

# **Focal Point Ireland: national report for 2025 – Treatment**

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

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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 current national drugs strategy comes to an end this year.

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 2024, a total of 12,663 treatment entrants were reported. This is a slight increase on the number of cases reported in 2023 (12,597).

In 2024, cocaine was the most common problem drug reported. The increase in the number of cases presenting for treatment for problem cocaine use continued in 2024. Almost one-quarter of cocaine cases (24.4%) were reported to be due to crack cocaine, which is similar to 2023 (24.2%).

Opioids (mainly heroin) (3,199 cases) 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 has been an almost consistent downward trend since then.

Cannabis was the third most common problem drug reported in 2024. 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 had been treated previously. The proportion of new treatment entrants remained relatively unchanged in 2024, at 37.7%, which is similar to the previous 10 years.

In 2024, cocaine was the most common drug reported by new treatment entrants, a continuation of the trend first seen in 2020.

On 31 December 2024, 11,233 clients were registered for OAT (including those receiving OAT in prison). In 2024, 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 drugs 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; 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.
- 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 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.

The current national drugs strategy comes to an end in 2025. An evaluation of the strategy found that while progress had been made on advancing a health-led approach, significant challenges remain, in particular in relation to fragmented care pathways for those seeking treatment (Grant Thornton 2025). For more information on this evaluation, 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**

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 at this time. Currently, 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 publication of the 1998 *Report of the Methadone Treatment Services Review Group* (Methadone Treatment Services Review Group 1998) (see also 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 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 11.8% of outpatient treatment reported to the TDI in 2024. This is because these agencies provide many additional services that do not meet the inclusion criteria for the 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, the TDI still does not accurately reflect the total number of OAT clients treated by GPs in the community (see Table I). In 2024, the coverage for GPs increased slightly to 43.7%, compared with 43.3% in 2023.

**T1.2.2. Further aspects of outpatient drug treatment provision**

Currently, Ireland is rolling out a new strategy for improving the country’s healthcare system (Department of Health 2021). It aims to improve equality of access to healthcare, in particular by developing primary and community healthcare services. This may change the way that outpatient services are organised and funded in the future.

**Table 1. 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	352	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.	8,800
Low-threshold agencies	44	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.	1,277
General primary healthcare (e.g. GPs) General mental healthcare	357		228

	Total number of units	National definition (characteristics/types of centre included within your country)	Total number of clients
Prisons (in-reach or transferred)	24	In-reach provided by voluntary services funded by the IPS and others.	556
Other outpatient units	0		
Other outpatient units	0		

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

A small number of community detoxifications are reported to the National Drug Treatment Reporting System (NDTRS) annually. This is where the individual is not admitted to a residential facility but is supported to reduce or stop their use of a specific drug (usually opioids or benzodiazepines) in the community by their GP and an affiliated outpatient service (Progression Routes Initiative 2011b) (Progression Routes Initiative 2011a). In 2024, it was reported that 134 cases had undergone a community detoxification (*Dáil Éireann debate. Question 297 - Addiction treatment services [Detoxification] [30199/24]. 2024*).

### 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 2. 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					100%
Low-threshold agencies					100%
General primary healthcare (e.g. GPs)	100				100%
General mental healthcare					100%
Other outpatient units (1)					100%
Other outpatient units (2)					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. 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 (Dáil Éireann debate. Question 18 - Addiction treatment services [2024/24]. 2024). The number of cases recorded attending residential treatment in 2024 (1,802) has increased very slightly compared with 2023 (1,768).

Mental health services provide inpatient addiction treatment in 66 different hospitals. Figures from these services are not included in the annual TDI figures.

### T1.2.6. Further aspects of inpatient drug treatment provision

See Section T1.2 of this workbook in relation to the new national strategy in relation to healthcare provision which may impact on how inpatient services are funded and organised in the future (Department of Health 2021).

**Table 3. 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.	142
Residential drug treatment (non-hospital based)	0		0
Therapeutic communities	0		0
Prisons	0		0
Other inpatient units (1 – please specify here)	65	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; therefore, both are reported together in this section.	1,660
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).

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 4, 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 4. 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%				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**

No new information.

**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 2024 (12,663) were slightly higher when compared with 2023 (12,597). The large annual increase seen in the last 3 years (2021–2023) was not observed.

In 2024, cocaine (5,012 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 37.4% (4,708) in 2023 to 39.6% (5,012) in 2024. This is a continuation of the upward trend observed since 2023 (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 2024 to 25.3% (3,199 cases), compared with 29.4% (3,704 cases) in 2023. However these proportions must be interpreted carefully, as opioids continue to represent a significant proportion of treatment demand.

Heroin continues to be the main problem drug in this category, with 84.7% of all cases with problem opioid use reporting heroin as their main problem drug in 2024, which is similar to 2023 (86.6%) (see also Section C T1.2.2 of the *Drugs workbook*).

Cannabis remains the third most common problem drug reported (16.9%, 2,143) in 2024. 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 2024 (2,143) is only slightly lower than what was reported in 2023 (2,220).

Benzodiazepines remain the fourth most common problem drug reported; the proportion of cases treated for problem use of benzodiazepines in 2024 was 13.5%, slightly higher than the proportion reported in 2023 (11.3%).

Amphetamines (0.2%) and ecstasy (0.01%) continue to make up a very small proportion of the main problem drugs reported in 2024, 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, 2024**

Published in May 2025, 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 8-year period 2017–2024 (Lynch et al. 2025).

This period aligns with the period of the current national drugs strategy, which runs from 2017 to 2025 (Ireland. Department of Health 2017). Note that the selection used for the cases reported in the NDTRS publication is slightly different to what is reported via the TDI.

In 2024, 13,295 cases were treated for problem drug use. This is the highest annual number recorded by the NDTRS to date, but a very small increase when compared with 2023 (13,104). 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 in order to fully understand the trends over time.

#### Main problem drug

Cocaine was the most common drug reported in 2024, accounting for 39.8% of all cases and showing a 7.4% increase from 2023 (5,289 versus 4,923). While this is a continuation of the upward trend seen between 2022 and 2023, the proportional increase is much smaller.

Opioids (mainly heroin) were the second most common main problem drug reported. The number of cases fell by 519, from 3,845 to 3,326 in 2024. 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 problem drug generating treatment demand. Among those aged 20–44 years, cocaine was the main problem drug generating treatment demand. Opioids were the main problem drug generating treatment demand among those aged 45 years and over.

#### Polydrug use

Problem use of more than one drug (polydrug use) was reported by three in five cases (60.4%), which is similar to previous years. Cannabis (40.1%) was the most common additional drug, followed by cocaine (36.7%), alcohol (36.2%) and benzodiazepines (30.1%). This is similar to previous years.

#### 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, citric, water to mix drugs, and water or bleach to clean equipment). In 2024, one in five people (18.7%, 2,485) reported that they had ever injected. Among these, almost one in four (24.1%, 598) was currently injecting (i.e. in the 30 days prior to treatment).

Among cases in 2024 that were known to be currently injecting, the majority were male (73.9%) and the median age when first injected (where known) was 23 years. The most common main problem drug reported by those known to be currently injecting was opioids (74.9%), followed by cocaine (15.7%) (but these were not necessarily the drugs that were injected). Four in five cases (81.1%) currently injecting reported polydrug use. Most were previously treated (83.4%), and 34.8% were homeless and 7.7% were living in unstable accommodation was common.

In 2024, two in five cases (40.3%) who had ever injected also reported ever sharing needles and syringes, which is similar to 2023. Among cases who report current injecting, where known, 16.9% 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 (69.8%) of cases male. One in ten (11.7%) cases were recorded as homeless. The proportion of cases with an Irish Traveller ethnicity was 2.7%. The majority (63.3%) cases were recorded as unemployed, with 21.8% cases in paid employment.

Key trends over time (2017–2024)

Over the period 2017–2024, there was a 252.6% increase in the number of cases where cocaine was the main problem drug. Powder cocaine increased by 216.0% over the time period, and crack cocaine increased by 668.2%.

There was a 426.1% increase among females who have sought drug treatment for cocaine, from 284 cases in 2017 to 1,494 cases in 2024. Between 2017 and 2024 there was a 299.4% increase in the number of previously treated cases reporting cocaine as a main problem, from 692 cases in 2017 to 2,764 cases in 2024.

The proportion of treatment demand attributable to opioids has decreased year on year (from 45.0% in 2017 to 25.0% in 2024). Opioids were the main problem drug generating treatment demand for cases aged 45 years and over, an increase when compared with earlier years, when the age group was 40 years and over.

The number of cases who reported ever injecting has fluctuated over the period 2017–2024. The highest number of cases (2,740) was reported in 2018 and the lowest in 2020 (2,260; but reporting may have been impacted by public health restrictions due to the COVID-19 pandemic).

Among *new cases*, the proportion that reported ever injecting decreased over the period, from 11.0% in 2017 to 3.4% in 2024. However, among previously treated cases the numbers reporting ever injected has fluctuated since 2017.

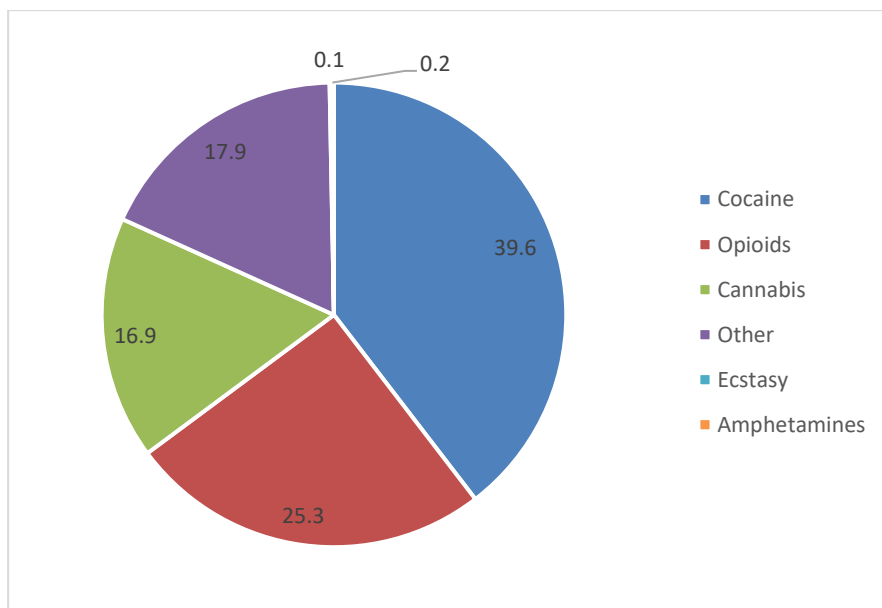
**T1.3.5. Further top level treatment-related statistics**

There has been a marginal increase (0.5%) in the number of cases reported in 2024 (12,663), compared with 2023 (12,597). Of note, there was increased investment by the Department of Health in cocaine-specific services in the past number of years (Department of Health 2023).

**Table 5. Summary table – clients in treatment**

	Number of clients
Total clients in treatment	12,663
Total OAT clients	11,233
Total clients entering treatment	Data on OAT and the 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 1. Proportion of treatment demands by primary drug (2024)**

## 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 6 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)

Up to 2024, only data on addiction counselling were provided to the TDI by the IPS. However, for 2025 onwards, data on OAT provided by the medical units will be reported and it is hoped that additional treatments such as detoxifications will be included in the future in order to provide a better understanding of the volume of and type of treatment provided by the IPS.

There are no data currently available for Table 6, with the exception of data on individual case management.

**Table 6. Availability of core interventions in outpatient drug treatment facilities**

	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

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 of 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 7 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 7. Availability of core interventions in inpatient drug treatment facilities<sup>i</sup>**

	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**

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 2023, 126 women were referred to the drug liaison midwife in the Rotunda Hospital, a large maternity hospital in Dublin (The Rotunda Hospital 2024). Twenty-five 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.

Results from a large-scale longitudinal study in Ireland has found that children exposed to individual and cumulative adverse childhood experiences (ACEs) – in particular parental conflict, mental illness and family history of substance use disorder – are at higher risk of using illicit substances as young adults (Mongan 2025). For more information see Section T1.7.2 of the *Harms and harm reduction workbook*).

**Other target groups: people receiving treatment in prison:** In 2022, the IPS estimated that approximately 70% of prisoners had 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. 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. (See also the *Prison workbook*.)

A 2023 study found that between 2012 and 2020, a total of 10,371 individuals were prescribed OAT, opioids, benzodiazepines, Z-drugs or gabapentinoids (Durand et al. 2023). History of opioid use disorder (OUD) was higher in women, with a median rate of 597 per 1,000 female prisoners, compared with 161 per 1,000 male prisoners. Gender-specific analyses found that men with OUD, compared with men who did not have this disorder, were more likely to be prescribed benzodiazepines (ARR=1.49; 95% confidence interval (CI): 1.41–1.58), Z-drugs (ARR=10.09; 95% CI: 9.0–11.31), and gabapentinoids (ARR=2.81; 95% CI: 2.66–2.97). For women, history of OUD was associated with reduced gabapentinoid prescribing (ARR=0.33; 95% CI: 0.28–0.39).

Also see Standard Table 24 and 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 2024**

The recent NDTRS publication on treatment demand included a section on treatment outcomes (Lynch et al. 2025). 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 via the TDI.

The outcomes are based on the condition of the case at the point of treatment exit only. These figures show that 11,658 cases exited drug treatment in 2024, which includes cases recorded as exiting treatment between 1 January 2024 and 31 December 2024 inclusive, irrespective of when treatment commenced. These figures are comprised of 7,731 (66.3%) cases who both entered and

exited treatment in 2023, as well as 3,927 (33.7%) cases who exited treatment in 2024 but had commenced treatment in previous years. A small number of cases were excluded, as the service provider was unable to provide adequate information.

### 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 2024 was when cases did not return for subsequent appointments ('no shows') (32.6%) followed by when cases completed their treatment (29.0%), which is similar to the results in 2023.

**Table 8. Reason for treatment exit (NDTRS 2024)**

	n	%
All cases exiting treatment in 2023	11,658	
Client did not return for appointments ('no show')	3,803	(32.6)
Treatment completed	3,383	(29.0)
Client declined further treatment	1,616	(13.9)
Transferred/referred to treatment in another drug/alcohol service	1,572	(13.5)
Sentenced to prison	285	(2.4)
Premature exit from treatment for non-compliance	258	(2.2)
Medical or mental health reasons	114	(1.0)
No longer lives in the area	104	(0.9)
Died	120	(1.0)
Staffing issues (resignation/retirement/maternity, etc)	15	(0.1)
Released from prison not linked to other treatment service	67	(0.6)
Prison-to-prison transfer	62	(0.5)
Unable to attend due to work/study commitments	108	(0.9)
Other	55	(0.5)
Not known	89	(0.8)

Reproduced from Lynch *et al.* (2025)

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

Additional information about services in relation to support for employment, housing, education or other social supports will be captured in the NDTRS database from mid-2025 onwards.

### **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 2024, according to data from the CTL, as of 31 December 2024, 55.5% of clients received OAT in specialist outpatient clinics; 37.3% received OAT from GPs; 7.4% received it in prison; and less than 1.0% received it in an inpatient setting (unpublished data, CTL, 2025; also see Figure IV in Section T2.2 of this workbook). These trends are similar to those reported for 2023 data.

The proportion of clients receiving OAT from GPs has remained stable for nearly a decade. 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 of this workbook, as well as ST24).

On 31 December 2024, 11,233 clients were registered for OAT (including those receiving OAT in prison) (personal communication, CTL, 2025), a 5% decrease compared with 2023, when 11,844 clients were registered.

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). In 2024, 90.5% of those receiving OAT were prescribed methadone. This is a decrease compared with 2023, when 94% of clients were reported to be receiving methadone, and represents an increase in the numbers prescribed buprenorphine-based products.

#### **T1.4.11 Characteristics of clients in OST**

Post-operative pain management for MMT patients

A recent case series in Ireland looked at the management of patients with OUD on MMT who require post-operative pain management (Mullins et al. 2025). The article highlighted the need to carefully evaluate each individual patient, to provide respectful and appropriate care, to ensure that their MMT is not interrupted and that they receive adequate pain management. This may be challenging if the patient is not adhering to their prescribed dosage, or if they are using methadone bought illegally.

Polydrug use among patients on MMT

A cross-sectional study design using an anonymised individual-level urine drug test (UDT) between 2010 and 2020 examined trends in polydrug use in patients on MMT in one of the largest OAT clinics in Ireland (Durand et al. 2024).

Samples from OAT patients were included if the patient had a minimum of five valid samples, one of which must have been positive for methadone. All urine samples were tested for benzodiazepines, methadone, other opioids, and cocaine using immunoassay testing. Annual positivity rates were calculated by dividing the number of samples tested for each substance and multiplying by 100. In order to evaluate trends in polysubstance positivity rates for drug combinations, mixed-effects logistic regression models were employed. Sensitivity analysis was used to assess the impact of COVID-19 on these observed trends.

A total of 221,564 samples were included over the study period, with an average of 114 samples per patient. The results showed that methadone was the most commonly detected substance followed by benzodiazepines, cannabis, other opioids, cocaine, and amphetamines. The magnitude of increase was greatest for cocaine, reflecting a weighted annual positivity rate of 12% in 2015, compared with 37% in 2020. In contrast, the detection of opioids decreased from 50% in 2015 to 39% in 2020.

For patterns in polysubstance positivity rates for drug combinations associated with increased risk of drug overdose, the main findings were as follows:

1. Combination of methadone and benzodiazepines was common over the period.
2. Combination of methadone and benzodiazepines with cocaine increased over the period.
3. Combination of methadone, benzodiazepines, opioids and cocaine increased between 2010 and 2020.
4. Combination of methadone and benzodiazepines with opioids decreased over the study period.
5. Patients aged 36 years and over were less likely to test positive for multiple substances.

This research only included patients attending a large Dublin-based clinic and focused on drugs that are routinely tested by the NDTC laboratory; therefore, they may not be generalisable outside this setting. In addition, immunoassay tests can be limited in scope, e.g. cannot detect prescription opioids such as tramadol, which could underestimate concurrent opioid use. Another issue which may affect the results is that cannabis and amphetamine testing was at the request of individual doctors, which may have led to some selection bias; moreover, it was not possible to ascertain whether the benzodiazepines were prescribed by a doctor or were sourced at street level. It should also be noted that there was an increase in the number of patients enrolled in OAT during the COVID-19 pandemic, but a decrease in the number of urine samples taken in that period.

The authors state that given the prevalence of polysubstance use among patients in OAT, and its associated risk with overdose fatality, there is a need to introduce measures to address the persistently high use of benzodiazepines and cocaine among this group. They also state that information from urine sampling can be very useful in relation to identifying changes in the trends of drug use over time and that it can inform interventions to help reduce polysubstance use in patients on OAT.

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

No new information.

## **T1.5. Quality assurance of drug treatment services**

### **T1.5.1. Quality assurance in drug treatment**

No new information.

## **T2. Trends**

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

#### **New treatment entrants (Figure II)**

In 2024, there were 4,771 new treatment entrants recorded (see Figure II; see also the TDI), which is similar to 2023 when 4,789 new treatment entrants were recorded.

Proportionally, in 2024, new treatment entrants represented 37.7% of all cases, which is similar to the 2023 figure (38.9%). The proportion of new treatment entrants has been decreasing very gradually since 2015.

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 continued for 2024, with 46.8% of new treatment entrants reporting cocaine as the main problem drug, compared with 27.5% reporting cannabis.

In 2024, '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 previously treated.

#### **All treatment entrants (Figure 3)**

The number of all cases reported in 2024 has increased very slightly when compared with 2023 (see Figure III and also see Section T1.3.5 of this workbook).

In 2024, a total of 12,663 treatment entrants was recorded, representing an increase when compared with 12,597 treatment entrants in 2023 (see also the TDI). However, this still represents the highest number of cases reported to date. Of the cases recorded in 2024, the majority (56.0%) had been previously treated, the same as in 2023 (56.2%). The proportion of new treatment entrants remained relatively unchanged in 2024, at 37.7%, which is similar to the period 2015–2025.

In 2024, cocaine (39.6%, includes powder and crack) remained 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 at 13.3%, dropping steadily until 2012, when it stabilised; however, the proportion of cases has increased since then to a new peak of 39.6% in 2024, compared with 37.4% in 2023. In 2024, 24.4% (1,224) of cocaine cases were known to be crack cocaine, which is similar to the 2023 figures (24.2%, 1,138).

In 2024, opioids (mainly heroin) were the second most common problem drug reported by treatment entrants (25.3%), compared with 29.4% in 2023. 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 this should be interpreted in the context of COVID-19 pandemic-related public health restrictions). Since 2020, the number of cases has increased slightly to 3,704 in 2023, but decreased to 3,199 in 2024. However, although overall coverage of the NDTRS is high, less than one-half of GPs providing OAT participate in the database; therefore, this number is likely to be an underestimation (see also Section T1.2.1 of this workbook).

Cannabis (16.9%) was the third most common problem drug reported in 2024. 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% (2,681) in 2015 and has fluctuated since then.

In 2024, '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 2024, 27 amphetamines cases were reported; this compared with 18 cases in 2023 when there were only 11 ecstasy cases reported, which was the same figure as in 2023. However, small numbers make interpretation difficult.

Please note that the data reported via the 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 2024**

The recent NDTRS publication on treatment demand in 2024 included a section on the number of continuous care cases (Lynch et al. 2025). When the report was published, there were a total of 11,998 cases who had commenced treatment prior to 2024 and were still in treatment on 1 January 2024 (see Table 9). Reporting continuous care cases can help provide a more complete picture of treatment demand for that year. Please note that the data reported via the 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 9. Number of cases treated for drugs as a main problem, new and continuing care cases (NDTRS 2024)**

	Cases commencing treatment in 2024		Continuous care cases 1 January 2024		Total (commencement plus continuous care)	
	n	%	n	%	n	%
All cases	13,296		11,998		25,294	
New cases	4,771	(35.9)	3,124	(26.0)	7,899	(31.2)
Previously treated cases	7,714	(58.0)	8164	(68.0)	15,878	(62.8)
Treatment status unknown	807	(6.1)	710	(5.9)	1,517	(6.0)

Reproduced from Lynch *et al.* (2025)

### Prescription drug misuse in Ireland

A national study using three sources of information, including treatment demand data from the NDTRS, intentional drug overdoses and drug-related deaths showed that benzodiazepines and Z-drugs consistently accounted for the greatest proportion of harms across all three indicators, making up 341 per 1,000 treatment cases, 408 per 1,000 IDOs, and 546 per 1,000 drug-related deaths (Durand *et al.* 2025). Notably, while the absolute burden remained highest for this group, the annual increase in harms was modest, indicating relative stability over time. In contrast, gabapentinoids, especially pregabalin, emerged as the most rapidly escalating threat. Despite lower initial prevalence, treatment demand linked to gabapentinoids grew by 44% annually.

Polydrug use significantly amplified risks across all metrics. The combined misuse of gabapentinoids and benzodiazepines, or opioids, increased sharply, particularly among women. Sex differences were also evident, with women more likely to misuse gabapentinoids and prescription opioids, and men more likely to misuse psychostimulants and certain benzodiazepines. For further information See **section D T4.3 in the *Drugs workbook***.

### Rise in cocaine-related harms in Ireland

A recent study has revealed a sharp increase in cocaine use and associated health harms in Ireland over the past two decades using multiple sources of data, including treatment data from the NDTRS (Mongan *et al.* 2025).

In relation to treatment, cases reporting cocaine as a main problem drug increased from 1.5 per 100,000 population in 2000 to 93.2 in 2023, with an annual percentage change (APC) of 17.6% (95% CI: 15.89, 20.74). Joinpoint analysis identified three change points: a significant increase between 2000 and 2007 (APC: 35.7%; 95% CI: 26.26, 54.88), a decrease between 2007 and 2013 (APC: 3.3%), and a significant increase between 2013 and 2023 (APC: 19.7%; 95% CI: 17.88, 22.31).

The study also looked at treated cases who reported cocaine as either a main or additional drug. In this group there was an increase from 16.3 per 100,000 population to 140.2 per 100,000 population between 2000 and 2023 (APC of 10.1%, 95% CI: 9.43, 11.09). Between 2000 and 2003, there was a significant increase (APC: 34.5%; 95% CI: 24.39, 55.10); and again between 2003 and 2009 (APC: 8.7%; 95% CI: 5.69, 11.43). However, the number of cases reporting cocaine as a main or additional

drug decreased significantly (APC: -10.4%; 95% CI: -14,17, -7.01) between 2009 and 2013 before increasing significantly between 2013 and 2023 (APC: 13.4%, 95% CI: 12.64, 14.43).

All the data sources showed similar trends, with the researchers identifying distinct periods of increase and decrease. Harms generally rose until 2007, declined during the recession years, and surged again from around 2013 onwards. This trend likely reflects both Ireland’s economic recovery and broader increases in cocaine availability and purity across Europe.

For further information see Section T1.7.2 of the *Harms and harm reduction workbook*.

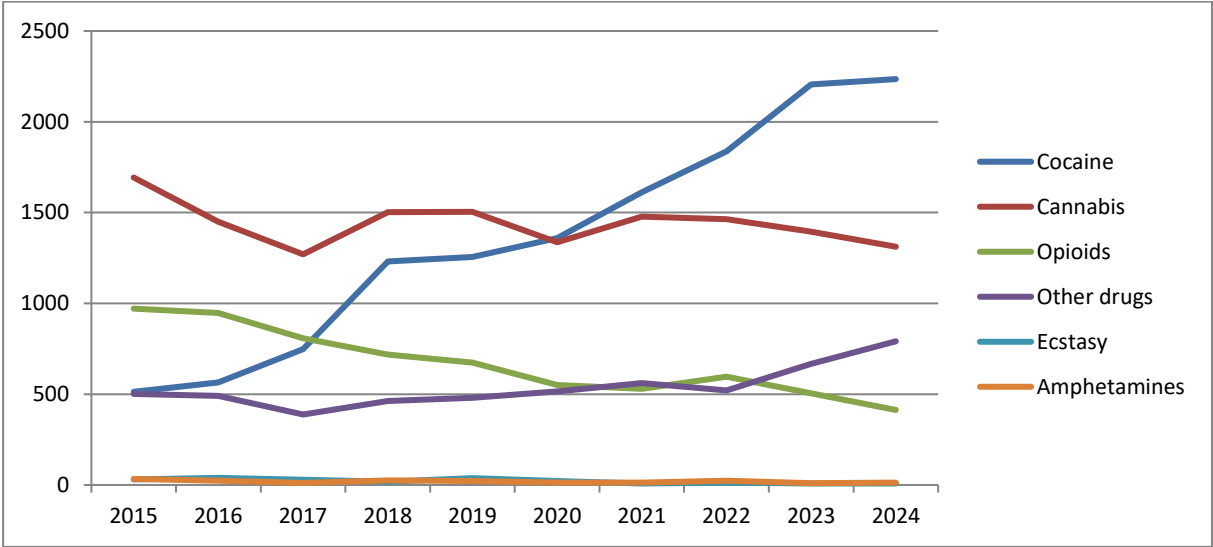


Figure 2. Trends in numbers of first-time clients entering treatment, by primary drug, 2015–2024

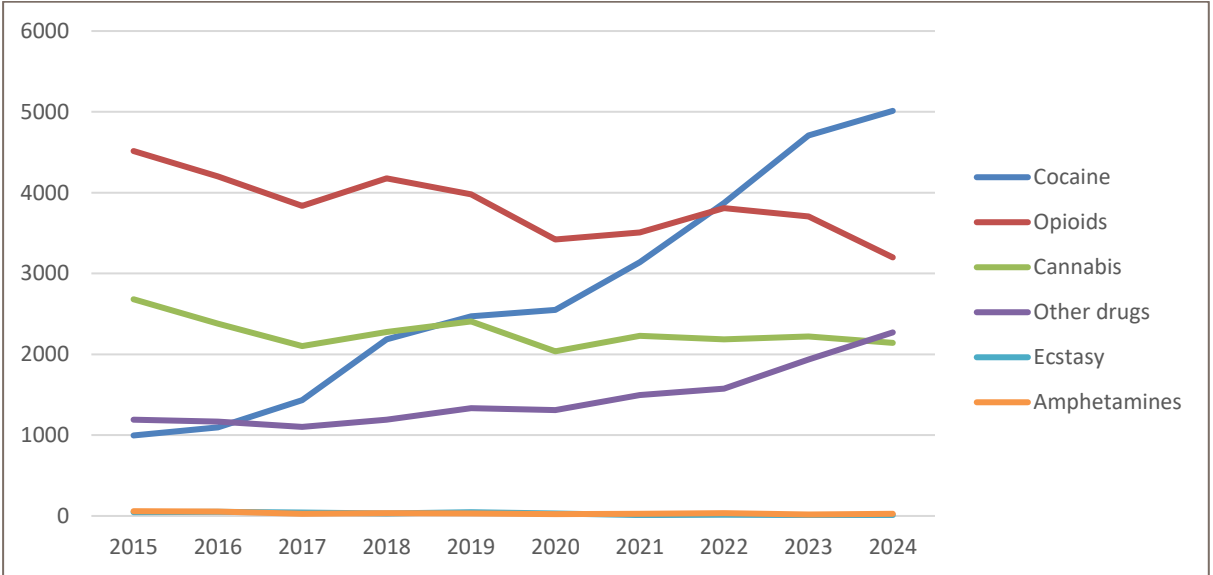
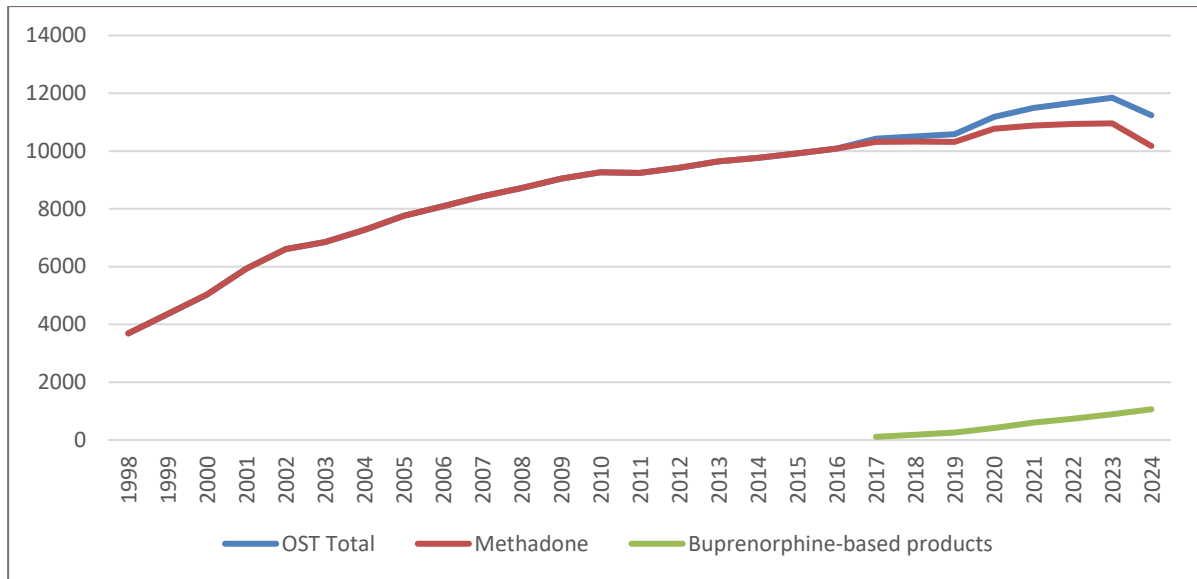


Figure 3. Trends in numbers of all clients entering treatment, by primary drug, 2015–2024



**Figure 4. Trends in numbers of clients in OST, 1998–2024**  
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 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 are shared between the service partners, primarily under the clinical governance of the HSE and in some cases under shared clinical governance with HSE Addiction Services. The service started in summer 2024 with data collection including psychiatric diagnosis (ICD 11), integrated with the NDTRS.

## **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 Union Drugs Agency

The European Union Drugs Agency (EUDA) is a decentralised European Union (EU) agency based in Lisbon. The EUDA 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 EUDA. These focal points gather and analyse country data according to common data collection standards and tools and supply these data to the EUDA. The results of this national monitoring process are supplied to the EUDA for analysis; from this, the EUDA produces the annual *European Drug Report* and other outputs.

The Irish Focal Point to the EUDA 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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