the NDTRS is high, less than one-half of GPs providing OAT

participate in the database, so this number is likely to be an underestimation (also see Section T1.2.1).

Cannabis (17.6%) was the third most common problem drug reported in 2023. In 2004–2018, 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% (2,681) in 2015 and has fluctuated since.

In 2023, '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 2023, there were 18 amphetamines cases reported, compared with 34 in 2022, while there were only 11 ecstasy cases reported in 2023, compared with 16 in 2022. 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 reports 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

Prevalence of drug treatment in 2023

In 2023, the NDTRS publication on treatment demand included for the first time a section on the number of continuous care cases (or prevalence) **(Lynch *et al.*, 2024)**. When the report was published, there were a total of 9,632 cases who had commenced treatment prior to 2023 and were still in treatment on 1 January 2023 (see Table 2.2.1). Reporting continuous care cases (prevalence) can help provide a more complete picture of treatment demand for that year. Please note that the data reported via TDI are a different selection from the data reported in the regular NDTRS reports and interactive tables (see https://www.drugsandalcohol.ie/tables/). Therefore, figures reported through these sources will differ slightly.

Table 2.2.1: Number of cases treated for drugs as a main problem, new and continuing care cases, (NDTRS 2023)

	Cases commencing treatment in 2023		Continuous care cases 1 January 2023		Total (commencement plus continuous care)	
	n	%	n	%	n	%
All cases	13 104		9,632		22 736	
New cases	4,792	(36.6)	2,561	(26.6)	7,353	(32.3)
Previously treated cases	7,588	(57.9)	6,604	(68.6)	14,192	(62.4)
Treatment status unknown	724	(5.5)	467	(4.8)	1,191	(5.2)

Reproduced from Lynch *et al.* (2024)

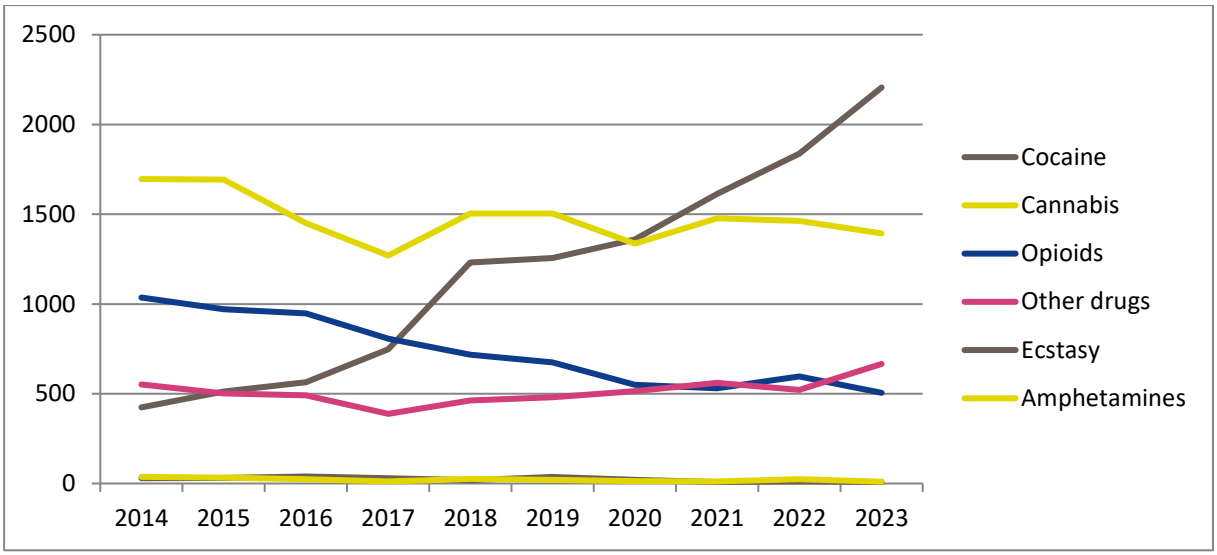

Figure II. Trends in numbers of first-time clients entering treatment, by primary drug, 2014–2023

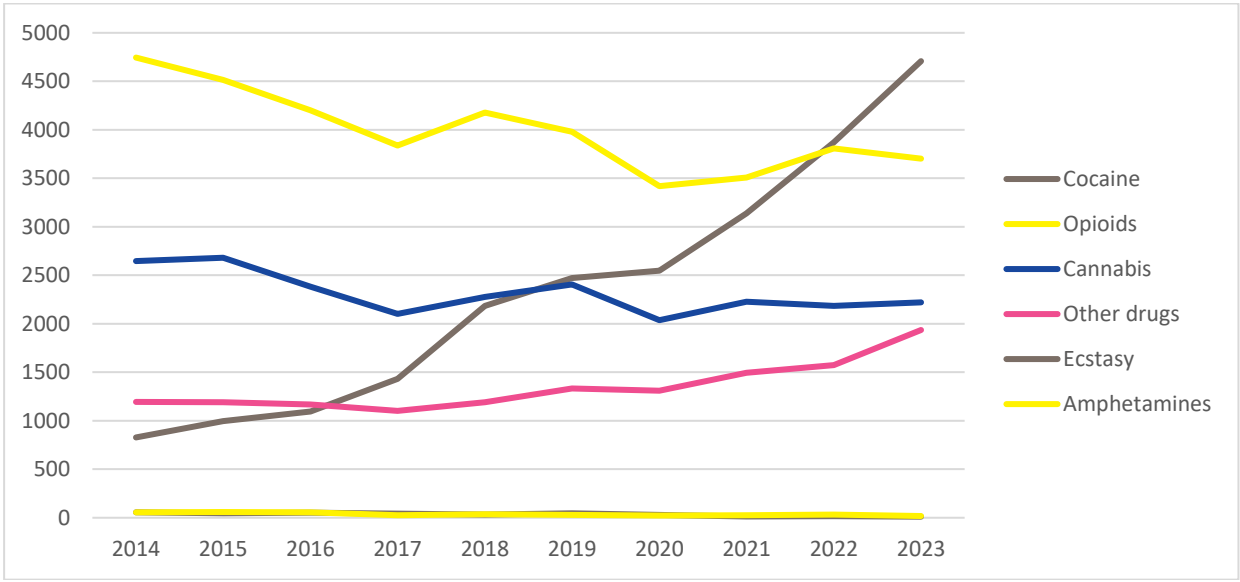

Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2014–2023

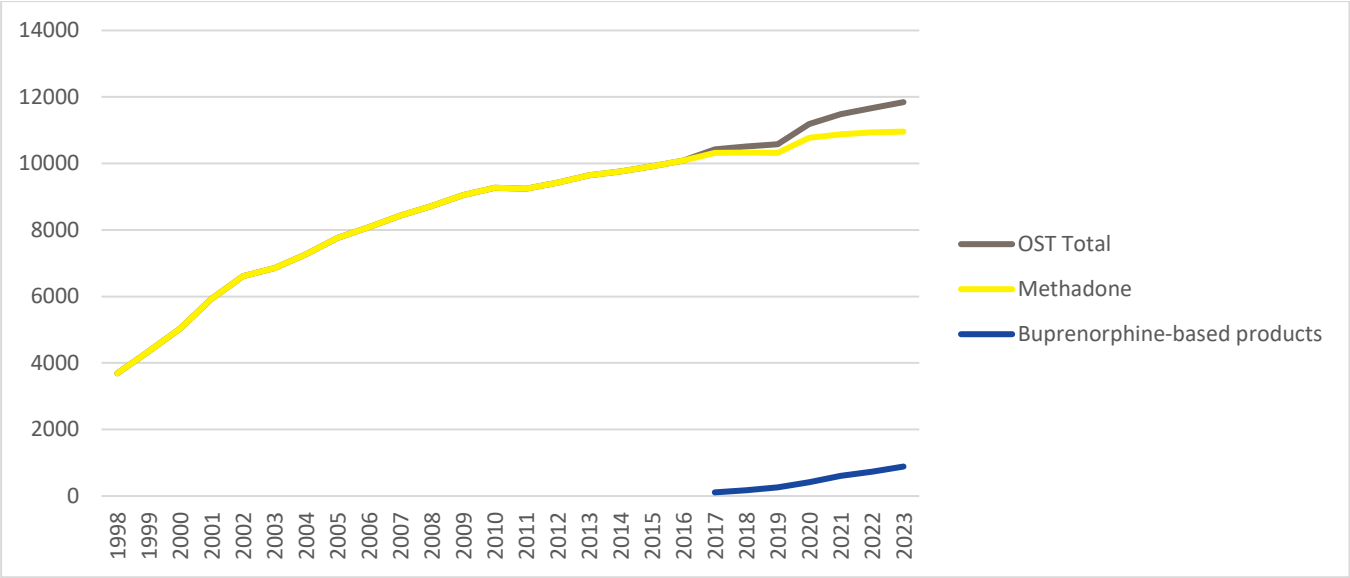

Figure IV. Trends in numbers of clients in OST, 1998–2023
Source: CTL

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

The 2023 NDTRS publication on treatment demand included a section on the most common treatment interventions provided (at time of publication) (Lynch *et al.*, 2024). The most common intervention received (in either inpatient or outpatient services) was a brief intervention (43.6%), followed by counselling (individual or group, 32.5%), education/awareness programmes (individual or group, 23.9%), and OAT (13.3%) (see Figure 4.2.1). In recent years, there has been an increase in non-medical interventions, especially brief interventions, and education/awareness programmes.

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

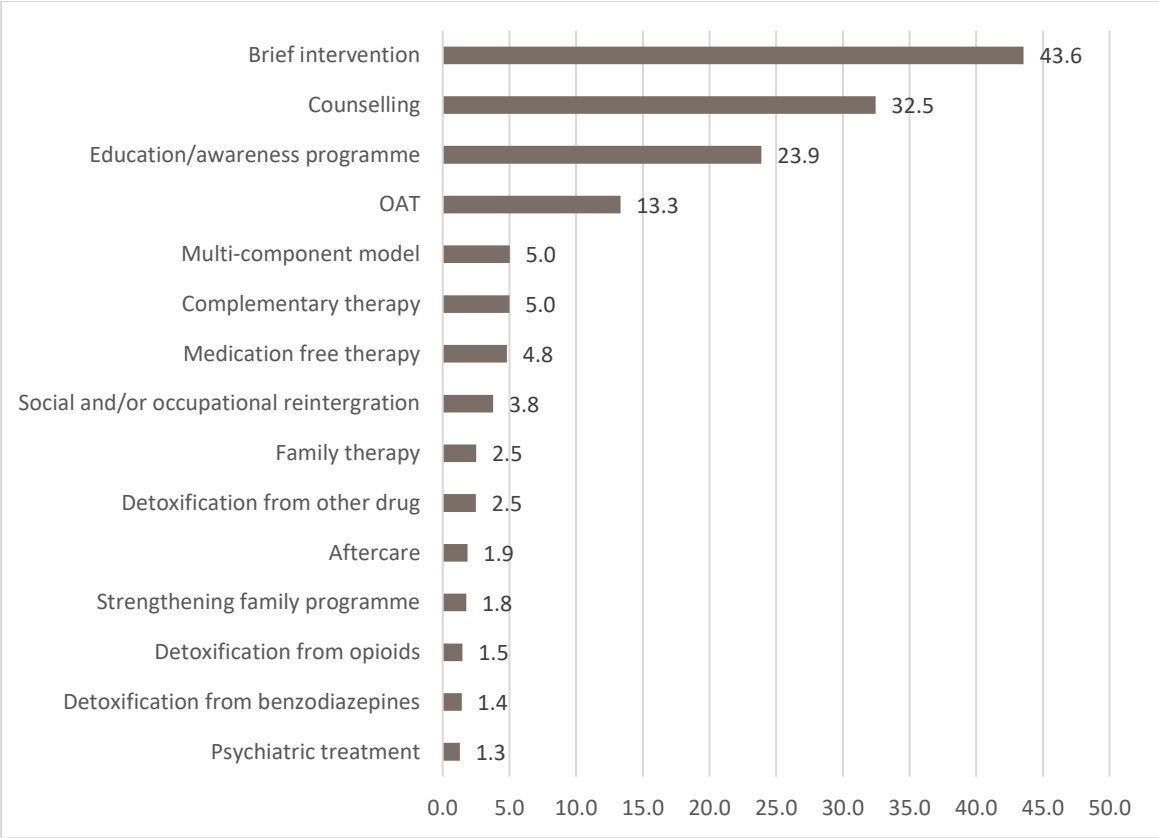

Figure 4.2.1 Percentage of treated cases by type of treatment intervention provided (NDTRS 2023)

Reproduced from Lynch *et al*. (2024)

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 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 unit and in some cases under shared clinical governance with HSE Addiction Services. The service is due to start summer 2024.

From August 2024, the NDTRS began collecting more detailed data on mental health for cases presenting to drug treatment. This includes up to three diagnoses (using ICD 11 codes). These data will be reported via TDI in the future.

T5. Sources and methodology

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 HRB on behalf of the Department of Health.

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