# Ireland: national report for 2015 - Treatment

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

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## 0. Summary

National Profile
The current National Drugs Strategy (2009 to 2016) sets out a range of priorities, each with associated actions, for drug treatment. The over-arching categories are development of general problem drug use treatment services; targeting of services for specific at-risk groups; development of a quality and standards framework; and training and skills development. The Health Service Executive (HSE) is responsible for the provision of all publicly funded drug treatment. Drug treatment is therefore provided through a network of HSE services (public), but also non-statutory/voluntary agencies, many of which are funded by the HSE. Some private organisations also provide treatment.

In 1998 a methadone treatment protocol (MTP) was introduced to ensure that treatment for problem opiate use could be provided wherever the demand existed. Outpatient methadone treatment for problem opiate users is provided only through specialised HSE outpatient drug treatment clinics, satellite clinics or through specialised general practitioners (GPs) in the community. Almost all opiate substitution treatment (OST) provided is methadone. Buprenorphine in combination preparations is not routinely available in Ireland.

Trends
The majority of drug treatment (over 75%) is provided through publicly funded and voluntary out-patient services. Outpatient services include low threshold and specialised OST GPs in the community. In-patient treatment is mainly provided through residential centres run by voluntary agencies. The proportion of clients attending in-patient services (excluding prisons) has dropped slightly over the past 11 years from 15% in 2004 to 14% in 2014.

Opiates (mainly heroin) are the main problem drug used by entrants to treatment, followed by cannabis and cocaine. The proportion of all entrants to treatment reporting an opiate as their main problem drug has decreased year-on-year since 2004, from a peak of 65% in 2004 to 50% in 2014. Over the period, cannabis has been consistently reported as the second most common main problem drug, with the proportion increasing from 21% in 2004 to 28% in 2014. The numbers presenting for treatment for problem cocaine use was highest in 2007 at 13%, dropping steadily until 2012, but increasing again in 2014 to 9%. For new clients to treatment, cannabis has been the main problem drug since 2010, replacing opiates (mainly heroin).

The majority of cases have been previously treated. The proportion of new entrants to treatment has fluctuated from 39% in 2004, to a peak of 47% in 2009 and down to 40% in 2014.

The majority of OST clients receive methadone in specialist outpatient clinics, with a smaller number receiving it from specialist GPs and a yet smaller proportion (less than 5%) in prison. The number of clients registered for OST on 31 December each year has increased from 3,689 in 1998 to 9,764 in 2014.

## 1. National profile

### 1.1 Policies and coordination

#### 1.1.1 Main treatment priorities in the national drug strategy

**Treatment and rehabilitation in the National Drugs Strategy**

The current National Drugs Strategy(2009–2016) broadened the approach to treatment and rehabilitation beyond tackling the consequences of problem drug use, especially opiates in disadvantaged areas, to developing a comprehensive substance treatment service capable of dealing with all substances, particularly given the increasing geographic dispersal of problem drug use (including opiates), the increased prevalence of polydrug use and cocaine use, the increasing strength of cannabis, as well as the pervasive misuse of alcohol and the level of misuse of prescription drugs in society (Department of Community 2009).

The Steering Group that developed the National Drugs Strategy was also conscious of the need to bring greater coherence and co-ordination to alcohol and drug issues at a policy, planning and operational level. In this context, the Group strongly endorsed the approach of the Health Service Executive (HSE), which was reorienting its addiction services towards polydrug use (including

alcohol), and using the four-tiered model as the national framework through which to deliver services. The integration of treatment services within the context of the National Drugs Strategy relates to the integration of addiction services and the development of appropriate pathways to and from general health service provision.

**Priorities in relation to treatment and rehabilitation in the National Drugs Strategy**
The overall strategic objective and aims, and operational targets and key performance indicators, set in the National Drugs Strategy, including those for Treatment and Rehabilitation, are outlined in Section 1.1.1 of the *national report for 2015 -* policy.

Below are the 'priorities' for treatment and rehabilitation services between 2009 and 2016 as set out in the National Drugs Strategy, together with progress in delivering on the priorities. This information is taken from the annual progress report on the implementation of the actions in the National Drugs Strategy (NDS) in 2014 (Department of Health 2015).

***Development of general problem substance use services***

- *Develop an integrated national treatment and rehabilitation service for all substances, using a 4-tier model approach, underpinned by an appropriate clinical and organisational governance regime*
  Action 32 in the NDS: People who present for addiction treatment are offered a range of interventions including initial assessment, comprehensive assessment, Minnesota Programme, brief intervention, individual counselling etc. HSE Substance Misuse services provide care and onward referral to other statutory and voluntary groups where appropriate (see Section T1.1.2 below).
- *Maximise operational synergies between Drug Addiction Services, Alcohol Treatment & Rehabilitation Services, General Hospital Services and Mental Health Services*
  Action 33 in the NDS: Each client receives a personalised care plan based on their individual needs, including mental health needs.
- *Expand the availability of detox facilities, opiate substitution services, under-18 services and needle exchange services where required*

  Action 34 in the NDS: The progress report reported on national availability of detox facilities, OST, under-18 services and needle exchange services. The most recent data are provided below (Detox. 1.2.4 and 1.4.3, and OST 1.4.5–8 and 2.1), and in the *national report for 2015 -* harms and harm reduction (needle exchange 1.5.2–3 and 2.1).

- *Implement the recommendations of the Report of the Working Group on Drugs Rehabilitation, and the Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse)*

  Action 32 in the NDS: The implementation of the National Drugs Rehabilitation Framework (NDRF) has been a priority for the HSE in its 2014 and 2015 service plans. Engagement with the Rehabilitation Framework is also a requirement in all Task-Force-funded treatment rehabilitation projects. The number of residential beds has increased significantly since 2007, when the Report of the HSE Working Group on Residential Treatment and Rehabilitation was published (O'Gorman and Corrigan 2008), largely owing to the increased provision of beds in community-based residential facilities. HSE areas have developed structured funding/referral process for service users looking to access residential treatment within their areas.
- *Establish a drugs interventions programme, incorporating a treatment referral option, for those who come to the attention of the Gardaí due to behaviour caused by substance misuse*
  Action 38 in the NDS: A 'Pathways to Support' programme has been developed incorporating a treatment referral option for young people arrested by the Gardaí. The Garda Síochána are examining how to implement this programme.

***Specific Groups***

- *Further develop engagement with, and the provision of services for, specific groups including Prisoners, Homeless, Travellers, New Communities, LGBTs and Sex Workers*

Actions 41–44 in the NDS: The treatment and rehabilitation needs of vulnerable groups including travellers, LGBTs, new communities and sex workers, as well as other groups such as families of drug users, service users and drug users, drug users in prisons, are being addressed on an ongoing basis.

***Quality and standards framework***

- *Develop a clinical and organisational governance framework for all treatment and rehabilitation services*
  Action 45 in the NDS: A clinical and organisational governance framework for all treatment and rehabilitation services has been developed by the Quality Standards Support Project (QSSP) of the Ana Liffey Drugs Project with the support of the HSE. The resources and supports can be found on line at www.drugs.ie/quality

***Training and skills development***

- *Develop national training standards for all those involved in the provision of substance misuse services, and co-ordinate training provision within a single national substance misuse framework*

  Action 47 in the NDS: The HSE's National Addiction Training Programme (NATP) was developing a supportive statement for the development of a workforce development plan to support staff and ultimately to improve outcomes for service users and their families. The voluntary sector, key academic institutions, drugs and alcohol task forces and other relevant partners were to be consulted on this in 2015, and this was to be the basis for a national training needs analysis also to be carried out in 2015.

### 1.1.2 Governance and coordination of drug treatment implementation

Established by the Health Act 2004, the Health Service Executive (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 Social Inclusion Services, which is part of the HSE's Primary Care Division. This Division promotes and leads on integrated approaches to health care 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.

Introduced in 2015, the HSE's new 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 (NSP) and the Primary Care Division Operational Plan (PCD OP). The achievement of 'improved health outcomes for persons with addiction' is a priority in the 2015 NSP, and the related PCD OP lists seven actions associated with this priority (Health Service Executive 2014). Progress in implementing these actions is reviewed regularly throughout the year, and actions to address variances considered.

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 drugs and alcohol task forces, which receive annual funding of over €20 million annually. This funding is governed by way of Service Arrangements and Grant Aid Agreements. The HSE's Primary Care Division assists the drugs projects 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.

### 1.1.3 Further aspects of drug treatment governance

In 1998 a methadone treatment protocol (MTP) was introduced, to ensure that treatment for problem opiate use could be provided wherever the demand exists (Methadone Prescribing Implementation Committee 2005, Methadone Treatment Services Review Group 1998). New regulations pertaining to the prescribing and dispensing of methadone were introduced. General practitioners who wish to prescribe methadone in the community must undergo formalised training and the number of clients they can treat is capped, depending on experience. See Section 1.4.8 below for an account of a review of the MTP and progress in developing national clinical guidelines for opiate treatment.

The Central Treatment List (CTL) was established under Statutory Instrument No 225 following the Report of the Methadone Treatment Services Review Group 1998 (Methadone Treatment Services Review Group 1998). This list is a complete register of all patients receiving methadone (for treatment of opiate misuse) in Ireland and is administered by the HSE National Drug Treatment Centre.[1]

## 1.2 Organisation and provision of drug treatment

### 1.2.1 Outpatient drug treatment system – Main providers

Summary of Table I.2.1: outpatient services are provided through a network of HSE services (public) and non-statutory, voluntary agencies (see also 1.1.2 and 1.4 in this workbook). Many of the non-statutory, voluntary agencies are partly funded by the HSE. 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 Mental Health Division of the HSE.

**Table I.2.1 Network of outpatient treatment facilities (total number of units)**

| | Total number of units | National Definition (Characteristics/ Types of centre included within your country |
|---|---|---|
| Specialised drug treatment centres | 300 | Treatment facilities where the clients are treated during the day (and do not stay overnight). They may open in the evening but where the opening time excludes the night. Include OST clinics, counselling, therapeutic day care and socio-economic training units |
| Low-threshold agencies | 75 | Aim to prevent and reduce health-related harm associated with drug dependence, in particular the incidence of blood-borne viral infections and overdoses, and to encourage active drug users to contact health and social services. May provide low dose OST, general medical assistance, brief interventions and needle exchange. |
| General/ Mental health care | | Provided through the mental health directorate of the HSE or funded by the mental health directorate. Not included in the TDI data. |
| Prisons | | See inpatient facilities |
| Other outpatient units | 346 | Specially trained general practitioners who provide OST in primary care |
| Other outpatient units | | |

Source: Standard table 24

### 1.2.2 Outpatient drug treatment system – Client utilisation

Summary of Table I.2.2: over 75% of all addiction treatment over the past 11 years has been provided by outpatient services. It is not possible to estimate the total number of clients in the national network as there is no information on those centres that do not report to TDI. However, analysis of the TDI data shows that in 2014, 77.7% of all cases were treated in outpatient services.

[1] www.addictionireland.ie

Only stable opiate substitution treatment (OST) clients are treated by specialised OST GPs in the community (see also 1.4.5 below).

**Table I.2.2 Total outpatient treatment provision (number of clients)**

| | **Total number of clients** | National Definition (Characteristics) |
|---|---|---|
| Specialised drug treatment centres | It is not possible to estimate the total number of clients in the national network as there is no information on those centres that do not report to TDI | Treatment facilities where the clients are treated during the day (and do not stay overnight). They may open in the evening but where the opening time excludes the night. Include OST clinics, counselling, therapeutic day care and socio-economic training units |
| Low-threshold agencies | It is not possible to estimate the total number of clients in the national network as there is no information on those centres that do not report to TDI | Aim to prevent and reduce health-related harm associated with drug dependence, in particular the incidence of blood-borne viral infections and overdoses, and to encourage active drug users to contact health and social services. May provide low dose OST, general medical assistance, brief interventions and needle exchange. |
| General/ Mental health care | | Provided through the mental health directorate of the HSE or funded by the mental health directorate. Not included in the TDI data. |
| Prisons | n/a | See inpatient facilities |
| Other outpatient units | It is not possible to estimate the total number of clients in the national network as there is no information on those centres that do not report to TD | Specially trained general practitioners who provide OST in primary care. |
| Other outpatient units | | |

Source: Standard table 24

### 1.2.3 Further aspects of outpatient drug treatment provision and utilisation

General practitioners (GPs) are medical practitioners who treat acute and chronic illnesses and provide preventive care and health education for all ages and both sexes. They may treat drug users for their drug problems, in some cases in liaison with outpatient or inpatient drug services, and some of them may have a specific training on the treatment of drug users. Those who have completed the specialist training can provide OST to clients who are stable. For further information, see Section 1.4.5 below.

### 1.2.4 Inpatient drug treatment system – Main providers

Inpatient addiction treatment services are provided mainly through non-statutory agencies. Most of these agencies are partially funded by the HSE Table 1.2.4. There are two dedicated inpatient HSE detoxification units.

The mental health services also provide inpatient addiction treatment in 69 different hospitals. Figures from these services are not included in the annual TDI figures. For further information, see 'Drug admissions to psychiatric facilities' in Section 1.2.3 of *national report for 2015 - harms and harm reduction*.

**Table I.2.4. Network of inpatient treatment facilities (total number of units)**

| | **Total number of units** | **National Definition (Characteristics/ Types of centre included within your country** |
|---|---|---|
| Hospital-based residential | 2 | Two wards or units in hospitals where the clients may stay overnight. Also includes |

| | Total number of units | National Definition (Characteristics/ Types of centre included within your country |
|---|---|---|
| drug treatment | | 69 psychiatric hospitals. Psychiatric hospitals do not report to TDI. |
| Residential drug treatment<br><br>(non-hospital based) | | See other inpatient units (below) |
| Therapeutic communities | | See other inpatient units (below) |
| Prisons | 33 | Includes all addiction treatment provided in prisons, whether in-reach services or provided by the medical service of the prison |
| Other inpatient units | 48 | Defined as centres where the clients may stay overnight. They include therapeutic communities, private clinics, units centres that offer residential facilities. It is not possible to differentiate between residential in-patient and therapeutic communities so both reported together in this section |
| Other inpatient units<br><br>Source: Standard table 24 | | |

### 1.2.5 Inpatient drug treatment system – Client utilisation

It is not possible to estimate the total number of clients in the national in-patient network as there is no information on those centres that do not report to TDI (see Table 1.2.5). However, over the past 11 years, TDI data have shown that the proportion of clients treated in in-patient facilities (excluding prisons) has dropped slightly, from 15.3% in 2004 to 13.5% in 2014.

None of the 69 psychiatric inpatient hospitals described in Section 1.2.5 above report through TDI. However, the annual reports on admissions to psychiatric hospitals show that there was a 17% decline in overall psychiatric admissions for addiction in the 10 years between 2004 and 2014 (Daly and Walsh 2014).

**Table 1.2.5 Total inpatient treatment provision (number of clients)**

| | Total number of clients | National Definition (Characteristics) |
|---|---|---|
| Hospital-based residential drug treatment | It is not possible to estimate the total number of clients in the national network as there is no information on those centres that do not report to TDI | Two wards or units in hospitals where the clients may stay overnight. Also includes 69 psychiatric hospitals. Psychiatric hospitals do not report to TDI. |
| Residential drug treatment<br><br>(non-hospital based) | n/a | See other inpatient units (below) |
| Therapeutic communities | n/a | See other inpatient units (below) |
| Prisons | It is not possible to estimate the total number of clients in the national network as there is no information on those centres that do not report to | Includes all addiction treatment provided in prisons, whether in-reach services or provided by the medical service of the |

| | | |
|---|---|---|
| | TDI | prison |
| Other inpatient units | It is not possible to estimate the total number of clients in the national network as there is no information on those centres that do not report to TDI | Defined as centres where the clients may stay overnight. They include therapeutic communities, private clinics, units centres that offer residential facilities. It is not possible to differentiate between residential in-patient and therapeutic communities so both reported together in this section |
| Other inpatient units | | |

Source: Standard table 24

## 1.3 Key data

### 1.3.1 Summary table of key treatment related data and proportion of treatment demands by primary drug

Opiates (mainly heroin) and cannabis are the two main drugs for which cases sought treatment in Ireland in 2014.

Just under half (49.8%) of all cases entering treatment in 2014 reported opiates as their main problem drug (see Figure 1.3.1 and Table 1.3.1). This is similar to 2013, when 51.3% of all cases entering treatment reported opiates as their main problem drug. Heroin is the main drug in this category, representing 89.2% of all those reporting an opiate, similar to 2013 when 89.1% reported heroin as their opiate.

The majority (72.8%) of those reporting an opiate as their main problem drug had been previously treated, compared to 73.9% in 2013.

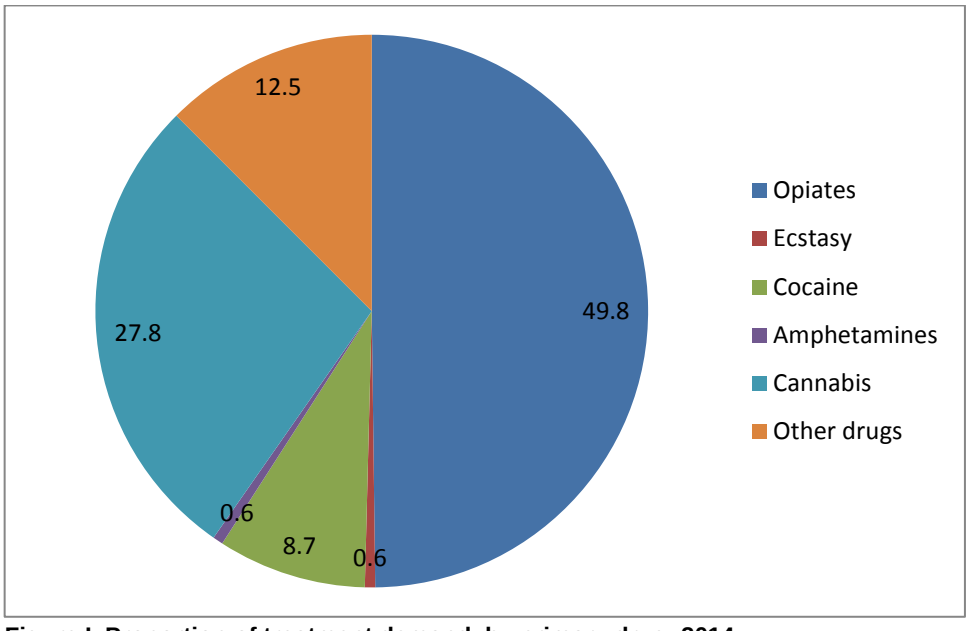



**Figure I Proportion of treatment demand, by primary drug, 2014**
Source: TDI

**Table 1.3.1 Summary table – Clients in treatment**

| | |
|---|---|
| **Opiates (mainly heroin)** | 4,745 |

| | |
|---|---|
| **Cannabis** | 2,645 |
| **Other drugs (mainly benzodiazepines)** | 1,194 |
| **Cocaine** | 828 |

Source: ST24 and TDI

| | **Number of clients** |
|---|---|
| **Total clients in treatment** | 9,523 (source TDI) |
| **Total OST clients** | 9,764 (source Central Treatment List) |
| **Total All clients entering treatment** | Data on OST and TDI are from different sources, collected using different methodology, also with some duplication, so therefore cannot be combined or compared meaningfully |

Source: ST24 and TDI

The next most common drug reported was cannabis. Twenty-nine per cent of cases reported cannabis as their main problem drug, identical to the percentage reported in 2013. The majority (64.1%) of those reporting cannabis as their main problem drug had never been treated before, compared to 65.0% in 2013.

Cocaine was the next most illicit common drug reported, with 8.7% in 2014, compared to 7.8% in 2013. Similar proportions of cases presenting had never been previously treated (51.2%) and had been previously treated (43.2%). This is the same pattern as in 2013 (47.1% and 47.6% respectively, with treatment status unknown for 5.3%).

Amphetamines and ecstasy make up a very small proportion of the main problem drugs reported, 0.6% and 0.6%. This is almost identical to 2013, when 0.6% of cases reported amphetamines as their main problem drug, and 0.5% reported ecstasy as their main problem drug.

Benzodiazepines comprise the majority of the 'other drugs' category. Seventy-seven per cent of cases reported benzodiazepines as their main problem drug in 2014, compared to 81.6% in 2013. There were more cases in 2014 reporting a benzodiazepine as their main problem drug (9.6%) than reporting cocaine (8.7%). A slightly lower proportion (49.1%) of these cases in 2014 were previously treated, compared to 51.2% in 2013.

### 1.3.2 Distribution of primary drug in the total population in treatment

The results shown below describe the characteristics of young people attending the Matt Talbot Services in Cork between January 2005 and August 2011, and their patterns of drug use, in particular benzodiazepines (Murphy K*, et al.* 2014). The authors retrospectively reviewed client notes and extracted data of interest from the notes. Collecting complete data for each participant on all the variables of interest was not possible, and so the denominators for many characteristics vary depending on the completeness of the data relating to the individual variables. As a result, the proportions reported in the following account also vary.

A total of 198 client files were included in the study. Almost all the clients included in the study were male (98%). This is because originally the service was just for males and only started to accept females for treatment in 2010. The average age of clients was 16.4 years (range 13 to 21 years). Most clients (55/113, 49%) were referred by the Department of Justice, either through Juvenile Liaison Officers or Probation Officers.

Almost all (182/187, 99%) had ever drunk alcohol, with half starting at 13 years or younger. After alcohol, most had also used cannabis (170/181, 94%) and tobacco (153/165, 93%). The next most prevalent drug ever used was cocaine (88/162, 54%) and then benzodiazepines (80/157, 51%).

Of the 80 clients who reported ever using benzodiazepines, one third (28/80, 35%) had used them at least once a week, and half (43/77, 56%; data on time of last use were not available for three) had used them in the previous month (classified as regular users). The average age of first use of benzodiazepines was 14.9 years.

The characteristics of regular benzodiazepine users were compared with non-regular users. Regular users were significantly more likely to be regular users of other drugs. There were also statistically significant differences between behavioural and physical symptoms. Regular users were more likely to report paranoia, loss of interest in sports or hobbies, attention-seeking behaviour, pale/white skin, and vomiting. Skin pallor is well-known to be associated with benzodiazepine withdrawal and can last several weeks.

The study had limitations. Information was missing for many of the variables because data were extracted retrospectively from client notes so the results were not comprehensive. More data on psychosocial and clinical systems, which could have been collected through a tailored questionnaire, would have helped to provide a more comprehensive understanding of the clients.

The authors note that benzodiazepines had been used by many of the young people attending the service over the period and that many of them were regular users. Regular users were more likely to suffer from known side-effects of the drug such as paranoia. The authors urged greater awareness among health professionals of the acute and chronic negative consequences associated with benzodiazepine use in young people as described in their study.

### 1.3.3 Further methodological comments on the Key Treatment-related data

Coverage of the National Drug-Related Treatment System (NDTRS), through which the TDI data are reported, has remained consistently high at over 70%. However, as there is no national unique health identifier, duplication can only be controlled for within treatment centres, not at a national level. Therefore a person may be counted more than once if they attend more than one treatment centre within the same calendar year.

NDTRS data undergo at least two levels of cleaning and validation before being submitted to the EMCDDA. There is on-going feedback of problems and training to ensure the completeness and validity of the data.

## 1.4 Treatment modalities

### 1.4.1 Outpatient drug treatment services

The types of treatment and services offered vary depending on the service. 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 activities, e.g. vaccinations (see also Section 1.4.5 below). Other services, which do not offer OST, may provide a wide variety of treatments including counselling, group therapy, socio-economic training, complementary therapies, relapse prevention etc.

### 1.4.2 Further aspect of available outpatient treatment services

In recent years, people have been able to undergo methadone and benzodiazepine detoxification in the community, rather than having to wait for admission to an in-patient unit, supported by outpatient services using a set of standardised protocols (Dermody and Lyons 2012).

### 1.4.3 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 service offer a wide range of treatments including counselling, group therapy, social/occupational activities, family therapy, complementary therapies and aftercare.

**Detoxification**

There are two dedicated HSE hospital in-patient detoxification units. Some residential centres provided by voluntary/non-statutory services also offer detoxification as part of their suite of treatments.

**Prison**
Addiction treatment in prison is provided by the prison medical service. Treatments include detoxification, OST and psychiatric treatment, while counselling is provided by in-reach services.

**In-patient psychiatric hospitals**
Addiction treatment provided in psychiatric hospitals includes psychiatric treatment, detoxification and any other medical treatment as required by the client.

### 1.4.4 Treatment outcomes and recovery from problem drug use

An evaluation of an educational substance use recovery and fitness programme, 'The Boxing Clever programme', found that the programme had a number of positive outcomes (Morton*, et al.* 2015). The programme aimed to support participants to develop more resilient identities, while encouraging educational achievement, physical wellness and reduction in harmful or risky behaviours. The authors of the report concluded that their research not only demonstrated the important role education and sport can play in substance use rehabilitation, but also the importance of inter-agency work in achieving the goals of rehabilitation and reintegration. Some of the positive outcomes included:

- Sport and physical exercise helped improve mood.
- The majority of participants completing the programme maintained their drug-free status or reduced their drug use, and attributed this to their participation in the programme.
- The programme supported and facilitated the majority of participants to achieve a Quality and Qualifications Ireland (QQI) minor award at levels 4 and 5, which is seen as a vehicle for further education.
- The California Assessment of Stigma Change (CASC) element of the programme was pivotal in supporting participants to understand substance use within their family of origin and the wider community.

The authors identified two major limitations to their research: (1) the sample size was small, with only 17 programme participants engaging in the research process, and (2) the research considered the immediate impacts and outcomes for participants. The authors called for further research to consider the 'long term impact and outcome of programmes that seek to build social and human capital, particularly those that utilise both fitness and education in the programme delivery' (pp. 57–58).

### 1.4.5 Main providers/organisations providing Opioid substitution treatment

Outpatient methadone maintenance treatment (MMT) for problem opiate users is provided only through HSE drug treatment clinics, satellite clinics or through specialised GPs in the community. MMT is provided free of charge. Under the methadone treatment protocol (MTP), GPs in the community are contracted to provide MMT at one of two levels – Level 1 or Level 2. Level 1 GPs are permitted to maintain methadone treatment for problem opiate users who have already been stabilised on a methadone maintenance programme. Each GP qualified at this level is permitted to treat up to 15 stabilised problem opiate users. Level 2 GPs are allowed to both initiate and maintain methadone treatment. Each GP qualified at this level may treat up to 35 problem opiate users. Practices where two Level 2 GPs are practising are permitted to treat up to 50 problem opiate users. These levels are currently being reviewed and may be revised upwards in the future.

In 2014, 54.6% of patients were receiving treatment in specialist outpatient clinics, 40.5% from GPs and 4.8% in prison. The proportion of clients receiving treatment from GPs has increased slowly but steadily over the years, from 31.7% in 2001 to 40.6% in 2014. The proportion of clients receiving treatment in specialist outpatient clinics has decreased, from 59.0% in 2008 to 54.6% in 2014.

### 1.4.6 Number of clients in OST

Almost all clients receive methadone as their opiate substitute. Buprenorphine in combination preparations is not routinely available in Ireland and less than 1% of clients receive it. The drug

suboxone, a combination of buprenorphine and naloxone, was licensed for use in 2006 in Ireland as an alternative to methadone for opiate dependency. In 2007 an expert group was set up to examine the regulatory framework for products containing buprenorphine/naloxone and buprenorphine-only (Expert Group on the Regulatory Framework 2011). The expert group considered a number of relevant documents, including an evaluation of a feasibility study on the use of suboxone in Ireland (Fitzgerald 2011). The group concluded that methadone is the drug of first choice for treating opiate dependency in Ireland, but that buprenorphine/naloxone may be appropriate for some patient cohorts in certain circumstances:

- patients already receiving treatment with buprenorphine/naloxone;
- patients with a specific medical condition where methadone is contraindicated, for example prolonged QT interval, an abnormal heart rhythm;
- patients who have never been prescribed methadone before, especially young patients, where detoxification is a primary goal of treatment;
- patients whose main problem drug is codeine or another pharmaceutical opioid; or
- patients whom the prescriber believes to have been stable for at least six months, particularly in regard to employment or education, and committed to compliance with the treatment.

The number of clients registered for MMT on 31 December each year is reported by the Central Treatment List (CTL) (see also Figure 2.1.2 in 2.1 below and Standard Table 24). On 31 December 2014, 9,764 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Comar, CTL). This is a slight increase (1.3%) on the previous year.

### 1.4.7 Characteristics of clients in OST

Of the 9,764 clients registered on the Central Treatment List (CTL) on 31 December 2014, the majority were male (69.2%). The proportion of men registered on the CTL has remained largely unchanged since 1998, never dropping below 66.5% or rising above 69.2%. In 2014 the largest proportion of clients (29.1%) were aged between 35 and 39 years, followed by 22.7% aged 30 to 34 years, then 17.7% aged 40 to 44 years, and 10.5% aged 25 to 29 years. This is the same trend recorded in 2013. No other characteristics are available for analysis from the CTL data.

#### Concurrent OST and benzodiazepine use

A recent study found that 84% of patients attending an opiate substitution treatment (OST) clinic in Dublin tested positive for benzodiazepines (Gilroy*, et al.* 2014). During the study period, 137 patients attended the clinic, of whom 115 (84%) tested positive for benzodiazepines.

The majority of participants were men (81%) and the median age was 35 years. Most (71%) reported daily or almost daily use of benzodiazepines. Participants reported using between zero and 24 tablets daily, but the majority (68%) used between zero and five tablets per day. Eighteen per cent reported using an average of 10 to 24 tablets per day. Just over half (51%) reported that they had maintained their reported pattern of use for less than one year. Nearly a third (30%) reported that they had maintained their pattern of use for three to five years. Diazepam was the most common type of benzodiazepine (94%), followed by flurazepam (35%). The majority (65%) of participants only used one type while the remainder (35%) used two or three types. Almost all participants (97%) used benzodiazepines orally, with only 3% injecting. Almost one third (30%) used benzodiazepines along with other drugs (48% alcohol, 39% heroin, 9% crack cocaine and 4% cannabis).

Half of all participants (50%) had a prescription for their benzodiazepines. Those who used illicit (street) benzodiazepines spent on average €40 a week (range €2 to €300). Most participants (87%) who only used prescribed benzodiazepines consumed one to five tablets per day while those who used illicit or mixed sources consumed on average a higher number of tablets per day.

#### Characteristics of prisoners receiving OST

See Galander et al. (Galander*, et al.* 2014) in Section 1.3.3 in *national report for 2015* - prison.

### 1.4.8 Further aspect on organisation, access and availability of OST

**Development of clinical guidelines for opiate treatment**

In April 2014 a draft of the clinical guidelines for opiate treatment was distributed to a wider group for consultation; the results of this consultation are still awaited (personal communication Suzi Lyons, Health Research Board). See Chapter 5.2.2.1 of the 2013 National Report (Health Research Board 2013) for a brief outline of the expected contents of the guidelines.

**Relapse in opioid substitution treatment (OST)**

A cross-sectional study of clients attending a large methadone clinic in Dublin was conducted in March 2012, with the aim of identifying the factors associated with relapse from OST and the reasons for the relapse (Darker*, et al.* 2015).

Almost two thirds (189, 63%) of the total 300 clients attending the clinic in March 2012 participated in the study. Participants were categorised into two groups: those who had a break in their OST (n=87, 46%) and those with no break in their OST (n=102, 54%).

The demographic profile of both groups was relatively similar. The majority were male and single. There was a very high level of unemployment in both groups, over 94%. A higher proportion of those with a break in OST were homeless (7.6% versus 1.1%), and co-habiting was more common among those with a break (34.5% versus 17.6%). The median age of those with a break was 33 years, slightly younger than those with no break (36 years).

Clinical factors were also similar in both groups, although just over half (52.3%) of those with a break in OST were taking a methadone dose of 60mls or less compared with only 32.4% of those with no break.

Of those who ever had a break in OST, most only reported one break (83.9%, 73). The length of break varied from less than one month to 18 months but the median duration was two months. Females were more likely to have shorter breaks compared to males but no other factors were found to be significant in relation to duration of OST.

Statistical analysis showed that age was the only *demographic* factor significantly associated with not having a break: older clients were less likely to have a break in OST. Three *clinical* factors were significantly associated with not having a break: current methadone dose higher than 60 mls, longer time in treatment, and less than one year in current treatment episode. In addition, although the numbers were small, nine out of the ten clients with a prescription for anti-psychotic medicine did not report a break in treatment.

The most common reasons for breaks in OST reported by the study participants were:

- 21.8% – relapse to drug use,
- 13.7% – 'fed up with methadone' and wanting to detox off,
- 11.4% – imprisonment or problems with the police,
- 10.3% – difficulty with travelling to the clinic or clinic times,
- 8.0% – being 'clean',
- 6.8% – being out of the country,
- 6.8% – emotional events, e.g. family bereavements,
- 3.4% – not wanting to take methadone while pregnant, and
- 3.4% – illness.

Reasons given for regular attendance were:

- 37.5% – wanting to get or stay 'clean',
- 16.1% – wanting to avoid sickness,
- 13.9% – methadone dependence,
- 10.2% – level of services provided by clinic,
- 5.1% – withdrawal symptoms,
- 5.1% – support from family members, and
- 4.4% – only having to attend a few times a week.

The findings of this study in relation to older age and higher methadone dose being predictors of retention in OST correspond with the findings of other national and international research studies.

The most common reason for break in treatment reported in other studies has also been relapse to drug use. While the study confirms that higher methadone doses may improve retention in treatment, the authors recommend that this should be balanced against the known side-effects of increasing the dosage, e.g. constipation, hypotension, drowsiness and increased dependence.

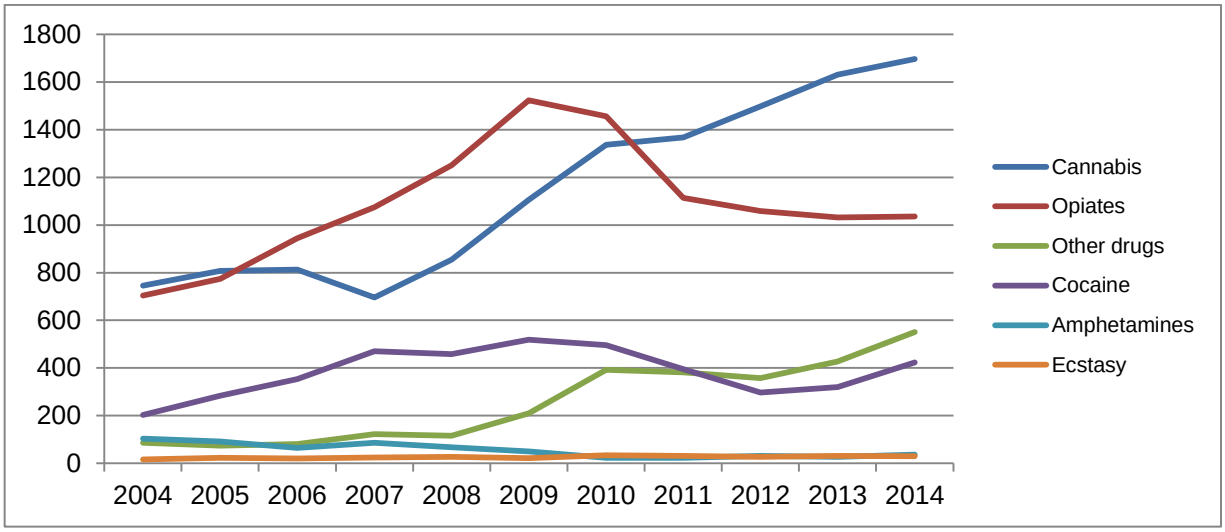
## 2. Trends

### 2.1 Long term trends in numbers of clients entering treatment and in OST

**New treatment entrants (Figure 2.1.1)**

In 2014 there were 3,774 new entrants recorded in the NDTRS (see also TDI table). This represents an increase of 8.8%, compared to 3,470 in 2013. New treatment entrants represented 39.6% of all cases in 2014. The proportion of new entrants in treatment has fluctuated slightly over the 10-year reporting period, from 39.3% in 2004 to a peak of 47.2% in 2009 and back to 39.6% in 2014.

Between 2006 and 2010 opiates (mainly heroin) were the main problem drug reported by new entrants, but this was superseded by cannabis in 2011, and this trend continued until 2014 Cocaine peaked among new entrants in 2009 at 19.0%, dropping steadily thereafter until 2012 and then increasing again to 51.2% in 2014. In 2004, 5.6% of new entrants reported ecstasy as their main problem drug, but it dropped to 1.0% in 2014. Both amphetamines and ecstasy are reported only very rarely by new entrants to treatment.
In 2014, 'other drugs', mainly benzodiazepines, were the third largest group of drugs reported by new entrants as their main problem drug.




Source: TDI
**Figure 2.1.1 Trends in number of first-time clients entering treatment, by primary drug, 2004–2014**

**All treatment entrants (Figure 2.1.2)**

In 2014, a total of 9,523 entrants were recorded in the NDTRS (see also TDI). This represents an increase of 9.7%, compared to 8,684 in 2013. Of these, the majority had been previously treated (55.4%).

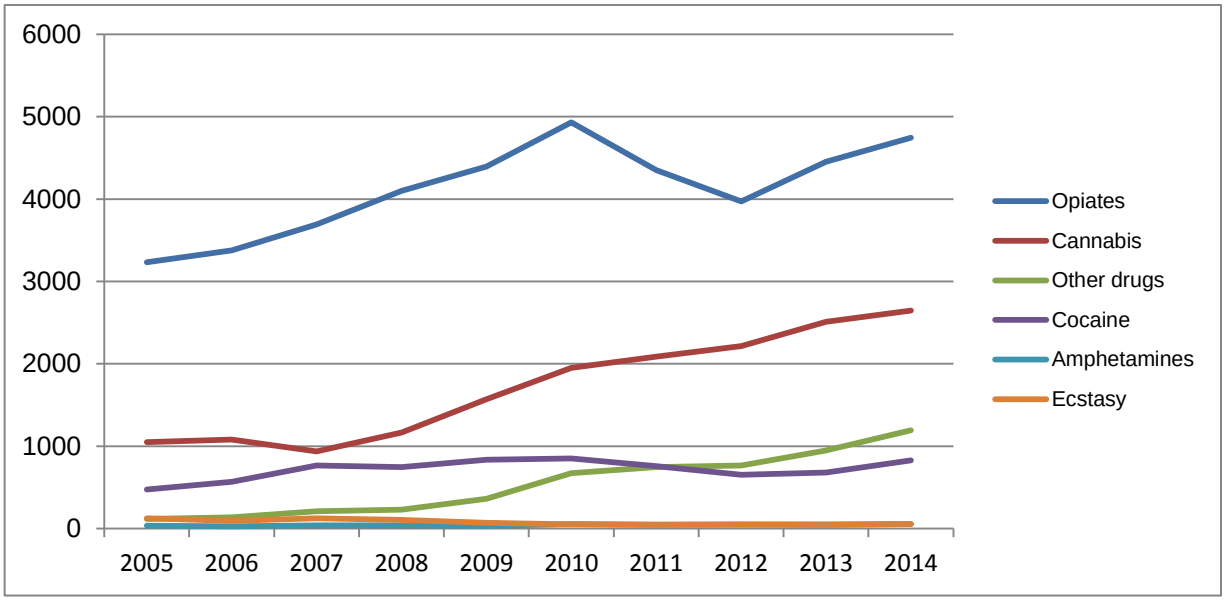
In 2014 opiates, mainly heroin, were the main problem drug used by entrants to treatment. The absolute number presenting for problem opiate use increased between 2004 and 2010, dropped in the two subsequent years, and then increased slightly in 2013.
However, looking at the *proportion* of opiate cases compared to the total, it has decreased year-on-year over the past 11 years, from 64.6% in 2004 to 51.6% in 2012, when it plateaued, but still with a slight decrease, in 2013 to 51.3%. In 2014 a further decrease to 49.8% was observed.

Between 2004 and 2014, cannabis was consistently reported as the second most common problem drug, with the proportion increasing slightly from 21.2% in 2004 to 27.8% in 2014. The numbers presenting for treatment for problem cocaine use was highest in 2007 at 13.3%, dropping steadily

then until 2012 when it stabilised, but the number of cases increased again in 2014. Both amphetamines and, to a lesser extent ecstasy, are reported very rarely by entrants to treatment.

In 2014, 'other drugs', mainly benzodiazepines, were the third largest group of problem drugs reported.

**Please note** the data reported through TDI are a different selection from the data reported in the regular NDTRS web updates and interactive tables, so figures reported through these sources will differ slightly.

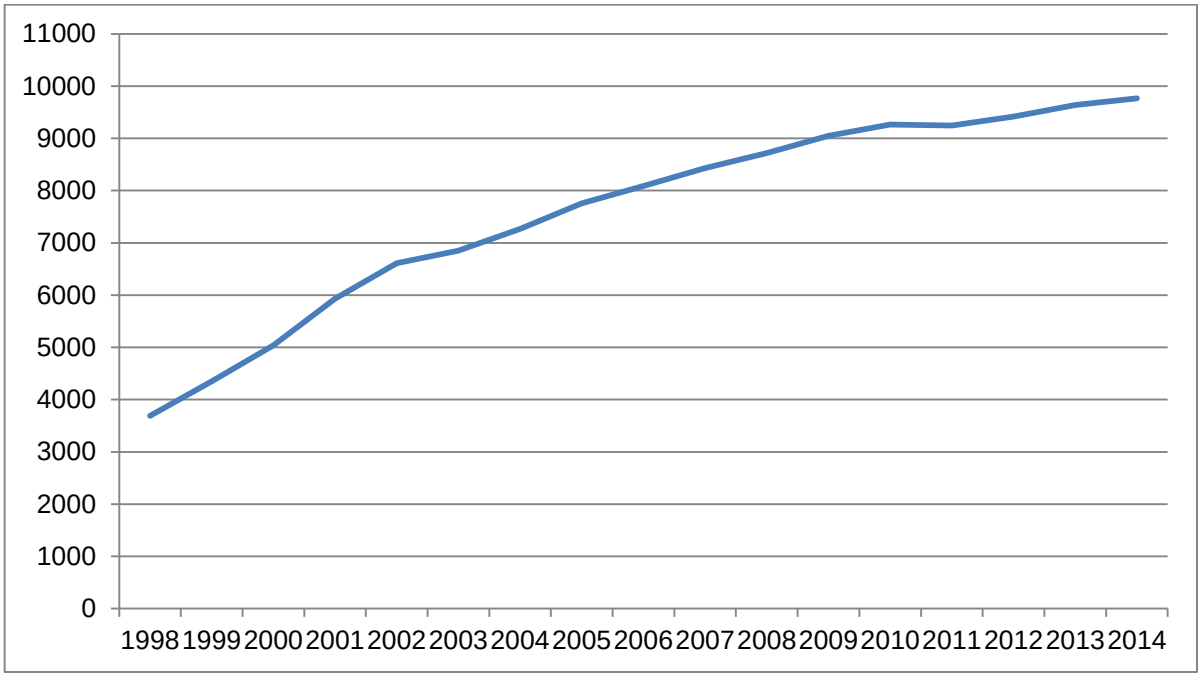



Source: TDI
**Figure 2.1.2 Trends in number of all clients entering treatment, by primary drug, 2002–2014**

### Opioid substitution treatment (OST) clients (Figure 2.1.3)

The number of clients registered for OST on 31 December each year reported by the Central Treatment List (CTL) has increased from 3,689 in 1998 to 9,764 in 2014 (personal communication, Caroline Comar, CTL). The increase is due to the inception of the service in 1998, with year-on-year more clients coming to treatment and more facilities becoming available (Farrell and Barry 2010). Since 2008 the rate of increase has been less than 4% annually. This may reflect a change in patterns of drug use, but analysis of other sources, including treatment data and numbers of problem drug users, is necessary to explore this further.

The proportion of older clients has fluctuated. In 1998, the proportion of clients aged 45 years or older was 18.1%, dropping steadily to a low of 9.1% in 2009 and then increasing to 16.4% in 2014. This trend is mirrored by the proportion of younger clients aged 25 years or younger, albeit smaller numbers. The proportion of this group increased from 0.1% in 2000 (none were registered before that) to a peak of 6.7% in 2010. Since then the proportion has decreased year-on-year to 3.0% in 2014.




Source: ST 24 (Central Treatment List)

**Figure 2.1.3 Trends in number of clients in opioid substitution treatment, 2004–2014**

## 3. Sources and references

### 3.1 Sources

Data on drug treatment in Ireland are collected through two national data collection tools – the **Central Treatment List (CTL)** and the **National Drug Treatment Reporting System (NDTRS).**

The **CTL** is an administrative database to regulate the dispensing of methadone treatment. Established under Statutory Instrument No 225 (Minister for Health and Children 1998), it is a complete register of all patients receiving methadone (as treatment for problem with opiate use) in Ireland. 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 dispensed in community pharmacies. Numbers on the CTL are published annually by the Health Service Executive and Health Research Board.

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 co-ordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health.

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## European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised 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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Drugs Policy Unit, Department of Health
Forensic Science Ireland
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Hospital In-Patient Enquiry Scheme, Health Service Executive
Irish Prison Service
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