

Ireland: national report for 2015 - harms and harm reduction

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

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0. Summary

Ireland maintains a special register which is a complete census of all drug-induced deaths. Opiates are the main drug associated with drug-induced deaths.

Data on drug-related acute emergencies in the Irish context refer to all admissions to acute general hospitals with non-fatal overdoses and are extracted from the Hospital In-Patient Enquiry (HIPE) scheme.

Incidences of newly diagnosed HIV, HBV and HCV are notified to the Health Protection Surveillance Centre (HPSC). Notification data for 2014 are included in this report.

The number of drug-induced deaths has fluctuated over the past five years but overall the trend is upwards. The majority of those who died were male, aged in their thirties. Between 2009 and 2013 opiates were the most common drug associated with most drug-induced deaths as per the EMCDDA Filter D inclusion criteria. In 2013, the number of deaths where heroin was implicated increased for the first time since 2009.

Trends over time indicate a decrease in overdose cases admitted to Irish hospitals, falling from 5,012 cases in 2005 to 4,233 cases in 2013, a reduction of 779 cases.

Since June 2014 there has been an increase in notifications of recently acquired HIV in people who inject drugs (PWID) in Dublin. This is possibly linked with injection of a synthetic cathinone PVP but epidemiological investigation is still under way. In addition, enhanced infection control measures are being implemented.

A naloxone demonstration project is currently under way in the country. The aim of the project is to assess and evaluate the suitability and impact of using naloxone in Ireland in order to make naloxone more widely available for problem opiate users.

Since the pharmacy-based needle exchange programme was established the number of participating pharmacies has grown from 42 in 2011 to 99 at the end of 2013. The number of people attending this service has also increased from on average 306 per month in 2012 to 933 per month in 2013.

1. National profile

1.1 Drug-related deaths

1.1.1 Overdose deaths

In 2013, there were 219 deaths owing to poisoning recorded in Ireland by the National Drug-Related Deaths Index (NDRDI). This represents a 16% increase compared to the 189 deaths reported in 2012. It should be noted that annual data previously reported have been changed as the NDRDI figures have been updated as new information has become available.

Overall, the mean age of those who died (36.5 years) owing to poisoning remained stable compared to 2012 (36.3 years). The mean age of those who died has gradually increased over the past 10 years from 31.7 years in 2004 to 36.5 in 2013. The majority of deaths were male (74.9%) similar to previous years.

The NDRDI does not routinely report the intentionality of the death.

1.1.2 Toxicology of overdose deaths

In 2013, opiates continue to be associated with most poisoning deaths (186/219, 84.9%) similar to previous years. Methadone (alone or with another drug) continues to be the opiate most commonly implicated in poisoning deaths. In 2013, there were 93 deaths where methadone was implicated, compared to 89 deaths in 2012. This is compared to a peak in 2011 when there were 119 deaths where methadone was implicated.

In 2013 there were 86 deaths where heroin was implicated, compared to 64 in 2012. This represents a 34% increase between the two years. This is the first increase in heroin-related deaths since 2009. There were 31 deaths where cocaine was implicated (alone or with another drug), a small increase on the 26 reported in 2012.

The majority of poisoning deaths (77.2%) in 2013 involved more than one drug. As in previous years, benzodiazepines, alcohol, antidepressants and other prescription medications were among the main drugs implicated in poly-substance poisonings.

Toxicology was available for 187 deaths in 2013. Opiates were found in the post-mortem toxicology of 90.3% (169/187) of these deaths.

1.1.3 Additional information on drug-related deaths

The National Drug Related Deaths Index (NDRDI) also publishes *national* figures on drug-related deaths. This comprises all deaths owing to poisonings, including both illicit drugs but also other drugs such as alcohol and prescription medication. It also includes data on non-poisoning deaths among drug users (Health Research Board 2015).

The number of drug related deaths and deaths among drug users has increased slightly from 658 in 2012 to 679 in 2013. Of the total number of deaths in 2013, 387 people died as a result of poisoning (i.e. toxic effect of drug[s] in the body), and 292 were drug users who died as a result of trauma, such as hanging, or from a medical cause, for example liver disease. It is important to note that the figures in this update supersede all previously published figures. Similarly, figures for 2013 will be revised when data relating to new cases become available, i.e. as more inquest cases close.

In the nine-year period 2004–2013, a total of 6,002 deaths by drug poisoning and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 3,519 were due to poisoning and 2,483 were deaths among drug users (non-poisoning). Deaths owing to polydrug use have increased by 98% over the reporting period, from 118 in 2004 to 234 in 2013.

Poisoning deaths, 2013

The annual number of poisoning deaths increased from 361 in 2012 to 387 in 2013. As in previous years, the majority (68%) in 2013 were male; the median age of those who died was 41 years, slightly older to previous years.

In 2013, alcohol was, once again, the drug most commonly involved in poisoning deaths (35%) nationally. Prescription drugs played a significant part in poisoning deaths, two fifths (41%) of these deaths involving benzodiazepines. Methadone was implicated in a quarter of deaths, with the majority (94%) involving polydrug use.

There were 86 deaths where heroin was implicated (22% of all poisoning deaths). This is the first time since 2009 that the number of heroin-related deaths has increased. Over two fifths (42%) of people who died where heroin (injecting or smoking) was implicated were not alone at the time they took the drug, therefore there may have been an opportunity to prevent deaths. Half (49%) of those who died from a heroin-related death were known to be injecting at the time of their death.

Over half (60%) of all poisoning deaths in 2013 involved more than one drug (polydrug use). Over two fifths (43%) of those who died from poisoning in 2013 had a history of mental illness.

Non-poisoning deaths, 2013

The number of non-poisoning deaths recorded among drug users decreased slightly in 2013 to 292 deaths compared to 295 in 2012. Where the specific cause of death is known, these deaths are categorised as being due to either trauma or medical causes.

Deaths owing to trauma

The number of deaths owing to trauma decreased slightly in 2013 to 292 deaths compared to 295 in 2012. Death due to hanging accounted for 25% (n = 74) of all non-poisoning deaths. More than half (44, 59%) of deaths due to hanging in 2013 had a history of mental health illness.

Deaths owing to medical causes

The most common medical cause of death in 2013 was deaths due to cardiac events, accounting for almost a fifth (52, 18%) of all non-poisoning deaths. A younger cohort died from traumatic causes (median age of 34 years) in comparison to deaths due to medical causes (median age of 47 years).

1.2 Drug related acute emergencies

1.2.1 Drug-related acute emergencies

Monitoring of drug-related acute emergencies in the Irish context refers to all admissions to acute general hospitals in Ireland with non-fatal overdoses. See Section 6.1 below for a description of the main monitoring systems and sources of data.

1.2.2 Toxicology of drug-related acute emergencies

Drug related emergencies – non-fatal overdoses

Data extracted from the Hospital In-Patient Enquiry (HIPE) scheme were analysed to determine trends in non-fatal overdoses discharged from Irish hospitals in 2013. There were 4,270 overdose cases in that year, of which 37 died in hospital. Only the 4,233 discharged cases are included in this analysis. The number of overdose cases decreased by 4% between 2012 and 2013. Trends over time indicate a decrease in overdose cases admitted to Irish hospitals, falling from 5,012 cases in 2005 to 4,233 cases in 2013, a reduction of 779 cases (Figure 1.2.2.1).

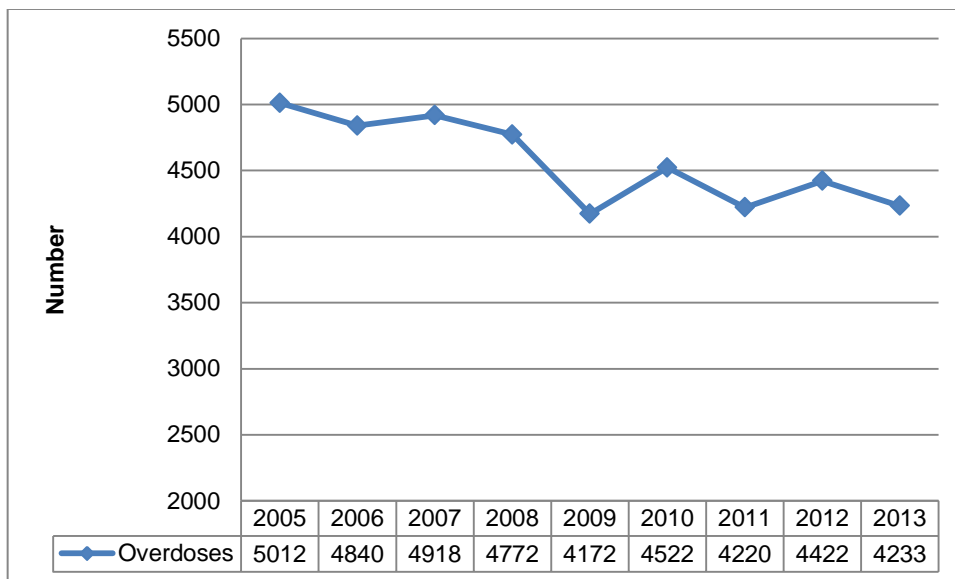


Figure 1.2.2.1 Overdose cases admitted to Irish hospitals, 2005–2013 (N=41,111)

Source: HIPE unpublished data, 2015

Gender

Between 2005 and 2013 there were more overdose cases among women than among men, with women accounting for 2,311 (55%) of all non-fatal overdose cases in 2013 (Figure 1.2.2.2).

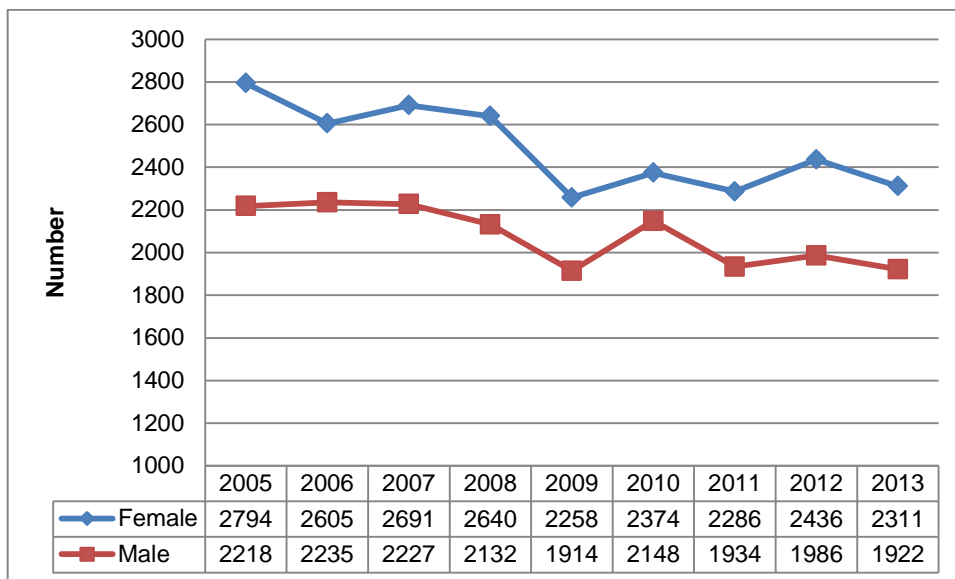


Figure 1.2.2.2 Overdose cases admitted to Irish hospitals, by gender, 2005–2013 (N=41,111)

Source: HIPE unpublished data, 2015

Age group

There was an increase in the number of non-fatal overdose cases among those aged 24 or under, those aged 65 to 74 years and those aged over 85 years between 2012 and 2013. There was a decrease in all other age groups. The incidence of overdose peaked in the 15 to 24 age category and thereafter decreased with age (Figure 1.2.2.3). Trends over time show that in 2005, 40% of cases were aged less than 25 years compared to 34% in 2013.

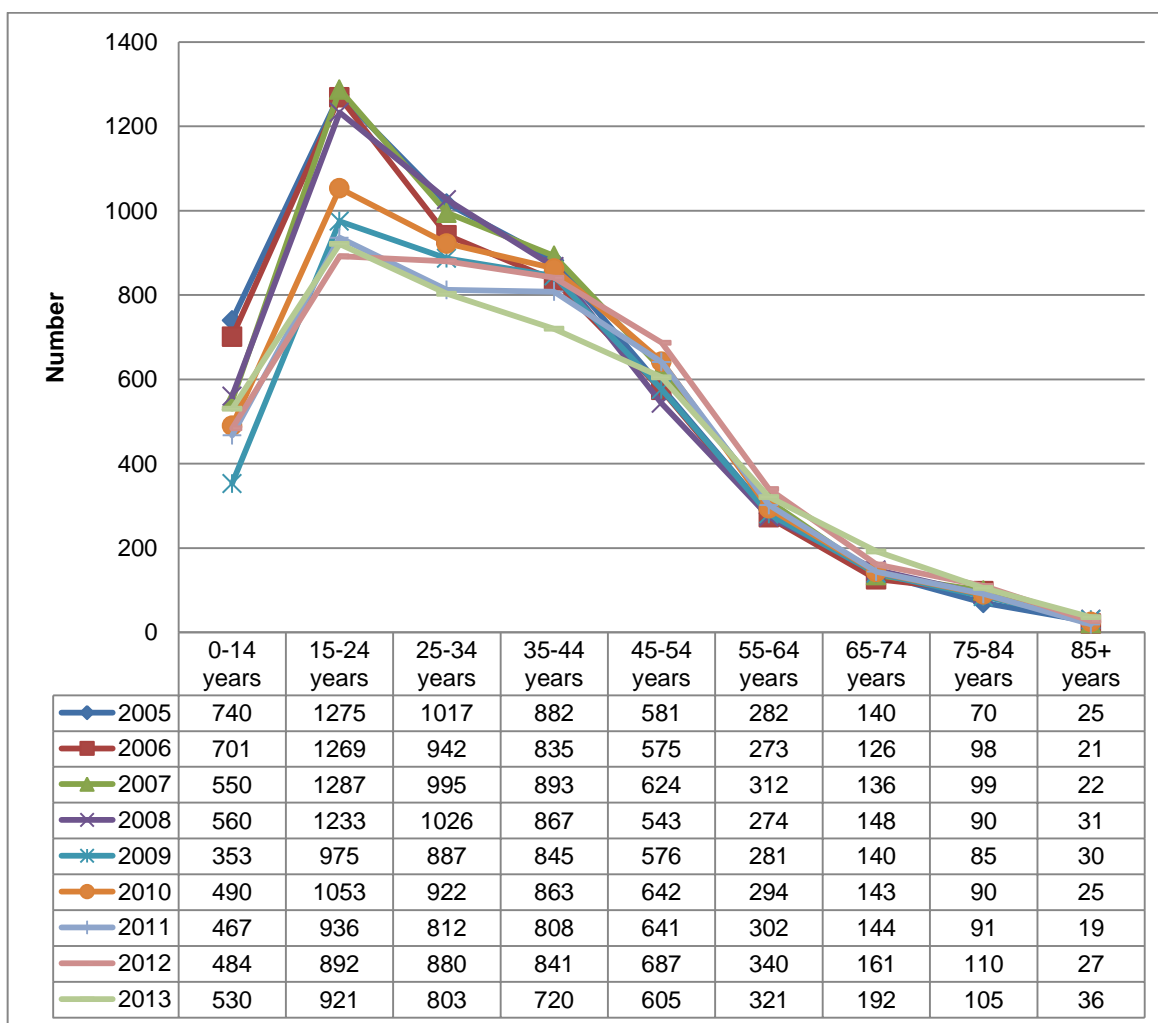


Figure 1.2.2.3 Overdose cases admitted to Irish hospitals, by age group, 2005–2013 (N=41,111)

Drugs involved

Table 1.2.2.1 presents the positive findings per category of drugs and other substances involved in all cases of overdose in 2013.

Non-opioid analgesics were present in 35% (1,482) of cases. Paracetamol is included in this drug category and was present in 28% (1,174) of cases. Psychotropic agents were taken in 24% (999) and benzodiazepines in 19% (818) of cases. There was evidence of alcohol consumption in 9% (365) of cases. Cases involving alcohol are included in this analysis only when the alcohol was used in conjunction with another substance.

Table 1.2.2.1 Categories of drugs involved in overdose cases admitted to Irish hospitals, 2013 (N= 4,233)*

Drug category	Number	%
Non-opioid analgesics	1,482	35.0
Benzodiazepines	818	19.3
Psychotropic agents	999	23.6
Antiepileptic/Sedative/Antiparkinson agents	1,940	45.8
Narcotics and hallucinogens	587	13.9
Alcohol	365	8.6
Systemic and haematological agents	140	3.3
Cardiovascular agents	139	3.3
Autonomic nervous system	119	2.8
Anaesthetics	8	0.2
Hormones	134	3.2
Systemic antibiotics	71	1.7
Gastrointestinal agents	65	1.5
Other chemicals and noxious substances	288	6.8
Diuretics	54	1.3
Muscle and respiratory agents	40	0.9
Topical agents	46	1.1
Anti-infectives / Anti-parasitics	29	0.7
Other gases and vapours	52	1.2
Other and unspecified drugs	878	20.7

Source: HIPE unpublished data, 2015

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.

Overdoses involving narcotics or hallucinogens

Narcotic or hallucinogenic drugs were involved in 14% (587) of overdose cases in 2013. Figure 1.2.2.4 shows the number of positive findings of narcotics or hallucinogens drugs among the 587 cases. Opiates were used in 80% (468) of the cases, cocaine in 10% (60) and cannabis in 10% (60) of cases.

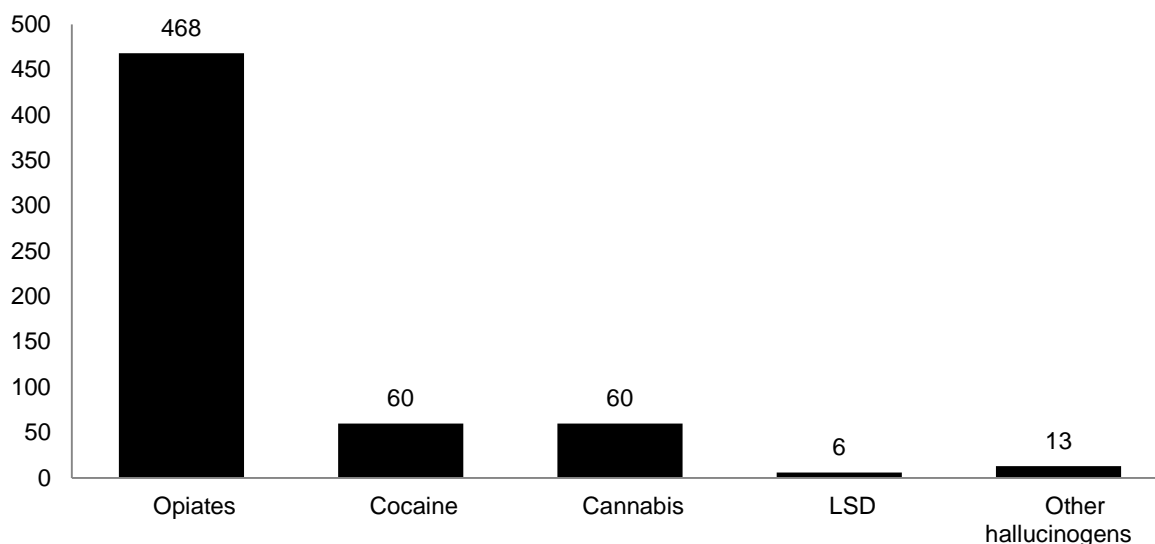


Figure 1.2.2.4 Narcotics and hallucinogens involved in overdose cases admitted to Irish hospitals, 2013 (N=587)*

Source: HIPE unpublished data, 2015

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug from this category.

Overdoses classified by intent

In 63% (2,682) of cases the overdose was classified as intentional (Figure 1.2.2.5). For 24 cases, classification of intent was not clear. These cases were not included in the analysis.

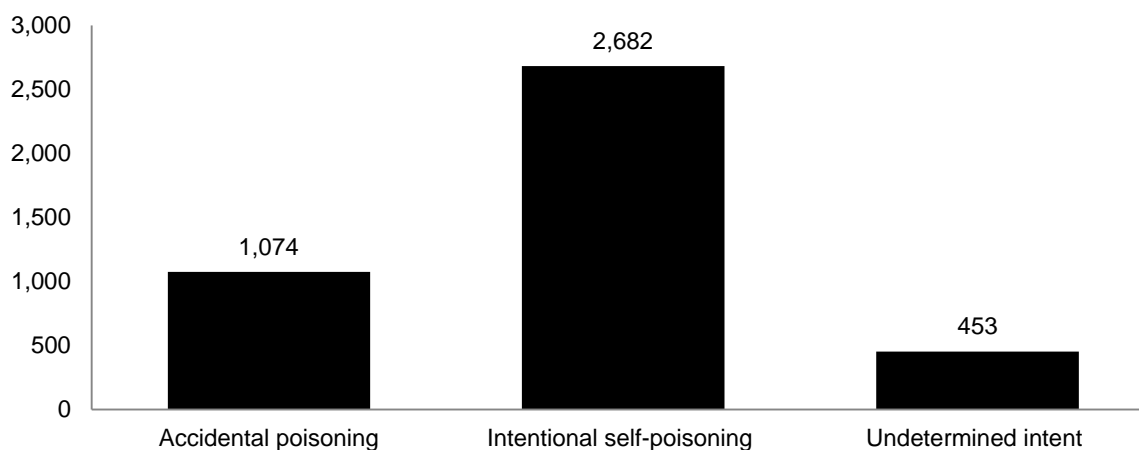


Figure 1.2.2.5 Overdose cases admitted to Irish hospitals, classified by intent, 2013 (N=4,209)

Source: HIPE unpublished data, 2015

Table 1.2.2.2 presents the positive findings per category of drugs and other substances involved in cases of intentional self-poisoning (n=2,682) in 2013. Non-opioid analgesics were involved in 42% (1,122) of cases, benzodiazepines in 23% (615) and psychotropic agents in 28% (748).

Table 1.2.2.2 Categories of drugs involved in intentional self-poisoning cases admitted to Irish hospitals, 2013 (N=2,682)*

Drug category	Number	%
Non-opioid analgesics	1,122	41.8
Benzodiazepines	615	22.9
Psychotropic agents	748	27.9
Antiepileptic/Sedative/Antiparkinson agents	1,430	53.3
Narcotics and hallucinogens	336	12.5
Alcohol	255	9.5
Systemic and haematological agents	75	2.8
Cardiovascular agents	86	3.2

Autonomic nervous system	75	2.8
Anaesthetics	4	0.1
Hormones	88	3.3
Systemic antibiotics	46	1.7
Gastrointestinal agents	49	1.8
Other chemicals and noxious substances	78	2.9
Diuretics	26	1.0
Muscle and respiratory agents	13	0.5
Topical agents	7	0.3
Anti-infectives / Anti-parasitics	15	0.6
Other gases and vapours	6	0.2
Other and unspecified drugs	507	18.9

Source: HIPE unpublished data, 2015

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.

1.2.3 Additional information on drug-related acute emergencies

Urban overdose hotspots in Dublin

A recent study looked at opioid overdoses in Dublin in order to understand more fully the risk factors involved, to help reduce the associated mortality and morbidity and to improve the response to such incidents (Klimas J, *et al.* 2014). The study had two aims: to establish a baseline incidence of all new overdoses that Dublin ambulances attend, and to look at the relationship between geographical location of overdoses, deprivation and location of methadone clinics.

There are two ambulance services in Dublin: the Dublin Fire Brigade (DFB), and the National Ambulance Service (NAS) operated by the Health Service Executive (HSE). Ambulance staff enter data on each individual that they attend on a patient care report (PCR). The PCR is a paper-based record of the pre-hospital care given by ambulance staff/first responders. All PCRs for a 12-month period in 2012–2013 were reviewed prospectively to identify opioid overdoses. All relevant data were extracted: clinical presentation; clinical care provided; administration of naloxone; response to naloxone; whether the patient was taken to hospital; and death, if confirmed by ambulance staff on scene. Follow-up data on patients who were taken to emergency departments were not collected for this study.

The locations of overdoses were categorised as 'street', 'residential' (house/hotel) or 'service' (homeless shelter, treatment centre, hospital, shop, pub, Garda station). DFB personnel assigned geographic co-ordinates for the location of every overdose attended. These data were not available for attendances by the NAS.

Over the study period, ambulances attended 469 opioid overdoses. This gives an overdose incidence of 4.9 cases per 1,000 cases per year.

Characteristics of patients who overdosed:

- 80% male
- Mean age 33 years
- Evidence of opiate use was observed in 89%.
- Evidence of use of other drugs, mainly alcohol, was observed in 28%.
- 45% of patients were attended on the street.
- 38% were attended in a residential location.
- 70% were attended during the day.
- 27% were repeat overdoses.

Data on clinical presentation of the patient:

- 39% were unresponsive.
- 10% were in respiratory arrest.
- 12% had respiratory depression.
- 4% were in cardiac arrest.
- Mean GCS score: 2
 - Pre-intervention 7.2
 - Post-intervention 12.3
- 3% were confirmed dead at the scene.

Type of intervention provided:

- 76% had naloxone administered:
 - 66% given naloxone intramuscularly
 - Mean number of doses 1.5
- 22% had assisted ventilation.
- 60% were administered oxygen.
- 89% were transported to hospital.

Geographic location of overdoses:

- 86% Dublin city centre
- 6% South Dublin
- 5% Fingal
- 1% Dun Laoghaire

The relationship between overdose and deprivation was examined using the Pobal-Haase-Pratschke Deprivation Index and pre-existing Small Area (SA) boundaries. The Deprivation Index is a composite score 'measuring the relative affluence or disadvantage of a particular geographic area'. The score ranges from -40 (most disadvantaged) to +40 (most affluent). Each overdose was mapped to its corresponding SA. There were some statistically significant differences found between the number of overdoses and level of area affluence, with a greater number of overdoses occurring in less affluent areas, and the locations where overdoses occurred, with overdoses occurring in residential locations having a lower deprivation score than overdoses occurring in street locations.

The study also looked at the location of methadone clinics in relation to overdoses. This showed that most overdoses occurred within a 1,000-metre radius of certain methadone clinics.

The authors identified some limitations to the study. PCR forms were not always reliable (they were hand-written under stressful circumstances and often involved difficult decisions) and data could not be validated. Geo-data were not available for NAS PCRs.

The results of the study highlight several issues which can help inform decisions about preventing overdose deaths. Dublin ambulance services attended an opioid overdose almost daily; the majority occurred in Dublin city centre, on the street, during the day and near certain methadone clinics; street overdoses were more likely to occur in the city centre and on the quays, while residential overdoses were more likely to occur in the suburbs. Clinical findings showed patients had low mean GCS scores pre-intervention, meaning that many patients were unconscious. However, the mean GCS scores post-intervention showed improvement, indicating the effectiveness of the intervention given by the ambulance staff. However, the results also showed that the GCS scores of 25% of patients did not improve after administration of naloxone.

Despite international research indicating that overdose prevention and naloxone distribution programmes can help to reduce overdose deaths, not many countries provide such programmes. The authors stated that the results point to the need for such a programme, based in the community, in Ireland.

Drug admissions to psychiatric facilities

Activities of Irish psychiatric units and hospitals 2013, the annual report published by the Mental Health Information Systems Unit of the Health Research Board in 2014, shows that the total number of admissions to inpatient care in 2013 had increased slightly since 2012. However, there was a 17% decline in overall psychiatric admissions in the 10 years between 2004 and 2013 (Daly and Walsh 2014).

In 2013, 890 cases were admitted to psychiatric facilities with a drug disorder (ICD-10 code F11-19, F55), which is a rate of 19.4 per 100,000 total population. Of these, 365 (41%) were treated for the first time. This is similar to the number of admissions in 2012 when there were 831 cases of which 358 were for the first time. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate.

Figure 1.2.3.1 presents the rates of first admission between 1994 and 2013 of cases with a diagnosis of drug disorder.

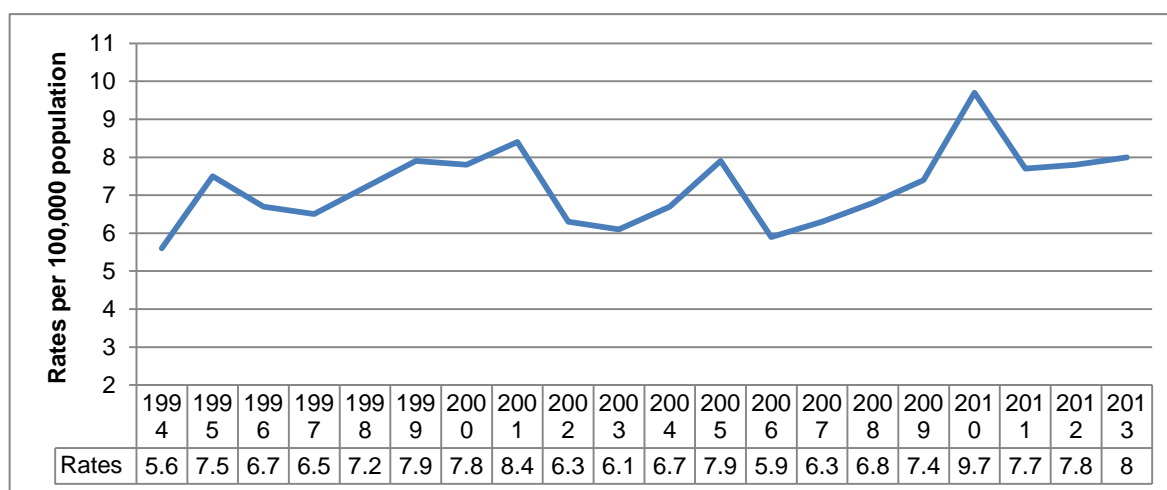


Figure 1.2.3.1: Rates of psychiatric first-admission cases with a diagnosis of drug disorder per 100,000 of the population in Ireland, 1994–2013

Source: (Daly and Walsh 2014)

Other notable statistics on first admissions for a drug disorder in 2013 include:

- The majority were to psychiatric units in general hospitals (250, 69%), followed by admissions to psychiatric hospitals (67, 18%) and to private hospitals (48, 13%).
- 10% were involuntary admissions.
- The rate was higher for men (11.7 per 100,000) than for women (4.3 per 100,000).

The majority of cases hospitalised for a drug disorder stayed just under one week (51%), while most were discharged within three months. It should be borne in mind that admissions and discharges represent episodes or events and not persons.

1.3 Drug related infectious diseases

1.3.1 Main drug-related infectious diseases among drug users – HIV, HBV, HCV

HIV surveillance, 2014

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1982

Figure 1.3.1.1 presents the number of new cases of HIV among people who inject drugs (PWID) reported in Ireland, by year of diagnosis; data from 1982 to 1985 are excluded as these four years were combined in the source records. According to the most recent report of the Health Protection

Surveillance Centre (HPSC), at the end of 2014, 377 people were newly diagnosed with HIV in Ireland (crude notification rate of 8.2 per 100,000 population). This marks an increase of 11% since 2013 and is due to increases in HIV cases among men who have sex with men and PWID. Prior to this, the annual rate of HIV had been stable from 2010 to 2013, ranging from 7.0 to 7.5 per 100,000 population.

In 2014, 7% (27) of newly-diagnosed HIV cases were PWID. This is the highest number of HIV cases among PWID since 2009. Of these 27 cases, 14 were women and 13 were men. The number of newly diagnosed women has increased from 3 in 2012 to 14 in 2014. The median age was 32 years (range 24 to 49 years). Twenty-three cases were born in Ireland and two in Eastern Europe. Country of birth was not unknown for two. Twenty-four (89%) were resident in Dublin. Where information is available (11 cases) the median duration of injecting drug use was 8 years.

Forty-one per cent of newly diagnosed cases of HIV among PWID in 2014 were recent infections, having had previous negative HIV tests in either 2013 or 2014; the proportion late diagnoses in 2014 (44%) was lower than in previous years (53% in 2013 and 56% in 2012). The increased incidence of recent HIV infection among PWID is being investigated and a detailed review of the mode of transmission conducted.

Among the PWID newly diagnosed with HIV infection, 89% (24) were co-infected with hepatitis C (Health Protection Surveillance Centre 2015).

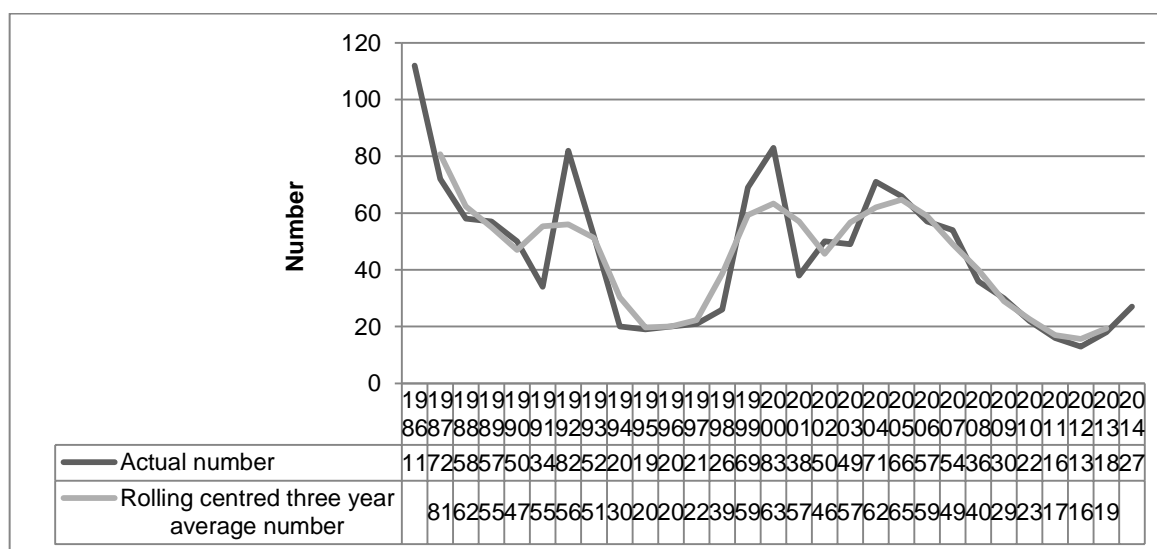


Figure 1.3.1.1 Number and rolling average number of new cases of HIV among PWID, by year of diagnosis, reported in Ireland, 1986–2014

Source: Unpublished data reported to Department of Health by National Disease Surveillance Centre and HPSC, 2015

Hepatitis B (HBV) notifications, 2014

There were 446 notifications of HBV in 2014 compared to 431 in 2013, a 3.5% increase (Table 1.3.1.1). This increase is likely to be associated with the level of immigration into Ireland. Of the cases notified, 60% (270) were male, 38% (169) were female and in a further seven cases the gender was unknown. The majority, 70% (313), were aged between 25 and 44 years. The number of acute cases remained low at 30, showing a small decrease since 2012 when there were 37 acute cases. Among acute cases of HBV in 2014, none were injecting drug users.

Table 1.3.1.1 Acute and chronic HBV cases reported to the HPSC, by risk factor status, 2013–14

Hepatitis B status	2013			2014		
	Acute N (%)	Chronic N (%)	Unknown N (%)	Acute N (%)	Chronic N (%)	Unknown N (%)
Total number of cases	31	386	14	30	399	17
% of cases by status	(7.2)	(89.6)	(3.2)	(6.7)	(89.4)	(3.8)

Cases with reported risk factor data	30	230	6	29	250	4
% of cases with risk factor data	(97)	(59.6)	(42.9)	(97)	(62.6)	(23.5)
of which						
Injecting drug users	1 (3.3%)	6 (2.6%)	0 (0%)	0 (0%)	4 (1.6%)	0 (0%)
Cases without reported risk factor data	1	156	8	1	149	13
% of cases without risk factor data	(3)	(40.4)	(57.1)	(3)	(37.3)	(76.4)
Total		431			446	

Source: Unpublished data reported to Department of Health by National Disease Surveillance Centre and HPSC, 2015

Hepatitis C (HCV) notifications, 2014

There were 710 HCV notifications in 2014 (Table 1.3.1.2), a decrease of 16% on 2013 when there were 847 notifications. The notification rate for 2014 was 15.5 per 100,000 population. There has been a downward trend in hepatitis C notifications since peak numbers (1,541) were recorded in 2007. The median age at notification has increased steadily since notification began in 2004, from 32 to 39 years among males and from 29 to 36 years among females. Decreasing HCV notifications and increasing median age are indicative of a reduced incidence of HCV in the population. Demographic data in 2014 remained similar to previous years, with 70% (503) of cases being male and 85% (601) aged between 25 and 54 years.

Table 1.3.1.2 HCV cases and notification rates per 100,000 population, 2004–2014

Year	n	Notification rate
2004	1119	26.4
2005	1403	33.1
2006	1210	28.6
2007	1541	36.5
2008	1511	35.8
2009	1240	29.3
2010	1236	29.2
2011	1257	29.6
2012	1036	24.4
2013	847	18.5
2014	710	15.5

Source: HPSC unpublished data

Risk factor data were available for 58% (409) of the 2014 cases (Table 1.3.1.3); for 68% (277) of these cases, injecting was the predominant risk factor, and of these cases 211 (76%) were men and the mean age was 37 years. Among the 277 cases where injecting was the predominant risk factor, 76% (211) were men, the mean age was 37 years, and 72% (199) lived in Dublin or the adjoining counties of Kildare and Wicklow (Table 1.3.1.4)

Table 1.3.1.3 HCV cases reported to the HPSC, by risk factor status, 2010–2014

Risk factor status	2010	2011	2012	2013	2014
	n (%)	n (%)	n (%)	n (%)	n (%)
Total number of cases	1236	1257	1036	847	710
Cases <i>with</i> reported risk factor data	728 (58.8%)	753 (59.9%)	651 (62.8%)	540 (63.8%)	409 (57.6%)
Of which:					
Injecting drug users	550 (75.5%)	616 (81.8%)	484 (74.3%)	372 (68.9%)	277 (67.7%)
Recipient blood/blood products	19 (2.6%)	19 (2.5%)	26 (4%)	16 (3%)	16 (3.9%)
Other risk factors	143 (19.6%)	106 (14.1%)	127 (19.5%)	135 (25%)	101 (24.6%)

No known risk factor identified	16 (2.2%)	12 (1.1%)	12 (1.8%)	17 (3%)	15 (3.6%)
Cases <i>without</i> reported risk factor data	511 (41.3%)	504 (40.1%)	385 (37.1%)	307 (36.2%)	301 (42.3%)

Source: HPSC unpublished data

Table 1.3.1.4 Hepatitis C cases who reported injecting drug use as a risk factor, by age, gender and place of residence, 2010–2014

	2010 n (%)	2011 n (%)	2012 n (%)	2013 n (%)	2014 n (%)
Total number of known injector cases	550	616	484	372	277
Gender					
Male	409 (74%)	419 (68%)	348 (72%)	272 (73%)	211 (76.1%)
Female	140 (25.5%)	196 (31.8%)	136 (28%)	99 (26.6%)	66 (23.8%)
Gender not known	1	1	0	1	0
Age					
Mean age	35.8	35.4	36.9	37.6	37
Median age	34	34	36	37	36
Under 25 years	32 (5.8%)	45 (7.3%)	23 (4.8%)	10 (2.7%)	19 (6.8%)
25–34 years	247 (44.9%)	269 (43.7%)	178 (36.8%)	137 (36.8%)	105 (37.9%)
Over 34 years	271 (49.3%)	300 (48.7%)	282 (58.2%)	225 (60.5%)	153 (55.2%)
Age not known	0 (0%)	2 (0.3%)	1 (0.2%)	0 (0%)	0 (0%)
Place of residence					
Dublin, Kildare or Wicklow	466 (84.7%)	538 (87.3%)	399 (82.4%)	297 (79.8%)	199 (71.8%)
Elsewhere in Ireland	84 (15.3%)	78 (12.7%)	85 (17.6%)	75 (20.2%)	78 (28.1%)

Source: HPSC unpublished data

1.3.2 Additional information on drug-related infectious diseases

Pregnant women with blood-borne infections, 2013

The DOVE Clinic in the Rotunda Maternity Hospital, Dublin, was established to meet the specific needs of pregnant women who have or are at risk of blood-borne or sexually-transmitted bacterial or viral infections. Figures from the clinic for 2013 were published in the hospital's annual report (The Rotunda Hospital 2014).

In 2013, a total of 206 women were booked into the DOVE clinic for ante-natal care. Of these:

- 28% (59) were positive for HBV surface antigen (down from 70 in 2012),
- 28% (59) were positive for HCV antibody (down from 61 in 2012),
- 12% (24) were positive for HIV (down from 36 in 2012),
- 10% (20) were positive for Treponemal serology (an increase from 15 in 2012), and
- 23% (48) were known to be on prescribed methadone programmes (down from 73 in 2012).

Deliveries to mothers attending the DOVE Clinic are outlined in Table 1.3.2.1. A total of 78 deliveries were to mothers attending the drug liaison midwife (DLM), 53 were HBV positive, 58 were HCV positive, 30 HIV positive and 10 tested positive for syphilis. Sixteen babies were admitted to the neonatal unit with neonatal abstinence syndrome.

Table 1.3.2.1 Deliveries to mothers attending the DOVE Clinic who were positive for HIV, HCV, HBV or syphilis or who were attending the DLM, 2013

Mother's status	HIV(+ve)	HCV(+ve)	HBV(+ve)	Syphilis (+ve)	DLM
Total Mothers Delivered	30	58	53	10	78
Total Mothers Delivered <500g (incl miscarriage)	0	7	1	1	5
Total Mothers Delivered >500g	30	51	52	9	73

Live infants	31	53 (inc 3 NND)	52	9	74 (inc 1 set twins)
Miscarriage	0	5	1	1	5
Stillbirth	0	0	0	0	0
Infants <37 weeks gestation	4	12	4	1	16
Caesarean Section	16	15	17	3	20
NICU admission for NAS					16
Maternal median age	34	32	28	34.5	
Newly diagnosed at ANS	6	6	11	2	

Source: (The Rotunda Hospital 2014)

NICU = Neonatal intensive care unit

NAS = Neonatal abstinence syndrome

ANS = Ante-natal screening

DLM = Drug liaison midwife

NND = Neonatal death

In 2014 the Coombe Women and Infants University Hospital published its annual report for 2013 and reported that 309 women attended the Addiction and Communicable/ Infectious Diseases service for ante-natal care and post-natal follow-up (Coombe Women and Infants University Hospital 2015). Of those attending ante-natal care:

- 42 were positive for HBV, of whom 6 were newly diagnosed;
- 45 were positive for HCV, of whom 11 were newly diagnosed;
- 26 were positive for HIV, of whom 1 was newly diagnosed; and
- 2 were co-infected with HCV, 2 with HBV and 4 with syphilis.

In terms of addiction, 82 women linked with the DLM, and of these, 68 delivered 69 live babies (one set of twins). Of the 69 babies, 48% (33) were admitted to special care and 19 of these required pharmacological treatment for NAS. The report stated that heroin continued to be the primary substance used but that cocaine and benzodiazepine use was also evident.

1.4 Other drug-related health harms

1.4.1 Other drug-related health harms

National Registry of Deliberate Self Harm Annual Report, 2013

The 12th annual report from the National Registry of Deliberate Self Harm was published in September 2014 (Griffin E, *et al.* 2014). The report, produced by the National Suicide Research Foundation (NSRF), contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in 2013, giving complete national coverage of cases treated. All individuals who were alive on admission to hospital following deliberate self-harm were included, along with the methods of deliberate self-harm that were used. Accidental overdoses of medication, street drugs or alcohol were excluded.

There were 11,061 recorded presentations of deliberate self-harm, involving 8,772 individuals, in 2013. This implies that one in five (2,289, 21%) of the presentations were repeat episodes. The rate of presentations decreased from 211/100,000 in 2012 to 199/ 100,000 in 2013, a 6% decrease. However, the rate in 2013 was still 6% higher than the pre-recession rate of 188/100,000 in 2007 (Figure 1.4.1.1).

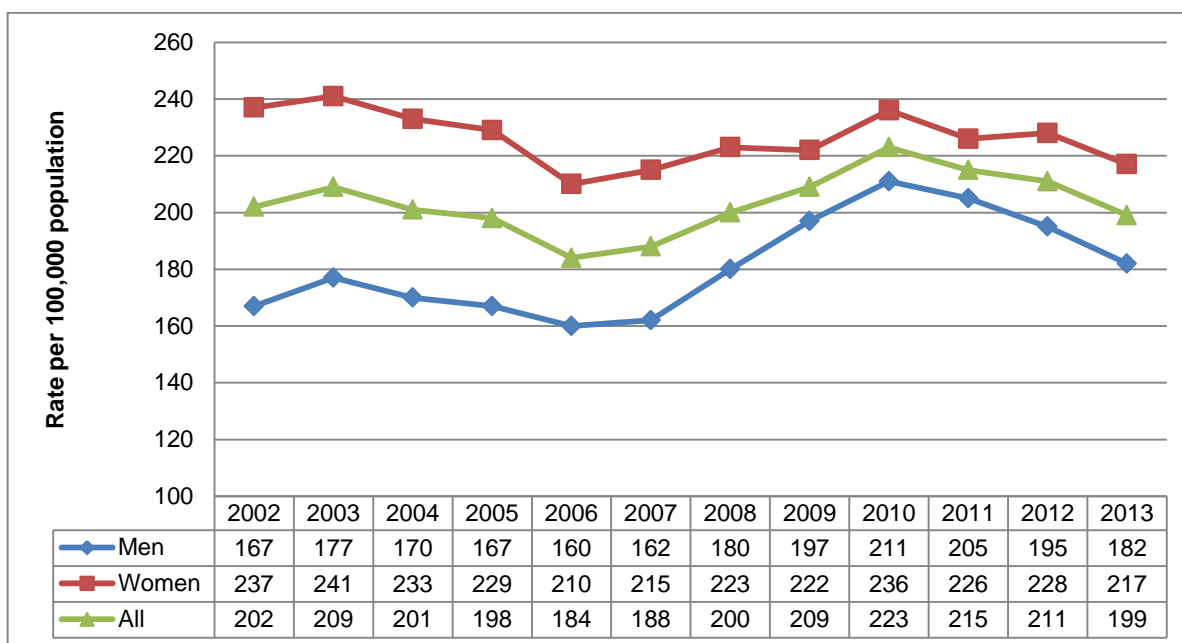


Figure 1.4.1.1 Person-based rate of deliberate self-harm, by gender, 2002–2013*

Source: (Griffin E, *et al.* 2014)

*'All' in the legend refers to the rate for both men and women per 100,000 population.

Forty-six per cent of self-harm presentations in 2013 were men. Just over half (53%) were aged under 30 years. Five hundred and sixteen (5%) self-harm presentations were living in hostels for the homeless or had no fixed abode. Presentations peaked in the hours around midnight and were highest on Sundays and Mondays; 31% of episodes occurred on these two days. There was evidence of alcohol consumption in 4,037 (36.5%) presentations and this was more common among men (40%) than women (34%).

Drug overdose was the most common form of deliberate self-harm reported in 2013, occurring in 7,457 (67%) of all such episodes. Overdose rates were higher among women (72%) than among men (62%). In 72% of cases the total number of tablets taken was known; an average of 30 tablets was taken in these episodes. The average among men was 33 tablets and among women 28 tablets.

Thirty-nine per cent of all drug overdoses involved a minor tranquilliser (most commonly benzodiazepines), 29% involved paracetamol-containing medicines, 21% involved antidepressants or mood stabilisers (most commonly Selective Serotonin Reuptake Inhibitors [SSRIs]), 10% involved a major tranquilliser and 27% involved other prescribed drugs.

The number of presentations involving street drugs in intentional overdose acts (420) was similar to the number recorded in 2007 (434). This reflected a fall of 3% from 2012, a fall of 10% from 2011 to 2012, and a fall of 27% from 2010 to 2011.

The next steps, or referral outcomes, for the deliberate overdose cases were: 49% discharged home; 29% admitted to an acute general hospital; 7% admitted to psychiatric in-patient care; a small proportion (1%) refused admission to hospital; and 14% discharged themselves before receiving referral advice.

The report provided information on what was being or could be done to reduce the number of self-harm cases. The total number of presentations involving drug overdose fell by 10% from 2012. This was most notable among overdoses involving minor tranquillisers, which fell by 13%. The report related this to proactive monitoring of prescribing patterns in primary care services since 2012. The authors recommended that a review the implementation of the paracetamol legislation

should also be undertaken in light of the continuing high level of overdose involving paracetamol-containing medicines.

The authors reported that alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, around the hours of midnight. These findings underlined the need for on-going efforts to:

- enhance health service capacity at specific times and increase awareness of the negative effects of alcohol misuse and abuse such as increased depressive feelings and reduced self-control;
- intensify national strategies to increase awareness of the risks involved in the use and misuse of alcohol, starting at pre-adolescent age, and intensify national strategies to reduce access to alcohol and drugs;
- educate self-harm patients and their families about the importance of reduced use of and access to alcohol; and
- arrange active consultation and collaboration between the mental health services and addiction treatment services in the best interest of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).

The authors reported that there was variation in the next care recommended to deliberate self-harm patients, and in the proportion of patients who left hospital before a recommendation, which ranged from 10% in the Dublin/Midlands Hospital Group to 19% in the Dublin North East and North Eastern Hospitals Groups. The National Office of Suicide Prevention has funded pilot projects to implement and evaluate suicide and self-harm awareness training for all emergency department staff, and to improve assessment procedures for self-harm patients in Cork and Kerry, which is a collaborative initiative between Cork University Hospital and the National Suicide Research Foundation.

The report highlighted the on-going work by the NSRF to link data of deliberate self-harm with suicide mortality data. This linking has shown that individuals who self-harm are over 42 times more likely to die by suicide than the general population. Further linkage is recommended in order to enhance insight into predictors of suicide risk.

1.5 Harm reduction interventions

1.5.1 Drug policy and main harm reduction objectives

The current National Drugs Strategy aims to reduce harm arising from substance misuse and to reduce the prevalence of blood-borne viruses (BBVs) among people who inject drugs (PWID) through the expansion of needle exchange provision to include community pharmacy-based programmes. For further details on the National Drugs Strategy, see Section 1.1 of the Policy chapter.

1.5.2 Organisation of Harm reduction services

There are three models of needle exchange programmes in use in Ireland:

1. static – 24 sites mainly in Dublin City,
2. outreach – 14 sites mainly in counties Dublin, Kildare, Laois, Offaly, Waterford and Wicklow, and
3. pharmacy – 63 sites in regions outside Dublin, Kildare and Wicklow, of which 33 had needle exchange transactions.

In a recent study conducted by the HSE, all needle exchange services reported that they provide at least five or more of the ten interventions listed below:

1. Specific harm reduction advice
2. Overdose awareness
3. Basic harm reduction messages repeated at each attendance

4. Service user referrals to A&E or a GP
5. Service user referrals to other health, outreach and social care services
6. Wound care advice
7. Injection site inspection
8. Service user referrals for BBV testing and hepatitis B vaccination
9. Service user assistance with the referral process, e.g. making phone calls
10. Other health advice

For further details on the needle exchange programme, see section 1.5.3 below

1.5.3 Harm reduction services

Needle exchange provision in Ireland, 2012

The Health Service Executive (HSE) recently published a review of needle exchange provision in Ireland (Bingham, *et al.* 2015).

The review was designed to assess the effectiveness of HSE-funded needle exchange services using evidence from 2012. In particular, the study examined:

- needle exchange activity nationally in 2012,
- referral rates to health and social care,
- data collection procedures and clinical governance, and
- quality assurance and clinical governance.

Data were collected between February and June 2013 using a questionnaire consisting of closed and open-ended questions. The data collection template was reviewed to ensure it met the data recording requirements of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). All six non-statutory needle exchange services and all HSE regional offices returned questionnaires. However, of the 63 pharmacies where needle exchange services were available, only 33 had reported transactions in 2012 and of these only 16 returned questionnaires.

Access

Pharmacy needle exchange programmes provided a far greater level of accessibility, with pharmacies typically open six days per week and providing on average 48 hours of service weekly. On the other hand, 15 of the 24 static services opened for less than eight hours and a further seven opened for between 25 and 43 hours per week. Half (7) of all outreach services opened for less than 25 hours per week, with a further five open for between 25 and 43 hours and two open whenever needed.

Activity

The review indicated that 13,763 individuals used the needle exchange during 2012, of whom 7,359 (80%) were men and 1,862 (20%) were women. However, the authors urged caution as there is no unique health identifier in Ireland and as a result service users can be counted more than once. A total of 65,099 transactions in needle exchange services during 2012 were reported in the review, of which the majority (84%) were in static or outreach services and took place in Dublin North East or Dublin Mid Leinster (see Figure 1.5.3.1). The variation in use of each exchange type was proportionate to the services available in the particular area.

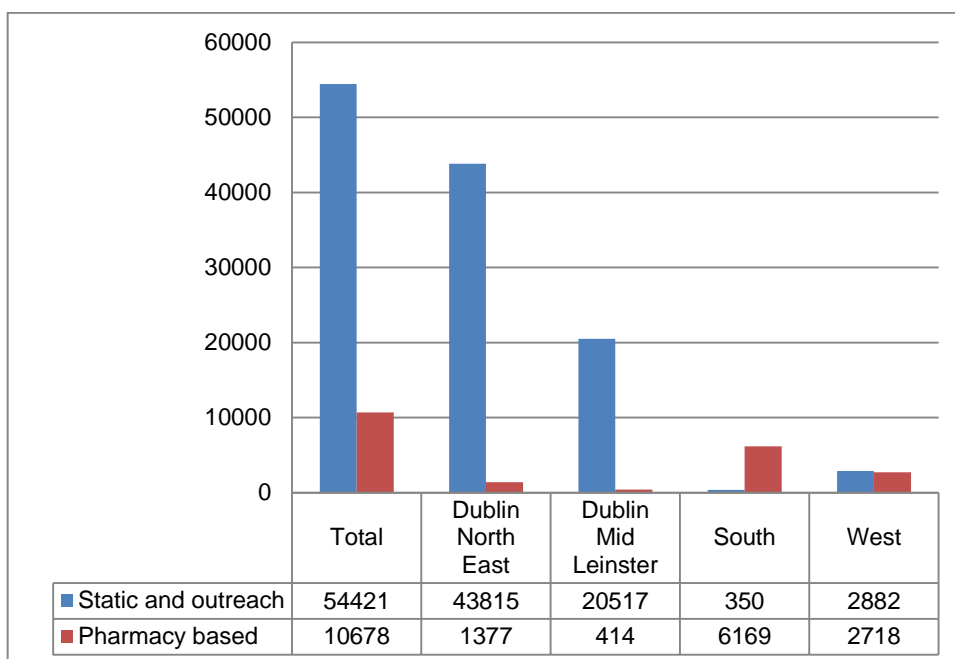


Figure 1.5.3.1 Number of transactions at needle exchange services by region and model of service, 2012
Source: (Bingham, *et al.* 2015)

Paraphernalia distributed

Detailed information on the quantity of injecting equipment distributed at all sites was made available to the reviewers with the exception of two static sites where only partial information was available. Individual items were distributed at the static and outreach services, whereas packs of equipment were distributed at the pharmacy-based exchanges.

Static and outreach services:

In total, 156,575 syringes and 135,696 needles were distributed. Almost half of all syringes (49%) were fixed needle and 1ml syringes. In addition, the following items were distributed in 2012:

Vials of 10ml water for injection	75819
Vials of 5ml water for injection	8377
Vials of 2ml water for injection	1572
Spoons/filters	25450
Citric acid	20125
Sterile swabs	20603
Foil (for smoking heroin)	12031
Tourniquets	476

The review pointed to a discrepancy between the number of needles and quantity of other injecting equipment distributed. In particular, the fact that 67,928 more needles than vials of water were made available was highlighted. This, the authors stated, might signal that some equipment was being used more than once, contrary to best practice.

Pharmacy-based needle exchanges:

In 2012, a total of 11,790 packs, each containing the equipment for 10 sterile injections, were distributed at pharmacy-based needle exchanges. Each pack contained 10 filter syringes (including needles), 10 stericups, 10 swabs, 10 citric acid packs, 10 vials with 5ml water for injection and one information leaflet (harm reduction and safer injecting advice).

Returns policy

All services reported that they encouraged the return of used equipment but that this was not a condition for accessing new equipment. All pharmacy-based needle exchanges kept a record of equipment returned. However, the level of record keeping varied across the static and outreach services.

Referrals and other services

The review stated that all services reported providing information on BBVs but that recording of the numbers referred for testing or for hepatitis B vaccination was inconsistent within the static and outreach services. Referrals from the pharmacy-based services were recorded and reported systematically.

The number of referrals reported to the review team is outlined in Figure 1.5.3.2, but this is an under-estimation of the level of referrals from the static and outreach services.

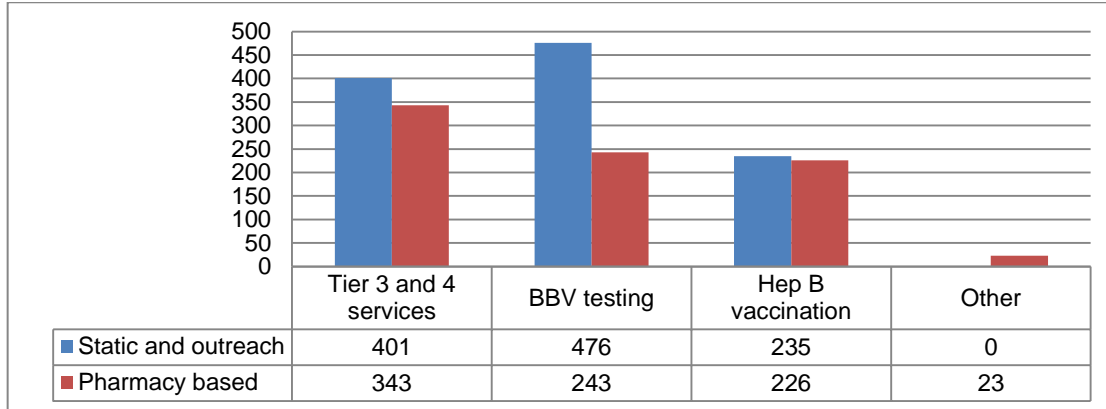


Figure 1.5.3.2 Number of referrals recorded by model of needle exchange, 2012

Source: (Bingham, *et al.* 2015)

All services reported providing face-to-face advice on overdose and harm reduction as well as referrals to other treatment and counselling services. Other services included referral to general practitioners, A&E, outreach and social care services as well as wound care and injection site inspection.

Quality assurance

The review detailed the quality assurance mechanisms in place in the various needle exchange services. Under the Pharmacy Act 2007, the Pharmaceutical Society of Ireland has powers of inspection, investigation and enforcement. All static and outreach needle exchange services work within the National Drug Rehabilitation Implementation Committee (NDRIC) framework, which is designed to ensure service providers offer individuals affected by drug misuse a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway. These services were reported as using a range of clinical governance approaches.

Recommendations

The review recommended that a standardised electronic reporting mechanism for regular monitoring and reporting of all needle exchange transactions be considered. It pointed to the need for a unique identifier for each service user to remove the risk of individuals being reported more than once in a reporting year. The need for specific data on injecting of image and performance enhancing drugs was highlighted. An examination of the potential barriers to BBV testing and vaccination was recommended in order to improve uptake. The review also included a number of recommendations with regard to the standards needed to enhance quality assurance and clinical governance. Finally, the review recommended the provision of injecting equipment (e.g. stericups, filters and foil) in addition to needles and syringes and pointed to the possibility of central purchasing of stock for all non-pharmacy needle exchange programme as a means of promoting value for money.

Pharmacy-based needle exchange in Ireland, 2013

In October 2011 the HSE rolled out the national pharmacy needle exchange programme, which is a partnership initiative between the Elton John Aids Foundation, the Irish Pharmacy Union and the Health Service Executive (HSE). The programme targets counties outside Dublin. Once pharmacies have signed a service level agreement with the HSE, their contact details are passed on to the relevant HSE services so that they can promote access to sterile injecting equipment at the participating pharmacies and accept referrals for investigation and treatment.

There were 42 pharmacies providing needle exchange at the end of 2011 and this had increased to 99 by the end of 2013. There were pharmacies providing needle exchange in each regional drugs task force area (Table 1.5.3.1), apart from those covering counties Dublin, Kildare and Wicklow, which were served by a mix of static and outreach needle-exchange programmes. These data were collected from participating pharmacies by the HSE.

Table 1.5.3.1 Number of pharmacies providing needle exchange by regional drugs task force area, 2011–2013

Regional drugs task force area	2011	2012	2013
Midland (Longford, Laois, Offaly, Westmeath)	5	13	15
North Eastern (Meath, Louth, Cavan, Monaghan)	3	9	16
North West (Sligo Leitrim, West Cavan, Donegal)	3	4	7
Southern (Cork and Kerry)	8	10	16
South East (Carlow, Kilkenny, Waterford, Wexford, South Tipperary)	13	21	22
Western (Galway, Mayo, Roscommon)	5	2	10
Mid West (Clare, Limerick, North Tipperary)	5	8	13
Total	42	67	99

Source: HSE unpublished data, 2015

An average of 933 individuals attended pharmacy-based needle exchanges each month in 2013 (compared to a monthly average of 360 in 2012). The number of individual drug users availing of sterile injecting equipment increased from 583 in January 2013 to 1,073 in December 2013 (Figure 1.5.3.2). The majority (78%) of individual attenders were male, and had an average age of 32 years; the average age of female attendees was 30 years.

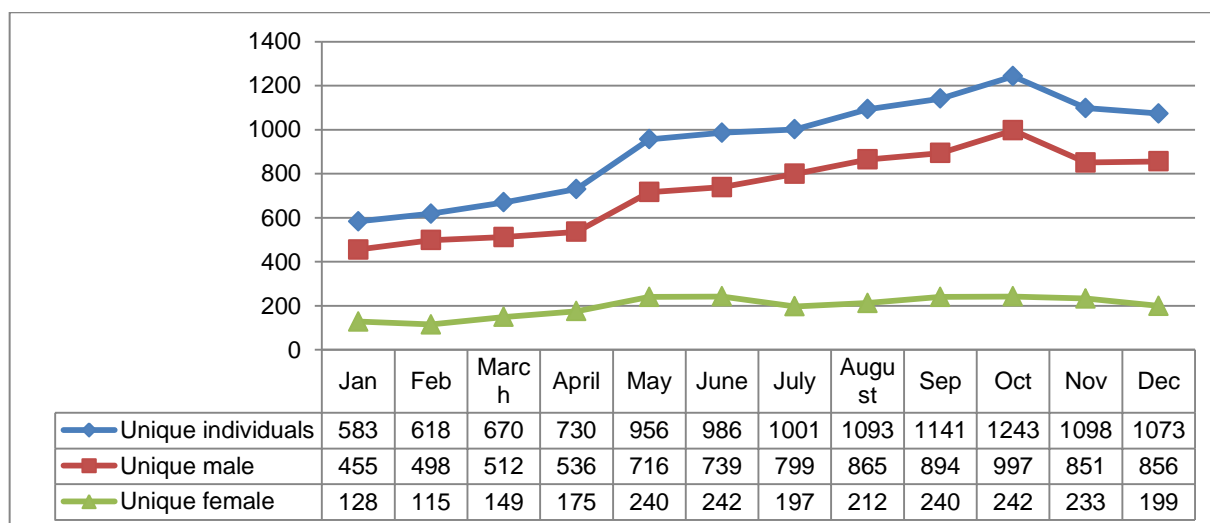


Figure 1.5.3.2 Number of transactions at pharmacy-based needle exchanges, packs distributed, and used packs returned, 2013

Source: HSE unpublished data, 2015

In 2013 the pharmacy-based needle exchanges provided a link between harm reduction services and drug treatment services through referring individuals for BBV testing (402), hepatitis B vaccination (262) and to tier three and tier four services (436).

Merchants Quay Ireland Review 2013

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and for drug users. Its needle exchange health promotion unit provides drug users with information about risks associated with drug use and the means to minimise such risks. It also provides drug users with a pathway into treatment and the possibility of living life without drugs. In September 2014 MQI published its annual review for 2013 (Merchants Quay Ireland 2014). In 2013, there were 25,190 visits to MQI's Drug Services and 22,898 needle exchanges, which was a 10% increase over 2012. In total, 3,260 individuals used the service, and of these, 614 were new clients. A total of 1,748 safer injecting workshops were undertaken with injecting drug users.

MQI, in association with the Midland Regional Drugs Task Force and the HSE, administer the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. The harm reduction service worked with 263 clients during 2013, providing 2,975 harm reduction interventions. An average of 257 needle exchanges were provided each month during the year.

2. Trends

2.1 Short term trends in drug-related harms and harm reduction services

a) Trends in drug-induced deaths among adults

The number of drug-induced deaths has fluctuated over the past five years (2009 to 2013), from 216 deaths in 2009 to a peak of 232 deaths in 2011; the number then decreased to 189 in 2012 but increased again in 2013 to 219. Reasons for the fluctuation are not known. The majority of those who died over the period were male, with a gradual increase in mean age from 34.5 years in 2009 to 36.5 years in 2013 (see also Sections 1.1.1 – 1.1.4 above).

Opiates continued to be associated with most poisoning deaths over the period. Of note, the number of cases where heroin was implicated increased in 2013 for the first time since 2009, to 86 deaths. The reason for this increase is not known.

b) Trends in prevalence and notifications of infectious diseases

- i) HIV – as outlined in Figure 3.2.1 below, there has been an increase in notifications of recently acquired HIV among PWID in Dublin, since June 2014. Clinicians from the drug services were concerned that the increase could possibly be linked to injection of a synthetic cathinone PVP, with the street name ‘Snow Blow’. However, epidemiological investigations are still under way and it is too early to draw any definite conclusions.
- ii) Hepatitis C (HCV) – as outlined in Section 1.3.1 above, there has been a downward trend in HCV notifications since peak numbers (1,541) were recorded in 2007. The median age at notification has increased steadily since notification began in 2004, from 32 to 39 years in males and from 29 to 36 years in females. Decreasing HCV notifications and increasing median age are indicative of a reduced incidence of HCV in the population.

c) Drug-related acute emergencies

Trends over time indicate a decrease in overdose cases admitted to Irish hospitals, falling from 5,012 cases in 2005 to 4,233 cases in 2013. Rate of first-time admission to psychiatric units with a diagnosis of drug disorder for 2013 remains similar to that in 2012 at 8 per 100,000 population.

d) Number of syringes distributed to injecting drug users

Since the pharmacy-based needle exchange programme was established in October 2011, the number of pharmacies providing needle exchange has increased from 42 at the end of 2011 to 99 by the end of 2013. The number of people attending these services also increased from on average 306 per month in 2012 to 933 per month in 2013. The expansion in these services forms part of Action 34 in the current National Drugs Strategy and the increase in numbers reflects the expansion in service availability. Full details of the pharmacy-based needle exchange programme are provided in section 1.5.3 above.

3. New developments

3.1 New developments in drug-related deaths

Naloxone demonstration study

A naloxone demonstration project is currently under way in the country (see <http://www.drugs.ie/resources/naloxone/> or (Lyons 2014)). The aim of the project is to assess and evaluate the suitability and impact of using naloxone in Ireland in order to make naloxone more widely available for problem opiate users. Up to 600 problem opiate users will receive a pre-filled syringe of naloxone on prescription along with training on how to administer it and also how to recognise the signs of overdose.

The HSE is commissioning an independent external evaluation of both the processes and outcomes of the project. It should be completed by the end of 2015.¹

The aim of the process evaluation is to determine the nature and quality of the programme implemented by examining:

1. the implementation of the main elements of the programme,
2. the nature and quality of the training sessions, and
3. participants' views of the programme as a whole.

The aim of the outcome evaluation is to explore:

1. learning and other outcomes from the training sessions,
2. practical application of naloxone in overdose events,
3. practical application of other harm-reduction actions in overdose events, and
4. the effect of naloxone in reducing the number of fatal overdoses.

3.2 New developments in drug-related infectious diseases

Increase in diagnoses of recently acquired HIV in people who inject drugs in Dublin

In July 2015 the Health Protection Surveillance Centre (HPSC) reported that an increase in notifications of recently acquired HIV among people who inject drugs (PWID) in Dublin, had been occurring since June 2014 (Health Protection Surveillance Centre 2015). The report defined recently acquired HIV infections as those in which the person who tests positive is p24 antigen positive, or has had an HIV negative test within the previous 12 months or suffers an acute HIV sero-conversion illness. Clinicians from the drug services were concerned that the increase could possibly be linked to injection of a synthetic cathinone PVP, with the street name 'Snow Blow'. In response, an epidemiological investigation was instigated.

The report stated that 15 cases of recently acquired HIV infection (confirmed cases) and one case with an epidemiological link to a recently acquired HIV infection (probable case) diagnosed among PWID had been reported between June 2014 and June 2015 (Figure 3.2.1). Of these, 11 were male and five were female, and the mean age was 35 years (range 24 to 51 years). Of the 15 confirmed cases, seven were p24 antigen positive, indicating very recent infection. At the time of reporting, a further 16 possible cases were under investigation and new cases continued to be detected.

¹ See http://www.drugs.ie/news/article/extended_deadline_to_initial_call_evaluation_of_the_hse_naloxone_demonstrat

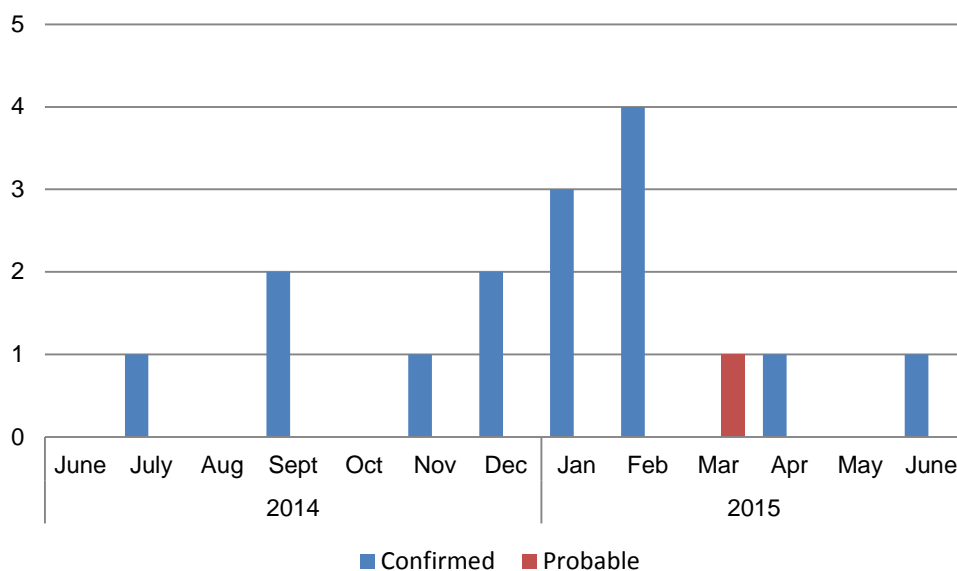


Figure 3.2.1 Number of confirmed and probable HIV diagnoses among PWID in Dublin by month of first diagnosis, June 2014–June 2015 (N=16)

In response to the increased incidence of HIV, the following immediate control measures are being implemented:

- provision of antiretroviral therapy to PWID diagnosed with HIV, where possible, and contact tracing to detect any additional cases among sexual or drug sharing partners;
- review of clients attending drug services, to identify those most at risk, and offering urgent HIV testing;
- pilot point of care testing (POCT) of PWID clients attending the Safety Net homelessness services;
- enhanced surveillance to identify new HIV cases as early as possible, including mode of transmission;
- awareness raising among clients, clinicians, networks of PWID and other stakeholders;
- provision of greater access to needle exchange and other preventive activities within the drugs and homelessness hostel services and prisons. The need for additional measures, including the provision of extended opening hours for needle exchange, is being evaluated;
- development and distribution of communications material, aimed at raising awareness of the risk of HIV among PWID, posed by unsafe injections and unsafe sex. This is available on the HPSC website;
- active case finding including Recent Infection Testing of possible cases; and
- phylogenetic analysis of cases.

3.3 New developments in harm reduction interventions

Low-threshold residential stabilisation service (LTRSS) demonstration project In June 2014 the Ana Liffey Drugs Project (ALDP) published a position paper proposing the provision, on a three-year demonstration basis, of a low-threshold residential stabilisation service (LTRSS). The paper outlines the concept of LTRSS and how this differs from current services as well as describing how the service would operate and the steps required to begin implementation (Ana Liffey Drug Project 2015). The ALDP is currently seeking funding and a premises to operate the service on a demonstration basis for three years beginning in 2017.

The overall aim of an LTRSS is to provide a 'genuine person-centred service, catering for those with greatest need'. The paper describes LTRSS as follows:

- low threshold – barriers to entry are kept as low as possible;
- residential – medically-led inpatient programme, with psycho-social support and follow-up care;

- stabilisation – stabilising the individual’s drug use, as well as providing detoxification (if appropriate) and referral to community or residential services;
- access to the service based on individual need, as measured by a comprehensive assessment tool; and
- time-bound (no more than a 28-day stay), but flexible to meet the client’s needs.

The proposed new service is described as differing from services currently available in Ireland in that it is open access, based on a holistic assessment of need and not determined by the individual’s drug use. There would be no cost to the client. Outcomes would not be solely clinically based but would also focus on enhanced stability.

The paper argues that services for polydrug users require particular attention. Polydrug use is a significant factor in drug-related deaths and as Ireland has one of the highest rates of drug-related deaths in Europe, there is a very strong rationale for the development of residential services which are not restricted to single drug use and which are responsive to the chaotic lifestyles of polydrug users. The paper states that polydrug users’ access to the majority of existing residential stabilisation and detoxification services is restricted, and that an LTRSS would provide a more flexible treatment model adapted to the needs of this particular at-risk group.

At the same time, the paper recognises that the client’s presenting needs, as opposed to the potential clinical outcome, should be the primary determinant of service provision. The paper lists patient characteristics that can help determine whether a client is likely to benefit from in-patient provision. These include:

- dependence on more than one drug,
- physical complications,
- co-morbidity,
- history of complications during previous withdrawals,
- chaotic polydrug use,
- pregnancy,
- failed outpatient withdrawal, and
- inability to cope with out-patient withdrawal owing to isolation, homelessness or lack of support.

The proposed LTRSS would target those presenting with these characteristics through a comprehensive assessment process.

The LTRSS would provide a 24-hour, seven-days-a-week programme based on the following principles:

- *Access based on the person’s need at the time of presentation:* when a bed becomes available, the person with the greatest need would be offered a place; there would be no waiting list.
- *Limited length of stay:* maximum stay of approximately 28 days depending on need; the goal would be stabilisation with an option for detoxification.
- *Type or level of drug use not a barrier to entry:* Polydrug users and those with comorbid mental health issues will not be excluded except where the individual’s mental or physical health is a barrier to their receiving the stabilisation service.

4. Notes and queries

4.1 Evidence of an increase in acute emergencies or deaths related to stimulants

Drug-induced deaths – small increase in the number of deaths where cocaine was implicated – see Section 1.1.2 above.

No increase in acute emergencies but a reduction in overdoses involving cocaine from 82 in 2011, to 71 in 2012 and 60 in 2013.

5. Sources and references

5.1 Sources

Established in 2005, the [National Drug-Related Death Index \(NDRDI\)](#), which is maintained by the HRB, is an epidemiological database which records cases of death by drugs poisoning, and deaths among drug users in Ireland, extending back to 1998. The NDRDI also records data on alcohol-related poisoning deaths, deaths among those who are alcohol dependent, extending back to 2004.

The [Health Protection Surveillance Centre \(HPSC\)](#) is Ireland's specialist agency for the surveillance of communicable diseases. Part of the Health Service Executive (HSE), and originally known as the National Disease Surveillance Centre, the HPSC endeavours to protect and improve the health of the Irish population by collating, interpreting and disseminating data to provide the best possible information on infectious disease. The HPSC has recorded new cases among injecting drug users of HIV since 1982, hepatitis B (HBV) since 2004, and hepatitis C (HCV) since 2006.

The [HIPE \(Hospital In-Patient Enquiry\)](#) is a computer-based health information system, managed by the Economic and Social Research Institute (ESRI) in association with the Department of Health and the HSE. It collects demographic, medical and administrative data on all admissions, discharges and deaths from acute general hospitals in Ireland. It was started on a pilot basis in 1969 and then expanded and developed as a national database of coded discharge summaries from the 1970s onwards. Each HIPE discharge record represents one episode of care; each discharge of a patient, whether from the same or a different hospital, or with the same or a different diagnosis, gives rise to a separate HIPE record. The scheme, therefore, facilitates analyses of hospital activity rather than of the incidence of disease. HIPE does not record information on individuals who attend accident and emergency units but are not admitted as inpatients.

The [National Psychiatric In-Patient Reporting System \(NPIRS\)](#), administered by the Health Research Board (HRB), is a national psychiatric database that provides detailed information on all admissions to and discharges from 56 inpatient psychiatric services in Ireland. It records data on cases receiving inpatient treatment for problem drug and alcohol use. NPIRS does not collect data on the prevalence of psychiatric comorbidity in Ireland. The HRB publishes an annual report on the data collected in NPIRS, entitled *Activities of Irish psychiatric units and hospitals*.

The [National Self-Harm Registry Ireland](#) is a national system of population monitoring for the occurrence of deliberate self-harm, established at the request of the Department of Health and Children by the National Suicide Research Foundation. Since 2006/07 the Registry has achieved complete national coverage of hospital-treated deliberate self-harm. The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences'. All methods of deliberate self-harm are recorded in the Registry, including drug overdoses and alcohol overdoses, where it is clear that the self-harm was intentionally inflicted. All individuals who are alive on admission to hospital following a deliberate act of self-harm are included. Not considered deliberate self-harm are accidental overdoses, e.g. an individual who takes additional medication in the case of illness, without any intention to self-harm; alcohol overdoses alone, where the intention was not to self-harm; accidental overdoses of street drugs (drugs used for recreational purposes), without the intention to self-harm; and individuals who are dead on arrival at hospital as a result of suicide.

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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 EU agency based in Lisbon. The EMCDDA provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the European Union 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 Centre 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. 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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