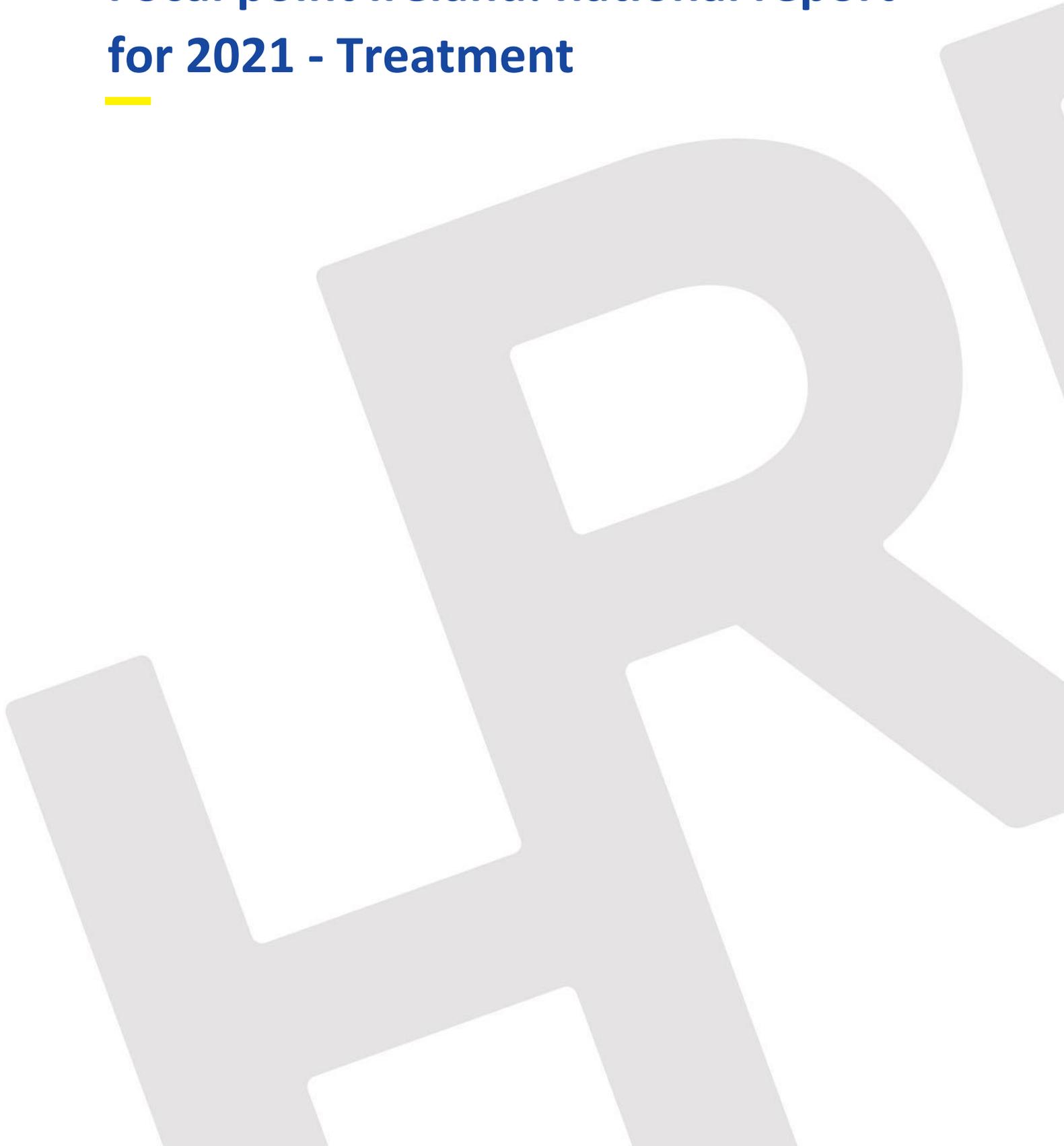


Focal point Ireland: national report for 2021 - Treatment



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

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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. The 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 the client.

The Health Service Executive (HSE) is responsible for the provision of all publicly funded drug treatment. 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 problem drug users, mainly in outpatient settings, but also in residential settings. Almost all opioid substitution treatment (OST) provided is methadone; however, since November 2017, Suboxone (buprenorphine and naloxone in-combination preparation) has been available 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 methadone treatment for problem opioid users is provided only through specialised HSE outpatient drug treatment clinics, satellite clinics, or through specialised general practitioners (GPs) in the community. The first national comprehensive clinical guidelines for OST were published in 2016.

Trends

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

In 2020, a total of 9,368 treatment entrants were reported. This is an 8.8% decrease from the number of cases reported in 2019, when 10,267 cases were reported. This decrease can be explained in part by the impact of public health restrictions due to the COVID-19 pandemic on addiction services, and in particular on residential services, but also on reduced reporting to the Treatment Demand Indicator (TDI). However, despite the decrease in case numbers, the overall trends remain similar to previous years.

Opioids (mainly heroin) are the main problem illicit drug used by entrants to treatment, followed by cocaine and cannabis. The proportion of all entrants to treatment reporting an opioid as their main problem drug has decreased year on year since 2004, from a peak of 65% in 2004 to 36.5% in 2020.

Cocaine remained the second most common problem drug reported in 2020, having surpassed cannabis in 2019. The increase in the number of cases presenting for treatment for problem cocaine use continued in 2020, but to a lesser extent than in previous years. Previously, the highest proportion 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 27.2% in 2020, compared with 24.1% in 2019.

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

The majority of cases entering treatment have been treated previously. The proportion of new entrants to treatment remained relatively unchanged in 2020, at 40.5%. The proportion of new treatment entrants has fluctuated, from 39% in 2004 to a peak of 47% in 2009, but the proportion has stabilised at around 39% over the past number of years.

In 2011, cannabis surpassed opioids (mainly heroin) as the main problem drug reported by new entrants to treatment, but in 2020, the number of new entrants reporting cocaine as their main problem drug (n=1,359; 35.8%) just surpassed cannabis (n=1,337; 35.2%) for the first time.

There is a change to reporting OST trends in this workbook. Previously, only methadone was reported, but as of 2020 buprenorphine-based products are now included in the annual totals reported in this workbook. The data for the period 2017 to 2019 have been revised to include buprenorphine-based products. Therefore, they differ from what was reported in previous years.

In 2020, more than one-half of all OST clients received OST in specialist outpatient clinics, two-fifths received it from specialist GPs, and an even smaller proportion (less than 6%) received it in prison. On 31 December 2020, 11,185 clients were registered for OST (including those receiving OST in prison). The total for 2020 is based on corrected figures, so it may differ from what has been previously reported elsewhere. Of those in OST on 31 December 2020, 96% were in receipt of methadone. There has been a 6% increase in the numbers registered for OST in 2020 compared to 2019. This is due to the response of addiction services to the COVID-19 pandemic, as there were concerted efforts to improve access to OST by reducing waiting lists, allowing some services and GPs to increase their caseload, and increasing remote teleworking and other resources as required. This increase is not reflected in the TDI figures, in part due to public health restrictions on data collection and reduced coverage of GP services in the NDTRS.

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 the second goal 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. The second goal 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” (page 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-tiered, person-centred model of rehabilitation which is based on the principle of ‘continuum of care’. This continues to be the national framework through which treatment and rehabilitation services are delivered, with all substances of misuse being dealt with and with a focus on polydrug use.

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

- Strengthening the implementation of the National Drugs Rehabilitation Framework (Doyle and Ivanovic 2010) by developing a competency framework on key working, care planning, and case management, and by extending the training programme on the key processes of the Framework.
- Expanding the availability and geographical spread of relevant quality drug and alcohol services and improving the range of services available, based on need. This will be done by identifying and addressing gaps in provision in the four tiers of the model, increasing the number of treatment episodes provided across the range of services, and strengthening the capacity of services to address complex needs.
- Improving the availability of opioid substitution treatment (OST) by examining potential mechanisms to increase access through the expansion of general practitioner (GP) prescribing and nurse-led prescribing, and through the provision of OST in community-based settings and homeless services.
- Enhancing the quality and safety of care in the delivery of OST by implementing the HSE's *Clinical Guidelines for Opioid Substitution Treatment* (Health Service Executive 2016) (see Section T1.5.1 of this workbook).

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

- Expand addiction services for pregnant and postnatal women
- Respond to the needs of women who are using drugs and/or alcohol in a harmful manner by improving the range of wraparound services available
- Expand the range, availability, and geographical spread of services for those aged under 18 years
- Examine the need to develop specialist services in order to meet the needs of older people with long-term substance use issues
- Improve outcomes for people with comorbid severe mental illness and substance misuse problems by supporting the Mental Health 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 in 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 – The Child and Family Agency, and the Irish Prison Service.

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. This 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 to provide 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 Task Forces to participate in planning and reporting in line with the monitoring tool developed by the National Addiction Advisory Governance group, and 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 National Service Plan and the Primary Care Division Operational Plan. 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 to ensure that treatment for problem opioid use could be provided wherever the demand exists (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 drug prescribed, in November 2017 there was a phased rollout of buprenorphine-based products nationally for appropriate clients (Expert Group on the Regulatory Framework 2011, Fitzgerald 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 Statutory Instrument 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 below). The CTL is a complete register of all patients receiving OST (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 OST in community and hospital settings (Health Service Executive 2016, Health Service Executive 2020a).

T1.2 Organisation and provision of drug treatment

T1.2.1 Outpatient drug treatment system – main providers

Outpatient services are provided through a network of HSE services (public) and non-statutory, voluntary agencies (see also Section T1.1.2 and Section T1.4.1 of this workbook). There are an unknown number of private organisations that also provide outpatient addiction treatment, such as counselling. Very few of the private agencies contribute data to the TDI figures. Some addiction treatment is also provided and/or funded through the HSE's Mental Health Division and are 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 only 9% of outpatient treatment reported to TDI in 2020. 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 OST to clients who are stable. As such, they represent an important part of drug treatment in Ireland, particularly for stable clients on OST. For further information, see Section T1.4.10 of this workbook. Not all GPs choose to provide OST, 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 OST clients treated by GPs in the community (see Table I). In 2020, the coverage for GPs increased slightly to 47.0%, compared with 44.2% in 2019. However, the reported number of cases treated was much reduced in 2020, mainly as a result of COVID-19 pandemic restrictions, which limited the collection of the data.

T1.2.2 Further aspects of outpatient drug treatment provision

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	306	Treatment facilities where the clients are treated during the day (and do not stay overnight). Includes OST clinics, any specialised addiction service (e.g. counselling), therapeutic day care, and socioeconomic training units 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.	6,533
Low-threshold agencies	79	May provide low- dose OST, general medical assistance, brief interventions, and needle exchange.	846
General primary health care (e.g. GPs) General mental health care	379	Specially trained GPs who provide OST in primary care.	82
Prisons (in-reach or transferred)	30	In-reach provided by voluntary services funded by the Irish Prison Service and others.	749
Other outpatient units			

Source: Standard table 24.

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 OST treatment 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 in this workbook). The proportion of agencies which are fully funded by the HSE is not currently available and is recorded as 'Other' in Table II, indicating that this is unknown. There is an unknown number of private organisations also providing outpatient addiction treatment, such as counselling. Some of this treatment may be covered by private health insurance; however, the proportion is not known. All addiction treatment in prison is provided free of charge.

Table II Ownership of outpatient facilities providing drug treatment in your country (percentage).

	Public/ Government	Non-government (not for profit)	Non- government (for profit - Private)	Other	Total
Specialised drug treatment centres					100%
Low-threshold agencies					100%
General primary health care (e.g. GPs)	100%				100%
General mental health care					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, which account for 9% of all inpatient cases reported through TDI, but other non-statutory agencies also provide inpatient detoxification services (Table III). The coverage of inpatient services in TDI is high.

As of June 2020, the HSE estimated that there were 636 residential beds (for both alcohol and other drugs), which consisted of: 12 inpatient unit detoxification beds; 86 community-based residential detoxification beds; 2 adolescent residential detoxification beds; 530 residential rehabilitation beds; and 6 adolescent residential beds. This includes 21 beds for women who can be accompanied by their children (Gould 2020, 23 July). However, in 2020, in order to comply with the associated public health measures during the COVID-19 pandemic, the number of residential beds was reduced (Bruton, *et al.* 2021a, Gould 2020, 23 July). This is a reduction from the total number reported for 2018 (793 beds) (Gould 2020, 23 July).

Mental health services provide inpatient addiction treatment in 66 different hospitals. Figures from these services are not included in the annual TDI figures, which show that in 2019, 1,090 cases with a drug disorder were admitted to psychiatric facilities (Daly and Craig 2021). Of these cases, 440 were treated for the first time. The admission rate in 2020 was higher than the previous year, and trends over time indicate an overall increase since 2011 in the rate of first admission with a drug disorder. For further information, see Section T1.2.4 of the Harms and harm reduction workbook.

T1.2.6 Further aspects of inpatient drug treatment provision

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 TDI.	108
Residential drug treatment (non-hospital based)			
Therapeutic communities			
Prisons			
Other inpatient units (1.please specify here)	56	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.	1050
Other inpatient units (2.please specify here)			

Source: Standard Table 24

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 in this workbook). The number of clients and the proportion of treatment facilities which 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 would be provided free of charge to social welfare clients with the appropriate entitlements. Some of the 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 Ireland (percentage).

	Public / Government	Non-government (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%

	Public / Government	Non-government (not for profit)	Non- government (for profit - Private)	Other	Total
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

T1.3 Key data

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

Opioids (mainly heroin) and cocaine are the two main drugs for which cases entered treatment in 2020. Cocaine was the second most common problem drug treated (27.2%), similar to 2019 (Figure I).

The proportion of all cases entering treatment reporting opioids as their main problem drug dropped again in 2020 to 36.5%, compared with 38.8% in 2019. This continues the overall downward trend in the number and proportion of cases presenting to treatment for problem opioid use, for example compared with 64.6% in 2004. Heroin continues to be the main problem drug in this category, with 89.7% of all people with problem opioid use reporting heroin as their main problem drug in 2020; this is similar to figures for 2019, when 86.8% of people with problem opioid users reported heroin as their main problem drug (also see Section C T1.2.2 of the Drugs workbook).

Cocaine remained the second most common problem drug reported in 2020, having surpassed cannabis in 2019. Both the number and proportion of cases entering treatment for problem cocaine use has increased, from 24.1% (n=2,471) in 2019 to 27.2% (n=2,548) in 2020. Cocaine was the only drug reported via TDI that showed an increase in the number of actual cases. This is a continuation of the upward trend observed over the past number of years (see also Section B T1.2.2 the Drugs workbook).

Cannabis was the third most common problem drug reported (21.7%). The proportion of cases treated for problem cannabis use peaked in 2013 at 28.9%, but has shown a downward trend ever since (see also Section A T1.2.2 of the Drugs workbook).

Benzodiazepines remain the fourth most common problem drug reported; the proportion in 2020 was 11.4%, an increase on the proportion reported in 2019 (10.1%).

Amphetamines (0.3%) and ecstasy (0.3%) continued to make up a very small proportion of the main problem drugs reported in 2020, with no change from previous years (Also see Section B 1.2.2 of the Drugs workbook).

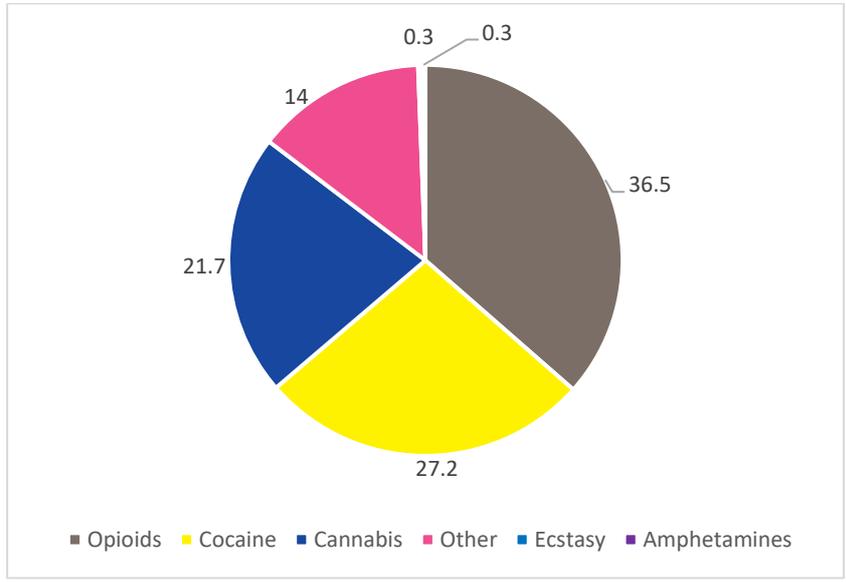
For further information, see Section T2 of this workbook and also see Section T3.1 for an overview of the impact of the COVID-19 pandemic.

Table V: Summary table - Clients in treatment

	Number of clients
Total clients in treatment	9,368
Total OST clients	11,185

	Number of clients
Total All clients entering treatment	Data on OST and TDI are from different sources, are collected using different methodologies, and also have duplication between them; therefore, they cannot be combined or compared meaningfully.

Source: ST24 and TDI



Source: TDI 2021

Figure I. Proportion of treatment demands by primary drug

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

Please note that there is a change to reporting OST numbers in this Workbook; previously only methadone was reported, but as of 2020 buprenorphine-based products are now included in the annual totals reported in this workbook. The data for the period 2017 to 2019 have been revised for Figure IV (see Section T2 of this workbook) and also Standard Table 24 to include buprenorphine-based products. Therefore, the data differ from what were reported in previous years (see also Section T1.4.12 of this workbook). The total for 2020 is based on corrected figures; therefore, it may differ from what has been previously reported elsewhere.

T1.3.4 Characteristics of clients in treatment

No new information

T1.3.5 Further top level treatment-related statistics

No new information

T1.4 Treatment modalities

T1.4.1 Outpatient and inpatient services

The types of treatment and services offered vary depending on the ethos and primary purpose of individual drug treatment centres. The majority of OST 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 OST may provide a wide variety of other treatments, including counselling, group therapy, socioeconomic training, complementary therapies, relapse prevention, etc. Clients who require specialised treatments which are not available in the service they are currently attending will be referred on to a service which can provide those treatments. It is not mandatory for GPs to provide OST (see also Section T1.4.9 of this workbook).

Addiction treatment in prison is provided 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), OST, and psychiatric treatment; counselling is mainly provided by in-reach services.

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

Table VI. Availability of core interventions in outpatient drug treatment facilities

	Specialised drug treatment centres	Low-threshold agencies	General primary healthcare (e.g. GPs)	General mental health care
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 known	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 information

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

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

(mainly run by voluntary services) can be found in Section T1.5.3 in the Harms and harm reduction workbook).

Detoxification: There are two dedicated HSE hospital inpatient detoxification units (with a total of 18 beds). Ten other residential centres, provided by voluntary/non-statutory services, also offer detoxification as part of their suite of residential treatments. There is one centre that provides adolescent residential detoxification, which has four beds.

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 OST due to staffing and governance issues, but will facilitate clients to continue their OST 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 which are not available in the service they are currently attending will be referred on to a service which 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.

	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%		
Opioid substitution treatment	>75%	>75%		
Other core outpatient treatment interventions (please specify in 1.4.1.)	not known	not known		

T1.4.4 Further aspect of available inpatient treatment services

No information

T1.4.5 Targeted interventions for specific drug-using groups

Senior drug users

There are no specific services for senior drug users; they can access treatment through the normal channels. A 2021 research study examined the intersecting levels of stigma experienced by service users who are growing older on long-term methadone maintenance treatment (MMT) in Ireland (Mayock and Butler 2021), a summary of which is detailed in Section T1.4.12 of this workbook.

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 drug liaison clinics in several maternity hospitals in Ireland. In 2019, 105 women were referred to the drug liaison midwife in the Rotunda Hospital, a large maternity hospital in Dublin (The Rotunda Hospital 2020) (see also Section T1.4.11 of this workbook and Section T1.3.6 of the Harms and harm reduction workbook).

There is just one residential treatment centre that caters for women and their children. Otherwise, women can access treatment through the normal channels.

Under-aged children and adolescents

There are some specific outpatient services that cater for children aged under 18 years. There is also one residential treatment centre for children aged under 18 years for both detoxification and residential rehabilitation. See also Section T1.4.7 of this workbook in relation to access to treatment for children aged under 18 years.

Other target groups

See Section T1.4.7 of this workbook for information on ethnic groups, homeless, and lesbian, gay, bisexual, transgender, queer, and intersexed (LGBTQI) communities.

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 EMCDDA, reported via TDI. However, the Drug Use Disorders Identification Test (DUDIT) drug screening tool is available online for individuals over the age of 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 (see <http://www.drugs.ie/drugtest>).

Teleworking in drug treatment data

As a response to public health restrictions due to the COVID-19 pandemic, many addiction services moved to remote working, providing care over video or by telephone. This was captured in the NDTRS as a supplementary option; for example, if a service provided counselling over a video call, it recorded counselling as an intervention and also the teleworking option. Twenty per cent of treatment cases in 2020 had teleworking recorded. Most commonly, this was associated with brief interventions (50.2%), individual counselling (35.6%), and individual education/awareness programmes (20.2%) (unpublished data, NDTRS) (see also Section T3.1 of this workbook).

The Medical Council published guidelines and advice to doctors on how to provide appropriate care via telemedicine (Medical Council 2021). Additional advice was published by the HSE (Smyth and Jones 2020). See also Section T3.1 of this workbook.

Impact of the COVID-19 pandemic on people who use drugs in Ireland

A national survey of drug users to assess the impact of the COVID-19 pandemic found that 11.9% reported an increase in their use of online or remote professional support services to seek support for reducing drug-related risk behaviours and/or drug use (Bruton, *et al.* 2021a) (see also Section T3.1 of this workbook).

T1.4.7 Treatment outcomes and recovery from problem drug use

A recent report used case-based treatment data from the NDTRS (2014 to 2019) to evaluate a number of elements of the current national drugs strategy (Department of Health 2017) (Bruton, *et al.* 2021b) (see also Section T4.1 of this workbook). Treatment data from the NDTRS are affected by different issues, including the participation of services in the NDTRS, and in 2017 the move to a new online data entry portal that needs to be considered when interpreting the data.

Time between assessment and entering treatment

The report used time between assessment and entering treatment to assess timely access to treatment for Goal 2 of the national drugs strategy, “Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery” (Department of Health 2017). The proportion of cases aged 18 years and over accessing treatment within 1 month of assessment dropped from 94% in 2014 to 91% in 2017, rose to 93% in 2018, but fell back to 92% in 2019. There was no consistent difference seen in this indicator between males and females.

On average, between 2014 and 2019, 90% of cases aged 17 years or under accessed treatment (for either alcohol or other drugs) in under 1 week (note: indicator is 1 week for those aged under 18 years, compared with 1 month for those aged 18 years and over). There was no gender difference in the proportion of male and female cases.

Access to treatment varied slightly for other age cohorts, with slightly higher proportions of the younger cohorts accessing treatment within 1 month; on average, 94% of those aged 18–19 years or 20–24 years accessed treatment within 1 month, compared with 91% of those aged 35–39 years or 40–44 years.

Access varied depending on the main problem drug reported. In general, a slightly higher proportion of cases reporting cannabis as their main problem drug (range: 94% to 97%) and cocaine (range: 92% to 96%) accessed treatment within 1 month. The comparable figures for opioids were between 89% and 92%, and for hypnotics and sedatives were between 89% and 94%.

Access times also varied by type of accommodation. Cases in prison had the highest rates of access within 1 month, ranging from 95% to 98%. However, the treatment data from prison in the NDTRS are not representative of all prison treatment. Most of the data are from in-reach counselling, as the medical units of Irish prisons do not participate in the NDTRS. Access times were lower for cases in institutions (residential care/half-way houses; range: 87% to 90%), in unstable accommodation (range: 91% to 93%), and who were homeless (range: 90% to 96%).

In relation to ethnicity, on average, 95% of Traveller cases accessed treatment within 1 month.

Access to treatment also varied by area, which may have also been affected by participation in the NDTRS.

Rate of successful exits

The report used case-based treatment data in relation to successful exits from the NDTRS (2014 to 2019). The definition of a successful exit for the purposes of this report was a treatment discharge whereby the case had completed treatment or was transferred/referred onwards for additional treatment in another addiction service.

The analysis used data on all treatment exit cases (discharges) as of 1 January 2020. The latest possible treatment entry date was 31 December 2019. The minimum follow-up period was 1 day while the longest follow-up period was 6 years. Year refers to year of treatment entry.

The authors stress that exits not defined as successful exits are not necessarily unsuccessful exits, because there is a range of reasons for which a case may have left treatment. Therefore, the analysis did not look at the reasons for early exit from treatment. In addition, when interpreting the results it is important to remember that they may vary depending on the main problem drug reported.

The rate of successful exits was lowest for cases entering treatment in 2014 and highest for cases entering treatment in 2017 (48.7%). On average females had a higher rate of successful exits (50%) compared to males (46%). On average, cases aged over 50 years had higher rates of successful exits (57%) compared to cases aged 18–19 years (40%). The rates of successful exits for cases reporting alcohol, opioids, cannabis, cocaine, and hypnotics/sedatives as the main problem drug remained relatively stable over the years under analysis (2014 to 2019). Small numbers for the other problem drugs make analysis more difficult.

Time (lag) between starting drug use and entering treatment

The report also looked at the median time (in years) between starting drug use and entering treatment (lag) in order to investigate ease of access to treatment for successful exits. Between 2014 and 2019, the median age at which cases started to use their main problem drug remained stable, at 16 years old. In 2014, the median time lag to treatment (in years) was 18 years increasing to 20 years in 2017, then dropping to 17 years in 2019. However, lag to treatment did vary considerably by type of main problem drug (not presented in the report).

Communities most affected

NDTRS treatment data were also used to evaluate Goal 4 of the current national drugs strategy: “Support participation of individuals, families and communities” (Department of Health 2017), looking at communities most affected by substance misuse and whether they accessed drug treatment after referral. The authors identified a lack of data to evaluate this goal and, for the purposes of this report, used treatment data for Traveller, LGBTQI, and homeless cases. The authors noted that a limitation of using treatment data for this goal was that a person had to be in contact with a treatment service in order to be included in the analysis, and therefore any evaluation was only partially representative.

Travellers

- Between 2014 and 2019, there was an increase in the number of cases in this group who were referred to treatment but who did not go on to enter treatment, rising from 6% to 10%. The small number of cases in this group makes interpretation difficult.

Homeless

- Between 2014 and 2019, there was an increase in the number of cases in this group who were referred to treatment but who did not go on to enter treatment, rising from 8% to 12%.

Cases identifying as homosexual or bisexual

- Between 2014 and 2019, the proportion of cases identifying as homosexual or bisexual remained stable, at 8%. However, the number of cases self-identifying as homosexual or bisexual is likely to be an underestimate, due in part to a reluctance by services to collect the treatment data, and also due to the non-participation of some LGBTQI-specific services in the NDTRS.

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

No information.

T1.4.9 Main providers/organisations providing Opioid substitution treatment

Outpatient OST 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 (Health Service Executive 2016, Health Service Executive 2020a), GPs in the community are contracted to provide OST at one of two levels: Level 1 or Level 2. Level 1 GPs are permitted to maintain OST for people with problem opioid use who have already been stabilised on OST. Each GP qualified at this level is permitted to treat up to 15 stabilised patients. Level 2 GPs are allowed to both initiate and maintain OST. Each GP qualified at Level 2 may treat up to 35 OST patients. Practices where two Level 2 GPs are practising are permitted to treat up to 50 OST patients in total.

Please note that there is a change to reporting OST trends in this Workbook. Previously only methadone was reported, but as of 2020, buprenorphine-based products are now included in the annual totals reported in this workbook (see Section T1.4.10). The total for 2020 is based on corrected figures, so it may differ from what has been previously reported elsewhere. In 2020, according to data from the CTL, as of 31 December 2020, 54.2% of patients were received OST in specialist outpatient clinics; 39.8% were received OST from GPs; 5.9% received it in prison; and less than 1.0% received it in an inpatient setting (unpublished data, CTL, 2021; also see Section T2 of this workbook). These trends are similar to those reported for 2019.

The proportion of clients receiving OST from GPs has increased slowly but steadily over the years, from 32% in 2001 to 41% in 2015. The change seen between 2001 and 2015 likely reflects the policy to move stable OST clients back to primary care, where they can receive all their care, including OST, from their own GP. The change may also reflect the increase in the number of specialist GPs in the community. The proportion of clients receiving treatment in specialist outpatient clinics decreased from 59% in 2008 to 52% in 2018, before rising slightly to 54% in 2020.

T1.4.10 Number of clients in OST

The number of clients registered for MMT **on 31 December each year** is reported by the CTL, the national register of all clients on MMT (see Figure IV in Section T2 of this workbook, as well as Standard Table 24). On 31 December 2019, 10,318 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Walsh, CTL, 2020). This is almost identical to the number registered at the end of 2018 (10,332).

Almost all clients receive MMT as their opioid substitute, as historically this has been the primary drug of choice for treating opioid dependency in Ireland. Since November 2017, Suboxone has been available by prescription for patients where clinically appropriate. As of 31 December 2019, there were 262 clients registered on Suboxone, compared with 177 clients in 2018 and 110 in 2017. These numbers are not included as yet in the overall number of patients receiving OST reported above or in Standard Table 24, which currently only apply to patients on methadone.

T1.4.11 Characteristics of clients in OST

In 2019, of the 105 women who were referred to the drug liaison midwife in a large maternity hospital in Dublin, 33 had a history of problem opioid use and were accessing MMT. Eight of these women commenced treatment because they were pregnant. (The Rotunda Hospital 2020) (see also Section T.1.4.5 of this workbook and Section T1.3.6 of the Harms and harm reduction workbook).

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

All actual clients registered for OST

The CTL also provides data on all actual clients registered for MMT during the year from 2005 onwards (personal communication, CTL, 2021). This is different from what is reported in Section T1.4.10 of this workbook and also in Figure IV and Standard Table 24, which report on clients in OST as of 31 December each year. These total data show a 31% increase in the number of clients registered in the 14-year period from 2005 to 2018, with a slight decrease in 2019 (Figure T1.4.12.1). An increase was reported again in 2020, to 11,838. This was due to the increased access to OST as part of the public health response to the COVID-19 pandemic (see Section T3.1 of this workbook for more information). The proportion of clients receiving their first methadone substitution decreased from 9% in 2005 to 5% in 2019, but increased again to 6% in 2020 (Figure 1.4.12.1).

In 2020, the majority of clients were male (71%), similar to previous years. The proportion of clients aged under 25 years continued to decrease, from 16% in 2005 to 2.1% in 2020. The decrease in the number of adolescents requiring OST, mainly due to changing drug use patterns in this group as they move away from heroin, has been noted in other publications (Smyth and McCarney 2020). The most common age group of those in OST 45 years or older (32.7%).

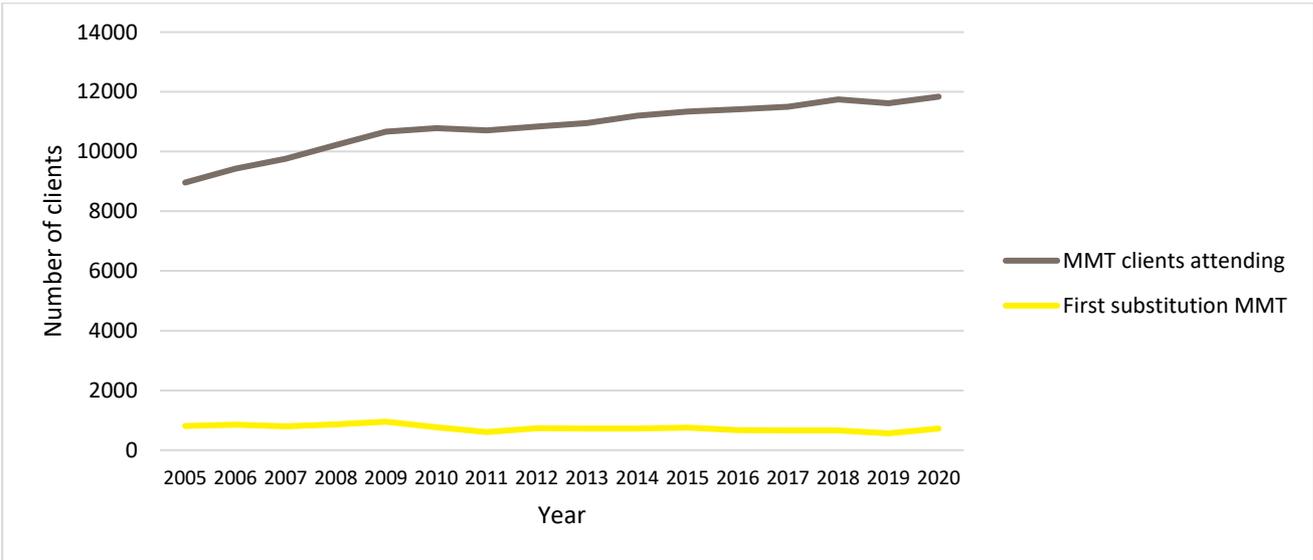


Figure 1.4.12.1 Total number of clients registered for MMT on the CTL, 2005–2020

There are data on the total number of actual clients registered for buprenorphine-based products on the CTL for 2020 (personal communication, CTL, 2021). There are no earlier data to combine trends pre-2020.

In 2020, 537 actual clients received buprenorphine-based products. Of these, 49.1% had been registered on the CTL for the first time (first OST substitution). This is much higher than those commenced on MMT; see the relevant guidelines for OST prescribing practices (Expert Group on the Regulatory Framework 2011, Fitzgerald 2011) (Health Service Executive 2016, Health Service Executive 2020a). Of those in receipt of buprenorphine-based products, 66.1% were male and 3.2% were aged under 25 years. The most common age group of those in receipt of buprenorphine-based products was 45 years or older (28.2%).

Factors associated with early and later dropout from MMT in specialist addiction clinics

An Irish study looked at factors associated with early and later dropout from MMT in specialist addiction clinics (Durand, *et al.* 2020). The authors conducted an observational cohort study of individuals who had experienced at least one episode of MMT lasting longer than 7 days in Irish specialist addiction services (Dublin Southwest and Kildare) between 1 January 2010 and 31 December 2015. Data were gathered through the CTL and the Methadone Treatment Scheme. Client records were also linked to the General Medical Services pharmacy claims database and the National Drug-Related Deaths Index. Using a statistical model, this study identified determinants of time to dropout from MMT at 3 months and at 12 months across multiple treatment episodes.

The 2,035 clients included in the study experienced a total of 4,969 MMT episodes over the observation period. The median age was 34.4 years at the time of initial treatment episode, and 68% of clients were men. Almost 42% of clients received a median methadone dose below the recommended optimal range of 60–120 mg/day. The study showed that:

- 2,724 dropout events occurred during the 6-year observation period.
- 82.8% of all dropouts occurred within the first 12 months of treatment.
- 49.7% of dropout events occurred within the first 3 months of treatment.

Dropout at 3 months was associated with low-dose methadone (<60 mg/day) and a history of previous dropout. Adherence to treatment, defined as not missing doses over the previous 30 days, was shown to be protective. Low-dose methadone and previous dropout remained as increased risk of dropout at 12 months. Being male, having a prescription for benzodiazepines, and having a higher number of comorbidities were also identified as additional risk factors in the longer-term model. Once again, adherence was protective at this time point.

The authors concluded that factors identified in this study could serve as indicators to risk stratify clients and provide service enhancements to increase engagement and retention in treatment. Previous dropout or missing doses are suggestive of instability, and these clients should be identified as high risk of both early and later dropout. It is noted that no study thus far has examined the persistent prescribing of low-dose methadone, but it is suggested by the study authors that a review of prescribing practices should be considered. Adherence was protective at 3 and 12 months and should be actively encouraged. The authors recognise both the strengths and limitations of this current research and note that further testing and validation is required in order to build on the associations identified here in understanding the determinants of dropout from OST.

Stigma of growing older on methadone maintenance treatment

A 2021 research study examined the intersecting levels of stigma experienced by service users in Ireland who are growing older and who are on long-term MMT (Mayock and Butler 2021).

In-depth qualitative interviews were recorded with 25 long-term clients who had been enrolled in MMT for at least 10 years prior to participating in the study. Recruitment was guided by a purposive sampling strategy within the geographical area of South Dublin and focused primarily on clients of specialist addiction clinics. An interview schedule of topics and questions was prepared in advance but maintained flexibility in order to ensure that collected data accurately reflected the respondents' personal perspectives. Analysis did not separate the sources of stigma in order to reflect the interwoven nature of these experiences by study participants. In total, 16 male and 9 female clients participated in the study, all of whom identified as Irish and were of white ethnicity. More than two-thirds of participants were aged over 40 years at the time the

research took place and 16 of the 25 recruited participants had first accessed MMT more than 20 years previously. The following is a summary of the key themes.

Methadone treatment system: While study participants had encountered kindness and empathy among some healthcare professionals, accounts overall summarised the methadone treatment regime as “demoralising” and unlike other healthcare services. For many, stigma was experienced and conveyed through an absence of trust from treatment providers and a sense of control exerted over the client. Privileges such as takeaway doses could be easily withdrawn and the requirement to provide urine samples under supervision was described by interviewees as “mortifying” and “degrading”. The lack of agency and palpable divide felt by clients with their treatment professionals served to reinforce feelings of inferiority and the perception of the client as deviant and a “junkie”.

Secrecy and concealment: For many participants, fear of public scrutiny and negative responses from family, friends, and the community dictated their behaviour towards clinic or pharmacy attendance. The pressure to manage public perceptions was reported by women in particular, with one respondent explaining how she would “go down at a certain time knowing that’s the time there won’t be many there and I’m in and out in a flash”. Many clients felt that they were treated differently and had experienced public shaming in these settings. One interviewee described how she was “outed” by a pharmacist due to a lack of discretion in the presence of a neighbour, and she reported feeling that “the ground couldn’t open up fast enough, I just wanted to die”.

Participants also believed that revealing their status as a methadone patient could jeopardise their employment opportunities, and opinions expressed in the workplace served to strengthen the need for secrecy. As one interviewee explained of her colleagues, “I’d be afraid for them to know. The things they say about drug addicts...It wouldn’t go down good”.

Private burden: For study participants, the stigmatising attitudes and experiences in their external environment had perpetuated a deep sense of self-stigma interwoven with their self-identity. This was highlighted by one interviewee, who described their personal perspective on addiction as follows: “that’s what you do as a drug addict – you let people down, you’re unreliable, you’re of fucking no use to nobody”.

Internalised shame also impacted participants’ ability to have close relationships or form new ones for fear of rejection, with one participant describing herself as a “junkie in disguise”. Such feelings of social isolation and loneliness were reinforced further with age, with participants already having experienced long periods of marginality. Many had resigned themselves to being cut off from wider society and felt that they were now condemned to ostracisation: “That sort of loneliness is physically painful, as well as emotionally, but I just can’t see that ever changing”.

This study describes how long-term methadone treatment was punctuated by stigma intersecting at macro, meso, and micro levels in clients’ lives. Methadone use in older patients implicitly revealed their histories as drug users and carried negative connotations that marked them as different to other health service users. The authors acknowledge the small sample size and the selection of participants primarily from specialist addiction clinics to be limitations of this work. They recommend that future studies engage with larger groups and wider treatment contexts. Nevertheless, these findings reveal that current practices and public perceptions severely hinder an improved quality of life for long-term MMT clients.

Qualitative insights into pregabalin use among individuals in OST

In recent years, research and reports have highlighted the use of pregabalin, due to its potential for dependence and abuse, and an increase in pregabalin-related overdose deaths in several European

countries. As a prescription-only central nervous system (CNS) depressant analogue to gamma-aminobutyric acid (GABA), it is used for an array of conditions, including neuropathic pain, epilepsy, generalised anxiety disorder, and fibromyalgia (Health Service Executive 2020b) (Lynn, *et al.* 2020) (Lynn 2019). A recent study looked at the experiences of patients in OST in relation to pregabalin (Brennan and Van Hout 2020). The authors selected OST patients as their study population due to their increased risk for problematic use of pregabalin and overdose. This study was the first in Ireland to capture the experiences of OST patients using pregabalin.

The qualitative descriptive study utilised one-on-one, semi-structured interviews. Participants were recruited from a service offering OST and harm reduction in Dublin. To be eligible, participants had to be both current or former OST patients and current or recent users of pregabalin. Of 15 participants, 9 were male and 6 were female, ranging in age from 25 to 45 years. The key findings were as follows:

- **Use patterns:** One-half of participants were initially prescribed pregabalin, predominantly for pain. The others first consumed pregabalin after receiving it from peers. For many participants, being part of a polydrug use/‘tablet-taking’ culture and having a history of using benzodiazepines or Z-drugs often preceded pregabalin use. Participants recounted combining pregabalin with substances such as methadone, benzodiazepines, and Z-drugs, and with stimulants such as crack cocaine in order to ‘come down’. Many stated consuming more than 1000 mg daily, with doses ranging from 800 mg to 6000 mg. Most took pregabalin orally; none reported injecting, given its connotation with past heroin use.
- **Motivators:** The reasons for consuming pregabalin included the self-regulation of negative emotions and enhancement of sociability and confidence. Participants specifically stated that they used pregabalin to numb distress and underlying psychological issues such as trauma.
- **Side effects:** Examples of undesirable side effects mentioned were losing consciousness or control, and behaviours such as shoplifting or aggression due to feeling ‘invincible’.
- **Sourcing routes:** Strategies included approaching multiple doctors and exaggerating symptoms while seeking prescriptions; buying pregabalin on the street or through social media; or diverting legitimate prescriptions from their network.
- **Role of medical professionals:** While some participants described doctors as gatekeepers to sourcing pregabalin, multiple participants received it from doctors or pharmacists illegitimately, either by filling prescriptions early or selling their prescriptions.
- **Detoxification and withdrawal symptoms:** One participant recounted experiencing very severe physical and psychological withdrawal symptoms while detoxing from pregabalin at home. Another reported undergoing a medically supervised detox. Several other participants described psychotic symptoms and suicidal ideation during pregabalin withdrawal, consistent with previous descriptions in the literature.
- **Combination with opioids:** The data provided some insights into the popularity of combining opioids with pregabalin. Participants reported using pregabalin to manage withdrawal symptoms from opioids and finding it superior to other substances. Use of pregabalin was also explained as resulting from its similarity in effect to opioids, specifically heroin. Additionally, pregabalin was described as being strong in its effect, and therefore attractive to those with built-up tolerance.

- **Harm perception and reduction:** Participants were alert to the risk of overdose, often due to personal experiences, and reported using indigenous harm reduction strategies, such as decreasing consumption and not buying counterfeit Lyrica.

Based on the participant responses, the authors conceptualise the consumption of pregabalin among service users receiving OST within a socio-ecological model, reflecting interacting risk factors on the individual, community, and systemic levels (see Figure 1.4.12.2). They extrapolate several recommendations for policy and healthcare service delivery from participants' accounts.

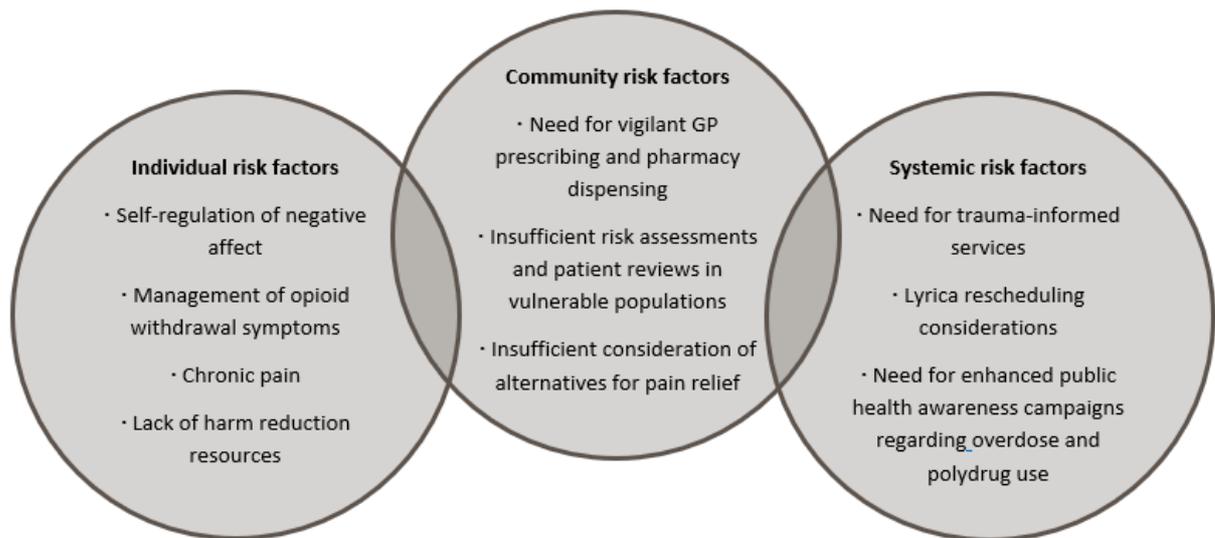


Figure 1.4.12.2 Risk factors for problematic pregabalin use in an OST patient sample in Dublin

(Source Brennan et al, 2020)

Given the participants' worrying descriptions of malpractice, the authors emphasise the need for monitoring pregabalin prescriptions and for doctors and pharmacists to carry out risk assessments that consider OST patients' vulnerability to pregabalin dependence; reduce off-label prescribing; and choose alternatives to pregabalin for pain relief.

The authors also call for increased healthcare support for OST patients using pregabalin, such as trauma-informed interventions; medical supervision and vigilance to psychiatric symptoms during pregabalin detox; harm reduction measures; and information campaigns.

The study's findings should be viewed in light of several methodological limitations, including the small sample size, single study location, and potential recall bias. Considering the prevalence of polydrug use, statements about the effects of pregabalin should be interpreted with caution.

The study nonetheless provides important first insights into the risk factors for pregabalin use among OST patients as an at-risk group, and features recommendations for policy and health service responses grounded in qualitative data.

Impact of OST on lifestyle behaviours

A qualitative study looked at clients' experiences of change, barriers to, and facilitators of positive lifestyle behaviours in relation to physical activity and diet after starting OST (Matthews, *et al.* 2021). Ten clients were

interviewed, and most felt that their lifestyle behaviours had improved since starting OST. Barriers to improved lifestyle behaviours identified were side effects of methadone, physical ill health, and social circumstances. Stigma was one of the psychological barriers to physical activity referenced. The authors concluded that lifestyle behaviours can be positively impacted by commencing OST, but a number of barriers remain.

Developing a client-driven, nurse-led addiction nursing model

A recent study was undertaken to develop a contextually appropriate addiction nursing model which was “implementable, practical, and measurable and that addressed clients’ needs” based on existing models (Comiskey, *et al.* 2021) (Comiskey, *et al.* 2019).

The study was conducted in 2017 and researchers interviewed 131 adult clients of six methadone clinics in Dublin. The researchers used a standardised, validated questionnaire incorporating the Opiate Treatment Index (OTI), the 28-item General Health Questionnaire, and treatment history questions.

Two-thirds of those interviewed were male, and participants had a mean age of 41 years (range: 26–66 years); women had a lower mean age (37 years) compared with men (43 years). Most participants were unemployed (90%), with 42% on disability benefits. Almost two-thirds (61%) had children aged under 18 years, and of these, just over one-half (56%) were not living with their children.

All clients were recruited from methadone clinics. The mean dose of methadone was 67 mL (range: 0–160 mL). The average length of time in treatment at the time of the interview was 7.6 years (range: 6 weeks to 26 years). With regard to drug use, both men and women used heroin and cocaine more than once a week, on average. Tranquillisers were used more than once daily, with men statistically more likely than women to have ever used tranquillisers. The proportion of men who had ever used cannabis was also statistically significantly higher than the corresponding proportion of women. Polydrug use on a daily basis was common for both men and women.

A summary of the OTI domain ‘Physical health’ showed that, on average, women experienced 17 health symptoms, while the comparable figure for men was 14. There was little difference between the symptoms experienced between genders, with the main symptoms being fatigue and energy loss, but with the exception of heart fluttering and headache for women and head injuries for men.

A summary of the OTI domain ‘Psychological adjustment’ showed that the study participants had scored higher than the recommended cut-off score of 4: 61% of men (mean score: 8) and 73% of women (mean score: 11) scored 5 or higher. Based on this, the researchers concluded that psychological adjustment was a priority for clients in order to be considered for any addiction nursing model.

The results were used to inform the development of an addiction nursing model where existing nursing models were reviewed by an expert practice nurse-led group. This expert group concluded that “a model must address client needs; hence, it must be adaptable with time, be nurse led, be measurable and implementable, must be cognizant of the person and the environment (clinic and community), must have a biopsychosocial approach, and possibly use a brief intervention approach to target a single measurable behavioural change outcome”. The group recommended a hybrid model based on the BRENDA, FRAMES, and Tidal models, to refocus services on the clients’ needs.

Average waiting times for OST

A recent report used treatment data to analyse the performance of the current national drugs strategy (Bruton, *et al.* 2021b). One of the actions in the national drugs strategy is to improve the availability of OST,

and therefore the report reviewed average waiting times for accessing OST using HSE data (page 55 of the report). The analysis showed that between 2017 and 2020, the average wait time for OST fluctuated widely from 16.0 days to 155.5 days.

T1.5. Quality assurance of drug treatment services

T1.5.1 Quality assurance in drug treatment

No information.

T2. Trends

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

New treatment entrants (Figure II)

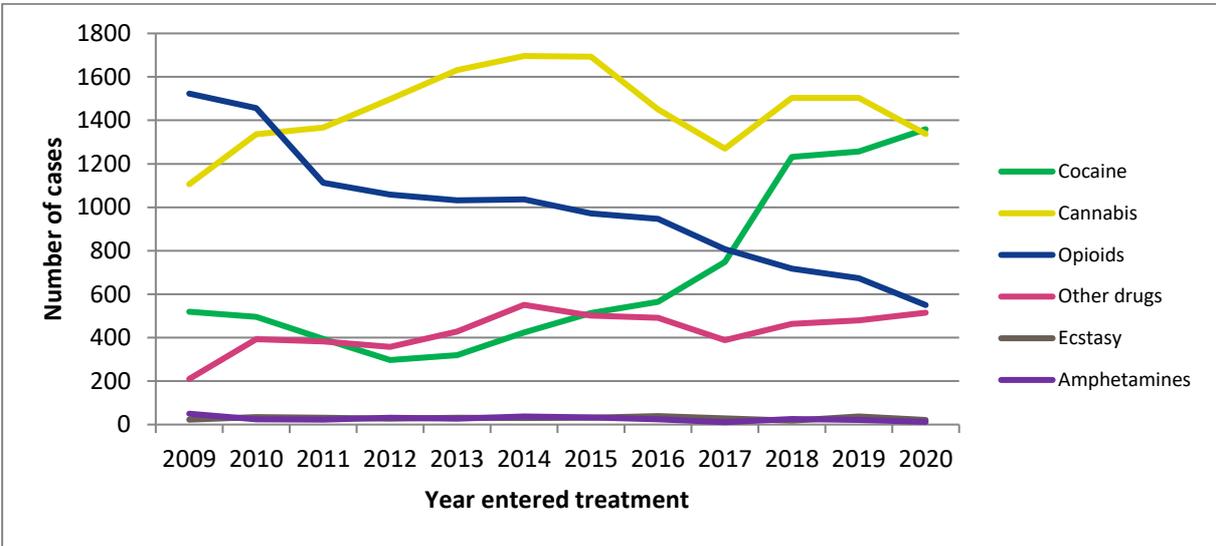


Figure II. Trends in numbers of first-time clients entering treatment, by primary drug, 2002–2020

In 2020, there were 3,795 new treatment entrants recorded (see also TDI). This represents a small decrease compared to the numbers reported in 2019, when 3,972 new entrants were reported. This decrease can be explained in part by the impact of public health restrictions due to the COVID-19 pandemic and its impact on data collection (see Section T3.1 of this workbook for further information). However, despite the decrease, the overall trends remain similar to previous years.

Proportionally, in 2020, new treatment entrants represented 40.5% of all cases, compared with 38.7% in 2019. The proportion of new treatment entrants has fluctuated over the 12-year reporting period, peaking at 47.2% in 2009, but it has stabilised since 2014 at around 39%.

In 2011, cannabis surpassed opioids (mainly heroin) as the main problem drug reported by new entrants to treatment, but in 2020, the number of new entrants reporting cocaine as the main problem drug (n=1,359; 35.8%) just surpassed cannabis (n=1,337; 35.2%) for the first time.

The number of new entrants reporting cocaine as the main problem drug has fluctuated over the 12-year reporting period, initially peaking at 19.0% in 2009, then dropping steadily until 2012 before increasing year on year to a new peak of 35.8% in 2020.

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

In 2020, 'other drugs' (mainly benzodiazepines) was the fourth largest group of main problem drugs reported by new treatment entrants, as was the case in previous years.

All treatment entrants (Figure III)

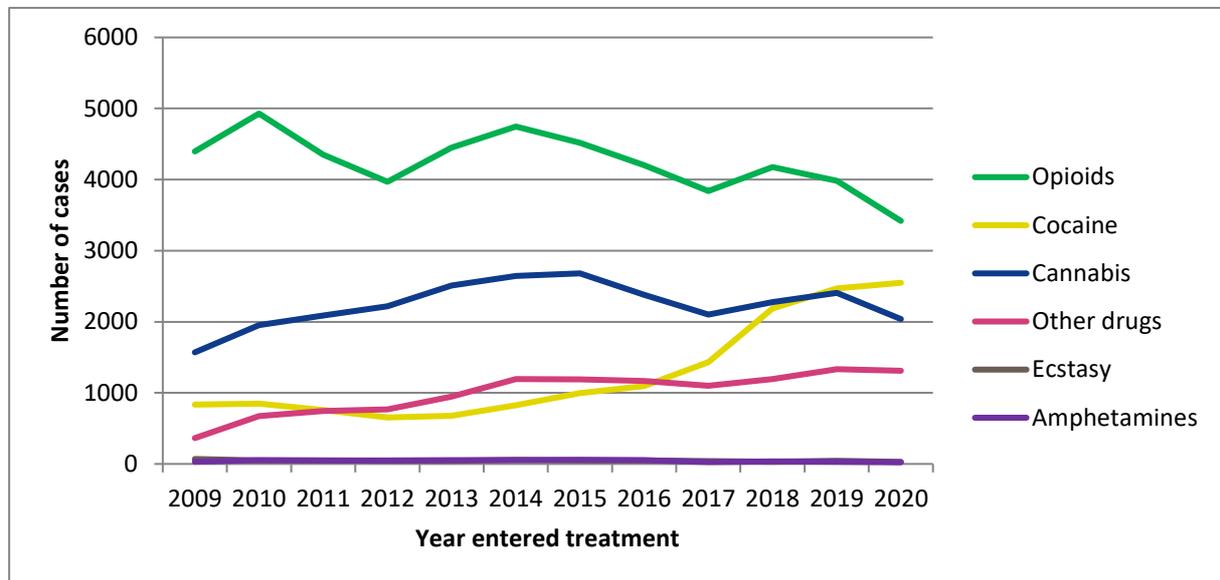


Figure III. Trends in numbers of all clients entering treatment, by primary drug, 2009–2020

In 2020, a total of 9,368 treatment entrants were recorded in the NDTRS (see also TDI). This represents an 8.8% decrease in the number of cases reported compared with 2019, when 10,267 cases were reported. This decrease can be explained in part by the impact of public health restrictions due to the COVID-19 pandemic and its impact on data collection (see Section T3.1 of this workbook for further information). However, despite the decrease in case numbers, the overall trends remain similar to previous years.

Of the cases recorded in 2020, the majority (54.5%) had been previously treated, which was very similar to 2019 (53.9%).

In 2020, opioids (mainly heroin) were the main problem drug used by entrants to treatment, reported by 36.5% of all entrants, compared with 38.8% in 2019. The number of cases reporting problem opioid use peaked in 2010 at 4,929, and has shown a consistent downward trend since then.

In 2020, cocaine (27.2%) remained the second most common problem drug reported among all treatment entrants. The increase in the number of cases presenting for treatment for problem cocaine use continued in 2020, but to a lesser extent than in previous years. Previously, the highest proportion 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 27.2% in 2020, compared with 24.1% in 2019.

Cannabis (21.7%) was the third most common problem drug reported. From 2004 to 2018, cannabis was consistently reported as the second most common main problem drug. The proportion of cases reporting cannabis as their main problem drug peaked at 28.9% in 2013, with the proportion decreasing almost every year since then.

Both amphetamines and, to a lesser extent, ecstasy are reported very rarely as main problem drugs by entrants to treatment in Ireland, with no discernible difference noted in 2020 compared to 2019.

In 2020, 'other drugs' (mainly benzodiazepines) was the fourth most common group of main problem drugs reported, which is similar to previous years.

Please note that the data reported through the TDI are a different selection from the data reported in the regular NDTRS bulletins (Kelleher, *et al.* 2021) and interactive tables (see <https://www.drugsandalcohol.ie/tables/>). Therefore, figures reported through these sources will differ slightly.

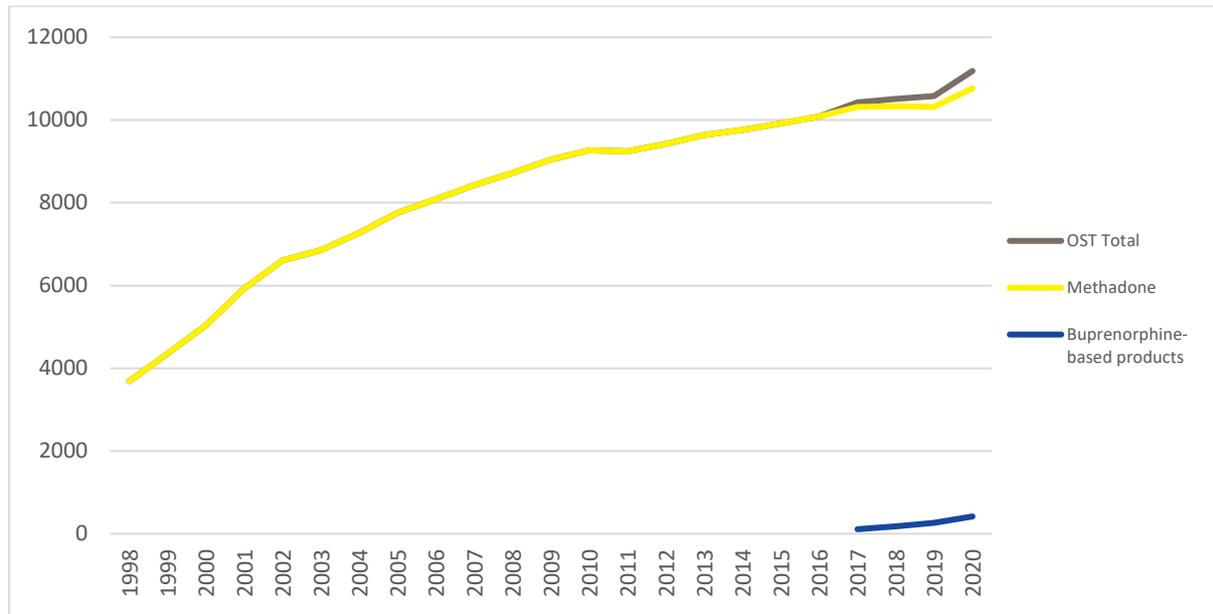


Figure IV. Trends in numbers of clients in OST, 1998–2020

Source: CTL.

Note: Change in reporting trends. Figures from 2017 to 2020 have been updated to include all OST (methadone and buprenorphine-based products). Prior to 2017, only methadone was reported.

T2.2 Additional trends in drug treatment

No new information.

T3. New developments

T3.1 New Developments

In mid-March 2020 the Irish Government announced a raft of public health measures to reduce the spread and impact of the COVID-19 pandemic, but by the end of the month the country was plunged into a full lockdown. This included working from home where possible, only leaving the house to shop for food or other essential items or to provide care to relatives, and the imposition of a travel limit within 2 km of home for brief individual physical exercise. These restrictions, initially designed to be temporary, lasted many months. This section summarises the impact of the COVID-19 pandemic and the associated public health restrictions on addiction clients and addiction services, as well as the responses to such.

Impact of the COVID-19 pandemic on TDI figures

The NDTRS conducted an internal survey of participating services in order to better understand how the capacity and functionality of treatment services were impacted by COVID-19 restrictions and any impact on the annual figures reported through the TDI (unpublished data, NDTRS, 2020). The NDTRS surveyed

participating services (excluding GPs) to estimate the impact of the restrictions on treatment data for 2020 (response rate: 80%).

Many services, particularly outpatient services, moved to remote working via the telephone or video (see also Section T1.4.6 of this workbook). There were both positive and negative observations from the services in relation to remote working. Some of the positives were: it allowed many services to continue working; they had better contact with some clients; clients appreciated not having to travel; and it worked well for stable clients. Some of the negatives were: difficulties with technology; it was tiring; it did not suit all client groups, e.g. chaotic users; it was harder to engage new clients; and it was not as effective as in-person support.

Around 40% of services surveyed stated that there was some impact on their ability to submit data returns, while around 50% expected some impact on numbers. The capacity of residential services was most affected, with most having to change the way they worked; for example, reducing bed capacity in order to allow for social distancing, reducing/stopping visits, and providing telephone supports for some activities. This information was supported by official figures showing the reduction in residential places, as outlined in Section T1.2.5 of this workbook.

GPs were not included in the internal survey. In 2020, the reported number of cases treated by GPs was greatly reduced, mainly due to COVID-19 restrictions, which limited the collection of the data.

In 2020, there was a 6% increase in the numbers registered for OST compared with 2019. This was due to the response of addiction services to the COVID-19 pandemic, as there were concerted efforts to improve access to OST by reducing waiting lists, allowing some services and GPs to increase their caseload, and increasing remote teleworking and other resources as required (see Section T1.4.10 of this workbook). This increase is not reflected in the TDI figures, in part due to public health restrictions on data collection and poor participation by GPs in the NDTRS.

The result is that in 2020, there was a 9% reduction in the number of cases reported via TDI – that is, from 10,267 cases in 2019 to 9,368 in 2020 (see also Section T2.1 of this workbook). This reduction is likely to be the result of a combination of the impact of public health restrictions on services, as well as being associated with issues in relation to data collection. However, the overall trends in drug treatment remained consistent with previous years.

Impact of the COVID-19 pandemic on drug and alcohol services and people who use drugs in Ireland: a report of survey findings

In January 2021, the Irish Government Economic and Evaluation Service (IGEES) published a report on the impact of the COVID-19 pandemic on services and people who use drugs (Bruton, *et al.* 2021a). The report is based on two surveys undertaken in 2020: one looking at the impact on people who used drugs and one looking at the impact on addiction services and their clients.

The Survey of Drug and Alcohol Services was undertaken in order to assess the impact of the COVID-19 pandemic on these services. In particular, the survey sought to capture how services have altered their operations in response to the COVID-19 pandemic and also to describe the effect on clients of services. Information on this final aspect of the survey was provided by service staff and service users who were not directly involved in the survey. An invitation to participate in the survey was sent to more than 500 email addresses for drug and alcohol services in Ireland and participants were given 2.5 weeks to complete the survey (online or by email) between August and September 2020.

A total of 157 completed responses were submitted. Community Drugs Projects (n=86), family support services (n=53), and counselling services (n=50) were well represented, particularly those based in Dublin. Some respondents can be included in more than one of these categories. There were also responses from Drug and Alcohol Task Forces, low-threshold services, peer support services, the HSE Addiction Service, residential services, and GPs.

Effects of COVID-19 on clients

Regarding the direct effects of COVID-19, 28% respondents said that clients were highly impacted by having to self-isolate or cocoon; 7% said a diagnosis of COVID-19 had highly impacted clients; and 4 (3%) said that hospitalisation had had a high impact on clients. The majority of services (85%) had some experience of clients self-isolating in the first wave of the COVID-19 pandemic, while just under one-half were aware of clients who had been diagnosed with COVID-19.

According to respondents, the most challenging aspects of the COVID-19 pandemic for clients were adhering to the restrictions concerning meeting people, self-isolating, restrictions on travel, and physical distancing. The majority of services responding (96%) reported a negative impact on clients' mental health, followed by the impact on family relationships (83%). The number reporting a positive impact as a result of these factors was very small. Other negative effects reported by a majority of services were the physical health and financial situation of clients.

Most services (73%) reported that social isolation impacted on clients to some extent, while 74% services said that increased domestic violence impacted on clients. Most services were also aware of the impact of increased drug-related intimidation and violence and increased overdoses. Fewer services (37%) reported drug-related deaths among those using their services. Regarding the effect of the COVID-19 pandemic on particular population groups, 65% of services that responded said that health and well-being were highly impacted among those who were homeless, while 60% of services said women were highly impacted.

Increased alcohol consumption among clients was observed by 68% of services, while 42% of services reported increased drug use, with just 8% reporting a reduction in drug use to a high extent among clients. In relation to availability of drugs, 73% of respondents had heard reports that clients were having difficulty getting drugs and had made greater use of novel methods of acquisition such as online purchases, 'drug drops', and home deliveries.

Impact on services

Most of the survey respondents (n=116, 74%) said that their services had been highly impacted by COVID-19, with 25% (n=40) reporting lower levels of impacts. Nearly one-half of the services responding (n=70, 46%) said the number of clients using their services had increased. Overall, harm reduction services had decreased for clients, with just 33% of services reporting increases. The majority of service types saw a reduction in face-to-face contact with clients. This was particularly true for Drug and Alcohol Task Forces, family support services, and peer support services. Most services were providing counselling and other supports by telephone or online. Residential treatment services were the type of service most likely to use video conferencing, which is an appropriate tool for group therapy sessions.

Drug and alcohol services adapted to a reduction in face-to-face contact, travel restrictions, and social distancing by prioritising the continuity of care for those who are opioid dependent; processing clients into treatment faster; stabilising drug use in isolation; and providing COVID-19 prevention information as part of outreach services. Clients were enabled to access their medications by new methods provided under

temporary changes to regulations, and the vast majority of services have developed new ways of engaging with clients and providing for their needs.

The survey of services outlines the impacts of the COVID-19 pandemic on service capacity, staff, operations, and governance and reporting. Services described how they adapted to the challenges and communicated with their clients online or by telephone. There was detailed information on the typical responses of health services to the pandemic, including the use of personal protective equipment and social distancing. Survey findings have also provided an indication of the negative impacts that the pandemic has had on the health and well-being of clients and on their consumption behaviours.

The second part of the study looked at the impact on people who used drugs. Of note in this part of the study, 6.6% of people who used drugs reported an increase in their intention to seek professional support to reduce or abstain from illicit drugs since the introduction of COVID-19 restrictions, while 11.9% reported an increase in their use of online or remote professional support services to seek support for reducing drug-related risk behaviours and/or drug use.

Response of tertiary addiction services to opioid dependence during the COVID-19 pandemic

The HSE addiction services have published an article summarising its response to the COVID-19 pandemic (Hennigan, *et al.* 2021), recognising that people with problem opioid use could be at higher risk of COVID-19 complications due to pre-existing health problems (e.g. chronic obstructive pulmonary disease, asthma, cardiovascular disease, or blood-borne viruses). Additionally, they are more likely to experience homelessness or overcrowding (e.g. drug use often occurs in groups), both of which increase the risk of COVID-19 infection. Other specific challenges include the risk of infection with COVID-19 through sharing of drug paraphernalia such as joints or other inhalation devices. Another concern is that opioid users may be at increased risk of drug overdose, where respiratory depression could be exacerbated by COVID-19 infection compromising lung function. This is all in the context of wider COVID-19 restrictions: disruption or suspension of regular addiction services, staff shortages, and travel restrictions.

Various guidelines and strategies which were developed in response to the COVID-19 pandemic are summarised in the article.

OST guidance

The document *Guidance on Contingency Planning for People who use Drugs and COVID-19* (Health Service Executive 2020c) was developed to address a number of concerns and challenges during the COVID-19 pandemic, including:

- Assessing those clients not on OST currently and who need to be commenced rapidly
- Providing naloxone for new and existing clients
- Managing clients who may be homeless or living in other temporary short-term accommodation, e.g. hostels and hotels, and who may not be able to self-isolate if required
- Assessing the risk to clients who may be stockpiling drugs, therefore increasing the risk of overdose
- Assessing the risk to clients who may be self-isolating and using illicit drugs alone, therefore increasing the risk of overdose
- Helping dual diagnosis clients (with coexisting addiction and mental health problems) who may find it difficult to comply with self-isolation/quarantine and other public health advice, and

- Helping clients who may not have sufficient access to clean injecting equipment due to limited access to needle exchange or due to isolation.

OST services were asked to urgently identify clients on their waiting lists in order to expedite their treatment. Services were also asked to ensure that they had contingency plans if they had to close suddenly, in order to ensure that their clients could be quickly transferred to another service without a break in treatment.

The guidelines outlined the pros and cons of either methadone or buprenorphine-based products for rapid induction to OST. The document also dealt with another area of concern in relation to polydrug use, specifically alcohol and benzodiazepines. It outlined evidence-based advice for short-term benzodiazepine maintenance and community-based alcohol detoxification. A guidance document for remote/teleworking was also provided (Smyth and Jones 2020).

Other actions that facilitated the reduction of waiting lists and rapid induction into treatment were the temporary amendment to drugs legislation (<https://www.irishstatutebook.ie/eli/2020/si/98/made/en/print>; see also Section T1.1.1 of the Legal framework workbook). This allowed the electronic transfer of prescriptions (including for OST) between the prescriber and the pharmacy without the need for a signed paper prescription to be handed over in person. The legislation also allowed for the emergency supply of 5 days' worth of controlled drugs (including OST).

In addition, agreement was negotiated with the appropriate authorities so that some GPs could take on additional clients above their agreed limit, as a temporary measure.

Other activities

The article also highlighted how statutory and voluntary services cooperated to set up medicine delivery services, including OST medications, around Ireland during the period of COVID-19-related travel restrictions so as to ensure that all clients had access to their medications. Naloxone was provided to any GP who indicated that they were willing to prescribe it to their clients.

The article details where other guidance and advice was published, for example in relation to harm reduction (HSE drugs.ie 2020), clinical guidance for medicine management in isolation units (Harnedy 2020), and methadone takeaways (HSE National Drug Treatment Centre Pharmacy Department 2020).

Conclusion

The authors state that many opioid users, identified as a population at risk during the COVID-19 pandemic, were successfully engaged in treatment for the first time as a result of the rapid response and sustained actions of addiction services and their staff. They note that these clients will continue to need additional support, which will require ongoing resources in a sector that was already under pressure. They hope that the responses that worked well will continue to be implemented, providing "a template for a new way of working", such as rapid OST induction and teleconsultations for users in more remote areas.

Caring for opioid drug users during the COVID-19 pandemic: the Irish experience

Practitioners caring for people who use opioids (PWUO) during the COVID-19 pandemic have documented their experiences, publishing a commentary on the Irish experience of challenges faced by PWUO and the service providers working with this vulnerable population (Crowley and Cullen 2020). The authors also described and discussed the evidence guiding the measures implemented to reduce the risks associated with COVID-19 to Irish opioid agonist treatment (OAT) services.

Various national and international bodies have highlighted additional dangers faced by PWUO and produced guidelines for drug treatment and harm reduction practitioners. To this end, the HSE published guidelines for GPs and pharmacies providing OAT services to those at greatest risk during the COVID-19 pandemic.

Many Irish OAT services have adapted treatment delivery to reduce the emerging COVID-19-related risks. These changes included:

- Restructuring OAT assessment and induction procedures in order to allow easy access to treatment and to avoid waiting lists
- Fast-tracking patients requiring isolation to OAT
- Delivering OAT and other medications to patients' homes
- Reducing OAT supervision requirements
- Adapting virtual patient care and telemedicine
- Reducing/postponing non-essential services, including drug and blood-borne virus (BBV) screening and hepatitis C treatment
- Providing remote counselling support
- Providing virtual multidisciplinary team meetings
- Increasing access to overdose prevention training and naloxone
- Providing targeted interventions for homeless and more vulnerable patients, including increased access to more suitable accommodation and supports, and
- Reducing the prison population.

In common with all health services, reducing the need for face-to-face interactions was advised. By reducing this requirement, the potential risk of COVID-19 transmission is minimised, thus protecting staff and patients.

Reduced supervision could have led to an increase in street diversion and drug overdose; therefore, risk assessment and individualisation of care were critical. Providing information on OAT-related dangers and safe storage may help reduce these risks. Irish overdose prevention and naloxone programmes have also been expanded in order to lessen the risks. Overdose education and naloxone programmes have been shown to reduce fatal opioid-related overdoses. Overdose prevention programmes have conventionally recommended the use of cardiopulmonary resuscitation (CPR) and the administration of intranasal or intramuscular naloxone. Given the increased risks associated with COVID-19, training programmes were revised and delivered remotely, thus removing the endorsement of CPR and the use of intranasal naloxone.

Reducing OAT supervision requirements provided services with an opportunity to evaluate the practicality of drug screening and to adopt a more evidence-based approach in a post-COVID-19 future. Currently, there is little published evidence on the efficacy of routine drug screening. Indeed, screening schedules tend to be philosophical and historical within services.

Irish OAT services have adopted telemedicine to conduct risk triaging, assessment, reviews, counselling, and psychosocial support. Using telemedicine, OAT services were able to offer patients quicker access to OST, and they were also able to reduce waiting lists (see also comments on teleworking in Section T1.4.6 of this workbook). OST induction is acknowledged as a high-risk period for overdose, and caution was advised as

with regard to establishing dependence and assessing tolerance, and also with regard to dosing over the first 4 days.

Given the risk profile of PWUO, many patients attending OAT services could be required or recommended to self-isolate. This presented difficulties for both service providers and patients. Irish OAT services established a home delivery network informed by local resources, geography, and need. Staff redeployed from statutory and non-statutory services and An Garda Síochána were engaged in providing risk assessments and supports, where necessary.

OAT services also suspended routine BBV screening, vaccinations, and new hepatitis C treatment. In the short term it was felt that these changes would have little impact, but there may be medium-term to long-term costs for patients. Central to the work of OAT services has been the identification and management of BBVs. Prior to the implementation of COVID-19 restrictions, OAT services had been engaged in increasing hepatitis C screening and treatment, with elimination of hepatitis C infection as their goal. Lack of testing and treatment, along with reduced supports and access to harm reduction services, may lead to increased rates of reinfection and may impact negatively on 'treatment as prevention' initiatives. The authors of the article state that Irish OAT services effectively used telemedicine for hepatitis C treatment, the provision of psychological support, and other supports.

The wider usage of telemedicine brought about a fundamental change in care delivery and work practices (see also comments on teleworking in Section T1.4.6 of this workbook). While patients were felt to have adapted well to this change, it highlighted the need to have up-to-date phone contact details. Provision of phones to those without them is also vital in order to capitalise on the benefits of these changes. Telephone consultations are adequate for most patients; however, video consultations may be more appropriate for patients with greater health and psychosocial needs.

From the onset of COVID-19 restrictions, some residential drug treatment and aftercare services closed. This created the opportunity to redeploy staff to provide remote counselling services and other supports. At first, patients struggled to adapt to the situation, but over time they increasingly reported satisfaction with this approach.

The authors note that while it is important to focus on emergency efforts to manage, treat, and develop a vaccine to control this pandemic, it is also important that new models of medical and social care delivery are fully evaluated. Models developed during this time of crisis may have real benefits for patients and healthcare systems in the future. It is also imperative to evaluate any potential negative impacts of these new models of care and to work to decrease them.

Adequate resources for such evaluations should be factored into health budgets, as many of these new measures could have significant health benefits and cost savings in a post-COVID-19 future.

In conclusion, PWUO have greater health and social risks that make them more vulnerable during the current COVID-19 pandemic. OAT services could and did adapt in order to reduce the risks faced by this marginalised population. Measures adopted have both immediate and future benefits for this group. Ongoing evaluation of such measures is critical, as it can inform how health and social care are delivered across health services. Many of these measures will also impact health and social care outcomes and potential cost savings in a post-COVID-19 future.

The report authors hope that these positive changes and learnings can address some of the social and health inequalities experienced by so many.

T4. Additional information

T4.1 Additional Sources of Information

Focused policy assessment of the national drugs strategy

A focused policy assessment (FPA) of the national drugs strategy (Department of Health 2017) was prepared by IGEES staff based jointly in the Department of Health and the Department of Public Expenditure and Reform (Bruton, *et al.* 2021b). The purpose of the FPA by the IGEES was to set out the rationale for a particular policy intervention; the public resources provided to support its delivery; the related outputs and services that are provided; and the achievements of the intervention relative to its stated goals for the time frame 2014 to 2020. The document had two objectives: to examine drug-related public expenditure, and to assess the performance of the strategy under its five strategic goals, depending on the availability of data (see also Section T1.4.7 of this workbook and Section T1.2.3 of the Drug policy workbook).

Treatment data were used as part of the analysis for the second objective to assess the performance of the current national drugs strategy, the results of which are summarised below.

Goal 2: Minimise the harms caused by the use and misuse of substances and promote rehabilitation and recovery

Since December 2018, more than 90% of problematic substance users aged 18 years and over have accessed treatment in NDTRS services within 1 month of their assessment, and within 1 week of their assessment for those aged under 18 years. This measure does not include the number of people waiting for assessment.

'Successful exits' from treatment averaged 47% from 2014 to 2019, although there was variation across different substance and treatment types.

The median number of years between starting to use drugs and entering treatment (lag) for those cases recording a successful exit dropped from 20 to 17 years in 2018, and remained at 17 years in 2019. This lag to treatment time may vary significantly by treatment type.

There is a gap in knowledge about problematic substance users who are not in contact with addiction services. The authors argue that "understanding the unmet need for services is important in interpreting much of the results under Goal 2 and as such the conclusions that can be drawn are constrained by this" (Bruton, *et al.* 2021b) (p. 69).

Goal 4: Support participation of individuals, families, and communities

Due to poor availability of data, the only measure reported under Goal 4 was the uptake of treatment by members of the Traveller, LGBTQI, and homeless communities. According to NDTRS data, members of the Traveller community increasingly do not take up treatment after being assessed (increasing from 6% in 2014 to 10% in 2019); a similar trend was found among people who are homeless. Uptake of treatment for cases of individuals who are homosexual and bisexual has remained stable over the reporting period.

Goal 5: Develop sound and comprehensive evidence-informed policies and actions

The only data to be analysed under Goal 5 came from the NDTRS. Between 2014 and 2019, there was a small increase in the number of services providing treatment; however, the number of services that submit data to the NDTRS has been consistent over the reporting period, at approximately 600.

T4.2 Further Aspects of Drug Treatment

No new information.

T4.3 Psychiatric comorbidity

National Clinical Programme for Dual Diagnosis

The most recent specialist mental health report, *Delivering specialist mental health services 2019* (HSE Mental Health Division 2020) (published in 2020), describes the National Clinical Programme for Dual Diagnosis, which is a joint initiative between the HSE and the College of Psychiatrists of Ireland.

The programme aims to develop a model of care that will ensure that all individuals with a dual diagnosis will have timely access to mental health services. The Dual Diagnosis Clinical Programme National Working Group (NWG) is a multidisciplinary group, including service users, which was established in October 2017. The aims of the programme are to develop “a standardised evidence-based approach to the identification, assessment and treatment of people with both moderate to severe mental illness and substance use disorder” (p. 34).

The programme updates for this report are as follows:

- Despite a recruitment campaign, the post of Clinical Lead for the programme remained unfilled (at the time of publication of the document).
- A draft Model of Care was developed.
- Links were established with the National Clinical Lead for the Drugs Strategy and Social Inclusion in order to ensure that a comprehensive approach is taken to the care of those with dual diagnosis.

Improvement in psychological well-being among adolescents with a substance use disorder attending an outpatient treatment programme

An Irish study sought to understand the impact of outpatient treatment on the psychological well-being of adolescent drug users (Gamage, *et al.* 2021). The study had been conducted as part of a wider research project (Smyth B P 2015) with data collected between April 2008 and January 2011 from participants attending an adolescent drug treatment service in Dublin. The participants were interviewed using the Beck Youth Inventories both pre-treatment and then again 3 months later. Of the 108 initial participants, 87 were followed up, with 36 eventually completing the follow-up assessment, and were included in this study. The majority of the participants were male (89%), were living with parents or family (92%), and were students (69%). Almost three-quarters (72%) reported cannabis use with 42% reporting polydrug use.

Analysis showed that on follow-up, participants had significant improvements in psychological well-being in relation to the depression, anger, and disruptive behaviour domains of the questionnaire. There were also significant improvements in the pathological categories of the domains of depression, anxiety, anger, and self-concept. Analysis showed a positive correlation between decreased cannabis use and a reduction in depression scores.

The authors conclude that drug treatment can help improve psychological and behaviour issues.

T5. Sources, methodology and references

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 methadone as a treatment for problems with opioid use. When a person is considered suitable for methadone detoxification, stabilisation, or maintenance, the prescribing doctor notifies the CTL by completing an entry form, a unique number is allocated to the client, and a treatment card is issued for clients when the methadone is dispensed in community pharmacies.

The NDTRS is a national epidemiological database which 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 which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems. The NDTRS is a case-based, anonymised database. It is coordinated by staff at the Health Research Board on behalf of the Department of Health.

T5.2 Methodology

T5.3 References

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European Monitoring Centre for Drugs and Drug Addiction

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

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

The Irish Focal Point to the EMCDDA is based in the Health Research Board (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 new psychoactive substances.

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